

Quality Account 2025/26

	Page
Part 1:	
Statement on quality from the Chief Executive	3
Part 2:	
Priorities for improvement and statements of assurance	5
Our approach to Quality Improvement	6
Our quality priorities for 2026-27	8
Statements of Assurance from the Board of Directors	14
Our commissioned services	16
Our participation in clinical audit and review	16
Our participation in clinical research	29
Commissioning for Quality and Innovation (CQUIN) payment framework	30
Our registration with the Care Quality Commission (CQC)	30
Our Data Quality	32
Our Information Governance Assessment Report	32
Payment by Results	33
Learning from deaths	34
Standards for Seven-day services	38
How our staff can speak up	38
Guardian of Safe Working	40
National Core Set of Quality Indicators	42
Part 3:	
Our performance against the Single Oversight Framework	48
Our performance against our Quality Priorities in 2025-26	49
Annex one:	
Statements from key stakeholders	53
Our response to the statements	56
Independent Auditor's statement	56
Annex two:	
Statement of Directors' Responsibilities in respect of the Quality Account	57

Part 1 Statement on quality from the Chief Executive

I am pleased to present our Quality Account for 2025/26, which sets out how we have worked to improve the quality of care across the St George's, Epsom and St Helier University Hospitals and Health Group. This report fulfils our statutory duty under the Health Act 2009 and the NHS (Quality Accounts) Regulations 2010 to publish an annual Quality Account describing the quality of our services in terms of patient safety, clinical effectiveness and patient experience.

This has been a demanding year for our services, shaped by sustained operational pressures, continued regulatory scrutiny, and ongoing financial challenges across the wider NHS. Despite this backdrop, our staff have worked tirelessly to maintain high-quality, compassionate and safe care.

As we mark the fourth anniversary of working together as a Group, we continue to see the benefits of shared leadership, aligned improvement approaches and strengthened governance arrangements. This is reflected in the development and implementation of our Group Quality and Safety Governance Improvement Plan, which is enhancing standards, improving oversight and embedding consistency across our hospitals.

A key achievement this year has been the launch of iClipPro, our new shared electronic patient record system, which brings together multiple IT systems and gives clinicians access to real-time information. This is a major step forward in improving safety, reducing delays and enabling more efficient care.

Demand for our services remained exceptionally high throughout 2025/26, particularly within urgent and emergency care, alongside increasing patient acuity and complexity. Whilst these pressures presented significant challenges, our staff demonstrated remarkable resilience and commitment in maintaining high standards of care. We recognise that there is more to do to improve patient flow, reduce waiting times and ensure patients receive care in the most appropriate setting, and these areas remain central to our improvement programme for the coming year.

Following CQC inspection in 2024/25 with receipt of the related final report in 2025, we have responded to the areas identified for improvement by the CQC including our Emergency Department. As a result, the safety domain is now at the Requires Improvement level rather than Inadequate. We remain fully committed to delivering services that are safe, well led and continuously improving including quarterly CQC engagement to provide assurance and monitoring of actions taken.

Our staff continue to be our greatest asset. Results from the 2025 NHS Staff Survey show encouraging improvements across several People Promise themes, alongside areas requiring further focus. We have continued to strengthen a culture of openness, psychological safety and inclusion, supported by Executive roadshows, Group-wide Teams Live events, and Freedom to Speak Up initiatives. These efforts remain vital to ensuring that colleagues feel heard, respected and supported.

Reflecting on our Quality Priorities for the past year, we acknowledge that while we did not achieve everything, we set out to do, meaningful improvements have been delivered, and we are clear about where to focus our efforts in the year ahead. As always, our staff remain at the heart of everything we do. Their compassion, professionalism and resilience, particularly during a period of sustained financial and operational pressure, continue to inspire me and define the care we provide.

I would like to extend my sincere thanks to all our staff for their dedication, professionalism and compassion during what has been an exceptionally challenging year for the NHS. Their commitment to our patients and to each other remains central to the progress we have made and to the improvements we will continue to deliver.

To the best of my knowledge, the information in this Quality Account provides an accurate and fair reflection of the quality of care we deliver across the Trust.

A handwritten signature in black ink, appearing to be 'MS' followed by a stylized flourish.

Matthew Shaw
Group Chief Executive Officer

24 June 2026

Part 2

2.0 Priorities for improvement and statements of assurance from the board

2.1 Our quality priorities for 2026/27

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

Our vision is to deliver outstanding care, together:



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

We will deliver our vision through:

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



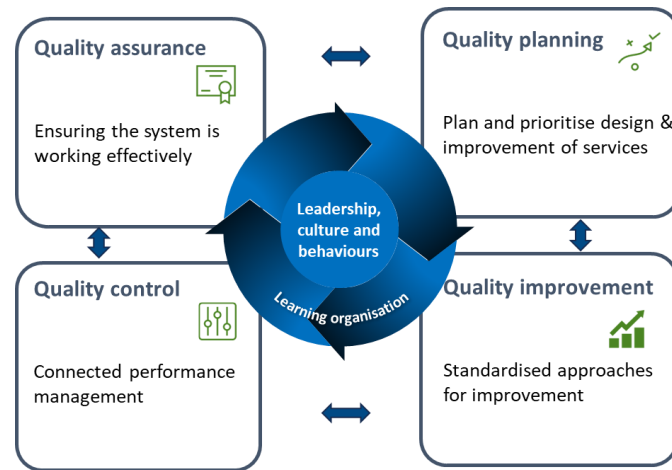
Our Approach to Quality Improvement

Building a Continuous Improvement Culture across and GESH group

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

At gesh, our Continuous Improvement (CI) approach is focused on delivering the components as outlined in NHS England’s NHS IMPACT programme and acts as a key delivery mechanism for our Trust Strategy. By building a systematic and iterative approach to improvement, we aim to ensure that quality improvement becomes embedded as “business as usual”, supporting a culture where continuous improvement is part of everyday practice, pursued by teams of staff at every level in our organisations, from Board to ward, within a common framework of priorities. Continuing into 26/27, those shared priorities are outlined in page 8.

During the past year we have taken further steps in our progress towards creating a CI culture across gesh group, it has seen us re-align & commit, through our Group Transformation Plan, to develop and implement a gesh **Quality Management System (QMS)** with a dedicated programme as an evolution of our former High Performing Teams (HPT) initiative. Embedding this across the organisation will ensure our management system provides teams at every level with the capability and capacity to achieve their objectives through continuous improvement, ultimately driving operational excellence across the Group. Our programme is based on the fundamental basis of four dimensions of quality, working together to deliver a connected and learning system with components as highlighted in NHS IMPACT.



Our QMS defines several core processes, listed below, and key capabilities we are defining and developing to enable shared standard practices and greater interaction throughout our system.

- Strategy deployment / embedding care
- Quality assurance / governance
- Performance rhythm, process & behaviours
- Improvement Capability Development
- Daily improvement system
- Leadership development
- Governance framework (SORD, Accountability framework)

Over the last 12 months, the roll-out of our approach has progressed steadily, with a strong focus on aligning all improvement activity to the Trust's strategic priorities and measures. This alignment ensures that improvement work supports delivery of our organisational objectives while empowering teams to address challenges within their local services.

To build our daily improvement system we have launched our **High Performing Wards** initiative across gesh, supported by the introduction of **Improvement Huddles**. These are short, focused conversations (10–15 minutes) where teams collaboratively identify problems, discuss improvement ideas, and agree tangible actions all aligned to ward priorities. Improvement huddles are designed to empower those closest to the work to solve problems and drive meaningful change, while strengthening the connection between ward-level improvement and Board priorities.

During 2025/26, the Continuous Improvement Team redesigned our improvement training offer with a new 5-year improvement capability development plan to improve accessibility and significantly expand our reach. This will enable us to increase the number of staff trained each year **from around 300 to over 1000 with common approaches, principles & tools**, supporting the development of improvement capability across the organisation. Many participants in our programmes have also been recognised through the gesh **CARE Awards**, our annual staff awards celebrating exceptional achievements and outstanding improvements led by our teams.

Notable examples of improvement driving benefits for patients, staff, the trust and the environment include:

- Supporting a successful innovation programme to transform the primary arthroplasty "Day Zero" pathway ensuring that 100% of suitable [patients are discharged within 23 hours, reducing length of stay from 2.07 to 1.76 days for total knee replacement and

from 1.76 50 1.5 days for total hip replacements, saving £344,518 through reduced bed days & an annual footprint reduction of 32,00 kgCO_{2e}

The continuous improvement team continue to support several priority areas and services across the group including maternity services at St George's building a team improvement huddle routine to embed and deliver improvements identified during staff engagement following CQC review, theatre efficiency at St George's, coaching the mechanical thrombectomy team in their project to reduce time to treatment, supporting the Fundamentals of care team at ESTH and supporting our Non elective care transformation programme as part of the organisations Medium term plan.

It has been a busy year building upon existing activities, embarking on closer collaboration with a number of core teams in defining and delivering on our Quality Management System ambition and enhancing our intranet information and further resources.

Our quality priorities for 2026/27

We identified our quality priorities under three quality themes:

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

Our Quality Priorities for 2026/27 were informed by:

- Progress against the Quality Priorities for 2025/26 (see Part 3)
- Themes highlighted from our ward and departmental accreditation programme
- The findings of CQC inspections between October 2024 and August 2025 and the resulting improvement action plans
- Analysis of our complaints and PALs enquiries
- Analysis of our incidents
- Local and national audit
- National priorities for sepsis, safe staffing, falls, pressure ulcer prevention, and infection prevention and control

As with previous years we have linked our Quality Priorities for 2026/27 to our 5-year strategy for St George's, Epsom and St Helier Hospitals Healthcare Group (2023-2028) which has the following domains:

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

Our Quality Priorities for 2026/27 will help us to deliver our strategy for Right care, Right place, Right time.

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

Priority 1 – Improve Patient Safety

Patients are safer when there is a safety culture that is fully embedded in everyday business. We believe that all our staff have responsibility to take all necessary steps to avoid harm to our patients, to learn from best practice, deliver the best possible outcomes and reduce unwarranted variation. **Priority 1 – Improve Patient Safety 2026-27**

Domain from 5-year Clinical Strategy: Right care, right place, right time

Improve patient safety	Improve patients' outcome and experience with us
------------------------	--

Quality and Safety Strategy

Strong Governance	A learning Organisation
-------------------	-------------------------

What	How	What will success look like
1.1 We will improve our VTE risk assessment / screening performance in line with national guidelines.	We will get the basics right every time and consistently complete VTE risk assessment and screening performance in line with expected standards of performance	VTE risk assessment reporting and processes for learning from hospital acquired thrombosis will be integrated into divisional governance frameworks across clinical divisions. Quarterly evidence-based audits of VTE prevention compliance will be completed at a ward and service level, ensuring it is routinely tracked, reported, and acted upon. Clear improvement will be seen from each site baseline towards 95% target for VTE risk assessment within 14 hours of admission.
1.2 We will improve our safety for patients undergoing interventional procedures.	We will ensure that all invasive procedures carried out in non-theatres settings are appropriately documented using a local safety checklist (LocSSIPs). We will ensure that we improve data collection of NatSSIPs compliance in theatres setting and implement an audit tool to monitor compliance.	Invasive procedures carried out in non-theatres settings will be appropriately documented using a local safety checklist (LocSSIPs). All clinical services will have an associated LocSSIP audit that measures compliance against standards and is reviewed at least annually within the service. NatSSIPs2 audit data in theatres will be collected at least 6 monthly in all theatre suites and results fed back and discussed within theatres teams to guide areas for improvement.

Priority 2 - Improve patient experience

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

Priority 2 - Improve patient experience 2026-27		
Domain from 5-year Clinical strategy: Right care, right place, right time		
Reduce waiting times		
Quality and Safety Strategy		
Shorter Waits		A learning Organisation
What	How	What will success look like
2.1 Corridor Care: We will improve quality and safety for all our patients who are cohorted or boarded, including those within the Emergency Departments	We will ensure consistent delivery of fundamentals of care.	The Trust will adopt the new NHS England definition of corridor care and use it consistently in internal reporting and escalation processes. Routine visibility of patients receiving care in non-designated clinical areas, including duration, location and associated risk. Regular review of harms associated with boarding or corridor care, including falls, pressure ulcers, deterioration, incidents and patient experience concerns.

Priority 3 - Improve effectiveness and outcomes

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

Priority 3 - Improve effectiveness and outcomes 2026-27			
Domain from 5-year Clinical Strategy: Right care, right place, right time			
Reduce waiting times	Improve patient safety	Improve patients' outcome and experience with us	Tackle health inequalities
Quality and Safety Strategy			
Shorter Waits		A learning Organisation	
What	How	What will success look like	
3.1 We will embed Martha's Rule across our organisation to ensure that patients, families and carers have access to urgent review from a separate care team if they have a concern.	We will embed an effective pathway for escalation and review.	Staff are able, at any time, to request review from a different team where they are concerned deterioration is not being responded to. A visible escalation route is available to patients, families and carers across both sites and is consistently advertised in inpatient areas. Martha's Rule activity, including escalation calls, themes, acute deterioration concerns and outcomes, is routinely monitored and reported through governance arrangements, to be further defined.	
3.2 We will improve our Quality and Safety Clinical Governance through standardised clinical data-sets, consistent reporting and delivery of the Quality and Safety Governance Improvement Work Plan.	We will embed an improved framework for Quality and Safety Governance.	A standardised minimum quality dataset is in place for all Divisions across the Group to support consistent divisional governance reporting. The Quality and Safety Governance Improvement Work Plan is in place, with agreed milestones, ownership and routine reporting on delivery through established governance routes. Core outputs from the improvement work plan are delivered, including improved agendas, annual planners and reporting cycles, so that quality and safety issues are tracked systematically rather than retrospectively.	

2.1.4 How progress to achieve these priorities will be reported

The progress against 'what will success look like' will be reported and monitored by quarterly progress reports to site Patient Safety and Quality Group meetings and the Quality Committees, a sub-committee of the Trust Board.

2.1.5 Progress against priorities for 2025/26

[See part 3 page 47]

2.2 Statements of assurance from the Board of Directors

We recognise the considerable pressures faced by our services this year, including industrial action, winter pressures and challenging financial constraints. Nonetheless, we remain assured that our staff have continued to provide safe, compassionate, patient-centred care, and that maintaining quality has remained the Trust's highest priority, even while making difficult decisions required for financial recovery. The Board has been unequivocal that no cost improvement plan will be approved if it has a negative impact on patient safety.

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

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

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

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

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

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

Regulatory Compliance and CQC Engagement

The Board has maintained close oversight of all Care Quality Commission (CQC) inspection activity during the year. This has included:

- The Well-Led inspection report for St George's published in August 2025 following the inspection in February 2025, confirming the Trust's rating remained "Requires Improvement." The Board recognises the significance of the findings, particularly the need to strengthen psychological safety, and is assured by the organisation's early, open response and commitment to improvement.

- The publication of CQC reports for maternity, urgent and emergency care, and surgery services at St George's in August 2025, noting improvements in maternity alongside areas requiring continued focus, and actions taken to address concerns such as overcrowding in urgent and emergency care.
- Recognition that the Section 29A warning notices for Maternity Services and Urgent and Emergency care services have expired following a period of targeted service improvement.
- The CQC carried a focussed assessment of Urgent and Emergency services in January 2026 to assess the improvements that the trust had made. They rated the service as requires improvement noting that in the safe domain the service had made improvements and was no longer in breach of regulations. However not all changes had been fully embedded in practice. The rating for Safe has moved to requires improvement.
- The publication of a CQC inspection report for urgent and emergency care at St George's in March 2026, noting improvements alongside areas requiring continued focus, such as overcrowding.

The Board is confident that the Trust has responded constructively to all CQC feedback and that robust governance arrangements are in place to monitor progress and maintain oversight.

Quality Governance and Improvement

We have overseen the development and implementation of the new Group Quality and Safety Governance Improvement Plan, which sets out the strengthened standards, training, governance processes and oversight arrangements required to embed high-quality care consistently across the Group. This improvement initiative will be built on further in 2026/27 and the Board will continue to receive regular assurance through the Quality Committee on the delivery of this improvement programme, which aligns with our Group Quality and Safety Strategy.

Patient Experience and Survey Outcomes

In May 2025 the Board welcomed the national CQC Maternity Survey results for 2024, which show performance in line with national averages and highlights areas of strong practice, including kindness after birth, mental health support and partner involvement. The results also showed above-average performance for staff communication and postnatal support at St George's. We recognise areas for continued improvement, including the need to strengthen staff awareness of women's medical histories during antenatal checks, and have oversight of actions to address these findings.

Workforce: Culture, Engagement and Inclusion

Our staff remain the Trust's greatest asset. The Board has been encouraged by the increased completion rates and positive trends in the 2025 NHS Staff Survey, including significant improvements at St George's and progress across the People Promise indicators.

We also note the mixed but improving picture presented in the latest WRES and WDES reports and are committed to delivering the associated action plans to build a more inclusive, fair and supportive organisation for all colleagues.

The Board has also valued staff engagement initiatives including Executive roadshows, Teams Live events, and the Freedom to Speak Up Month, which has focused on psychological safety and listening well—critical areas aligned with the CQC Well-Led findings.

Service Transformation and Digital Innovation

A major milestone this year was the successful launch of iClip Pro, our new shared electronic patient record system across the Group. This represents a transformational development for care quality, patient safety and efficiency, giving clinicians access to comprehensive real-time information, reducing delays and streamlining administrative processes. The Board is assured by the strong clinical leadership and preparation that underpinned this significant rollout.

Financial Stewardship and Impact on Quality

The Board has maintained clear oversight of the significant financial challenges facing the organisation and the wider system. We have engaged directly with staff through financial recovery roadshows and ensured that governance arrangements—particularly around cost improvement plans—include rigorous quality and safety impact assessments. We are assured that the organisation remains committed to protecting high-quality, safe services while addressing financial pressures responsibly.

For our commissioned services

2.2.1 During 2025/26 the Trust provided and/or subcontracted 84 relevant health services. A detailed list is available in the Statement of Purpose on our website www.stgeorges.nhs.uk/about

2.2.1.1 The Trust has reviewed all the data available to us on the quality of care in 84 of these relevant health services through our performance management framework and our assurance processes.

2.2.1.2 The income generated by the relevant health services reviewed in 2025/26 represents 100% of the total income generated from the provision of relevant health services by St George's University Hospitals NHS Foundation Trust for 2025/26.

Participation in clinical audit and National Confidential Enquiries

During 2025/26, 70 national clinical audits and 6 national confidential enquiries covered NHS services that St George's University Hospitals NHS Foundation Trust provides.

During that period St George's University Hospitals NHS Foundation Trust participated in 97% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that St George's University Hospitals NHS Foundation Trust was eligible to participate in during 2025/26 are listed below in Table 1.

Table 1

Project Title	Project Workstream	Relevant	Participating
BAUS Data & Audit Programme	a) British audit Of the investigatiOn and referral of woMen with rEcurrent uRinary trAct infectioN using recent Guidance (BOOMERANG)	Y	Y
BAUS Data & Audit Programme	b) Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	Y	Y
Breast and Cosmetic Implant Registry	Breast and Cosmetic Implant Registry	Y	Y
British Spine Registry	British Spine Registry	Y	Y
Case Mix Programme (CMP)	Case Mix Programme (CMP)	Y	Y
Child Health Clinical Outcome Review Programme	Emergency procedures in children and young people	Y	Y
Child Health Clinical Outcome Review Programme	Stabilisation of the critically ill child	Y	Y
Cleft Registry and Audit NETwork (CRANE) Database	Cleft Registry and Audit NETwork (CRANE) Database	N	N/A
Emergency Medicine QIPs:	a) Adolescent Mental Health	Y	N
Emergency Medicine QIPs:	b) Care of Older People	Y	Y
Emergency Medicine QIPs:	c) Mental Health Self Harm	Y	Y
Emergency Medicine QIPs:	d) Time Critical Medications	Y	Y
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Y	Y
Falls and Fragility Fracture Audit Programme (FFFAP):	a) Fracture Liaison Service Database (FLS-DB)	Y	Y
Falls and Fragility Fracture Audit Programme (FFFAP):	b) National Audit of Inpatient Falls (NAIF)	Y	Y
Falls and Fragility Fracture Audit Programme (FFFAP):	c) National Hip Fracture Database (NHFD)	Y	Y
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	Y	Y
Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal, Newborn and Infant Clinical Outcome Review Programme	Y	Y
Medical and Surgical Clinical Outcome Review Programme	Acute illness in people with a learning disability	Y	Y
Medical and Surgical Clinical Outcome Review Programme	Acute limb ischaemia	Y	Y
Medical and Surgical Clinical Outcome Review Programme	Rib fractures	Y	Y
Medical and Surgical Clinical Outcome Review Programme	Pleural procedures	Y	Y
Mental Health Clinical Outcome Review Programme	Mental Health Clinical Outcome Review Programme	N	N/A
National Adult Diabetes Audit (NDA):	a) National Diabetes Core Audit. Includes: - Care Processes and Treatment Targets - Complications & Mortality - Type 1 Diabetes - Learning Disability and Mental Health - Structured Education - Prisons and Secure Mental Health Settings	Y	Y
National Adult Diabetes Audit (NDA):	b) Diabetes Prevention Programme (DPP) Audit	Y	Y
National Adult Diabetes Audit (NDA):	c) National Diabetes Footcare Audit (NDFA)	Y	Y
National Adult Diabetes Audit (NDA):	d) National Diabetes Inpatient Safety Audit (NDISA)	Y	Y
National Adult Diabetes Audit (NDA):	e) National Pregnancy in Diabetes Audit (NPID)	Y	Y
National Adult Diabetes Audit (NDA):	f) Transition (Adolescents and Young Adults) and Young Type 2 Audit	Y	Y
National Adult Diabetes Audit (NDA):	g) Gestational Diabetes Audit	Y	Y
National Audit of Cardiac Rehabilitation	National Audit of Cardiac Rehabilitation	Y	Y
National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)	National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)	N	N/A
National Audit of Care at the End of Life (NACEL)	National Audit of Care at the End of Life (NACEL)	Y	Y
National Audit of Dementia (NAD)	National Audit of Dementia (NAD)	Y	Y

National Audit of Eating Disorders (NAED)	National Audit of Eating Disorders (NAED)	N	N/A
National Bariatric Surgery Registry	National Bariatric Surgery Registry	Y	Y
National Cancer Audit Collaborating Centre (NATCAN):	National Audit of Metastatic Breast Cancer (NAoMe)	Y	Y
National Cancer Audit Collaborating Centre (NATCAN):	National Audit of Primary Breast Cancer (NAoPri)	Y	Y
National Cancer Audit Collaborating Centre (NATCAN):	National Bowel Cancer Audit (NBOCA)	Y	Y
National Cancer Audit Collaborating Centre (NATCAN):	National Kidney Cancer Audit (NKCA)	Y	Y
National Cancer Audit Collaborating Centre (NATCAN):	National Lung Cancer Audit (NLCA)	Y	Y
National Cancer Audit Collaborating Centre (NATCAN):	National Non-Hodgkin Lymphoma Audit (NNHLA)	Y	Y
National Cancer Audit Collaborating Centre (NATCAN):	National Oesophago-Gastric Cancer Audit (NOGCA)	Y	Y
National Cancer Audit Collaborating Centre (NATCAN):	National Ovarian Cancer Audit (NOCA)	Y	Y
National Cancer Audit Collaborating Centre (NATCAN):	National Pancreatic Cancer Audit (NPaCA)	Y	Y
National Cancer Audit Collaborating Centre (NATCAN):	National Prostate Cancer Audit (NPCA)	Y	Y
National Cardiac Arrest Audit (NCAA)	National Cardiac Arrest Audit (NCAA)	Y	Y
National Cardiac Audit Programme (NCAP):	a) National Adult Cardiac Surgery Audit (NACSA)	Y	Y
National Cardiac Audit Programme (NCAP):	b) National Congenital Heart Disease Audit (NCHDA)	Y	N/A
National Cardiac Audit Programme (NCAP):	c) National Heart Failure Audit (NHFA)	Y	Y
National Cardiac Audit Programme (NCAP):	d) National Audit of Cardiac Rhythm Management (NACRM)	Y	Y
National Cardiac Audit Programme (NCAP):	e) Myocardial Ischaemia National Audit Project (MINAP)	Y	Y
National Cardiac Audit Programme (NCAP):	f) National Audit of Percutaneous Coronary Intervention (NAPCI)	Y	Y
National Cardiac Audit Programme (NCAP):	g) UK Transcatheter Aortic Valve Implantation (TAVI) Registry	Y	Y
National Cardiac Audit Programme (NCAP):	h) Left Atrial Appendage Occlusion (LAAO) Registry	Y	N/A
National Cardiac Audit Programme (NCAP):	i) Patent Foramen Ovale Closure (PFOC) Registry	Y	Y
National Cardiac Audit Programme (NCAP):	j) Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	Y	Y
National Child Mortality Database (NCMD)	National Child Mortality Database (NCMD)	Y	Y
National Clinical Audit of Psychosis (NCAP)	National Clinical Audit of Psychosis (NCAP)	N	N/A
National Comparative Audit of Blood Transfusion:	Major Haemorrhage Audit 2025	Y	Y
National Early Inflammatory Arthritis Audit (NEIAA)	National Early Inflammatory Arthritis Audit (NEIAA)	Y	Y
National Emergency Laparotomy Audit (NELA)	Laparotomy	Y	Y
National Emergency Laparotomy Audit (NELA)	No Laparotomy	Y	Y
National Joint Registry	National Joint Registry	Y	Y
National Major Trauma Registry	National Major Trauma Registry	Y	Y
National Maternity and Perinatal Audit (NMPA)	National Maternity and Perinatal Audit (NMPA)	Y	Y
National Neonatal Audit Programme (NNAP)	National Neonatal Audit Programme (NNAP)	Y	Y
National Obesity Audit (NOA)	National Obesity Audit (NOA)	Y	Y
National Ophthalmology Database (NOD):	a) Age-related Macular Degeneration Audit	N	N/A
National Ophthalmology Database (NOD):	b) Cataract Audit	N	N/A
National Paediatric Diabetes Audit (NPDA)	National Paediatric Diabetes Audit (NPDA)	Y	Y
National Perinatal Mortality Review Tool (PMRT)	National Perinatal Mortality Review Tool (PMRT)	Y	Y
National Pulmonary Hypertension Audit	National Pulmonary Hypertension Audit	N	N/A
National Respiratory Audit Programme (NRAP)	a) COPD Secondary Care	Y	Y
National Respiratory Audit Programme (NRAP)	b) Pulmonary Rehabilitation	Y	Y
National Respiratory Audit Programme (NRAP)	c) Adult Asthma Secondary Care	Y	Y
National Respiratory Audit Programme (NRAP)	d) Children and Young People's Asthma Secondary Care	Y	Y
National Vascular Registry (NVR)	National Vascular Registry (NVR)	Y	Y

Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	N	N/A
Paediatric Intensive Care Audit Network (PICANet)	Paediatric Intensive Care Audit Network (PICANet)	Y	Y
Perioperative Quality Improvement Programme (PQIP)	Perioperative Quality Improvement Programme (PQIP)	Y	Y
Prescribing Observatory for Mental Health (POMH):	a) Improving the quality of valproate prescribing in adult mental health services	N	N/A
Prescribing Observatory for Mental Health (POMH):	b) Use of clozapine	N	N/A
Prescribing Observatory for Mental Health (POMH):	c) Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services	N	N/A
Sentinel Stroke National Audit Programme (SSNAP)	Sentinel Stroke National Audit Programme (SSNAP)	Y	Y
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Y	Y
UK Cystic Fibrosis Registry	a) Cystic Fibrosis - Adults	N	N/A
UK Cystic Fibrosis Registry	b) Cystic Fibrosis - Children	N	N/A
UK Interstitial Lung Disease (ILD) Registry	UK Interstitial Lung Disease (ILD) Registry	Y	N
UK Parkinson's Audit	UK Parkinson's Audit	Y	Y
UK Renal Registry Chronic Kidney Disease Audit	UK Renal Registry Chronic Kidney Disease Audit	Y	Y
UK Renal Registry National Acute Kidney Injury Audit	UK Renal Registry National Acute Kidney Injury Audit	Y	Y

The national clinical audits and national confidential enquiries for which data collection was completed during 2025/26 are listed in Table 2 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. For the remaining projects that the Trust participated in (Table 1) the 2025/26 data collection completes during 2026/27 and therefore submission rates are not available at the time of this report.

Table 2

Project Title	Project Workstream	Submission rate (%)
BAUS Data & Audit Programme	a) British audit Of the investigatiOn and referral of woMen with rEcurrent uRinary trAct infection using recent Guidance (BOOMERANG)	100
BAUS Data & Audit Programme	b) Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	100
Breast and Cosmetic Implant Registry	Breast and Cosmetic Implant Registry	100
British Spine Registry	British Spine Registry	100
Case Mix Programme (CMP)	Case Mix Programme (CMP)	Ongoing
Child Health Clinical Outcome Review Programme	Emergency procedures in children and young people	100
Child Health Clinical Outcome Review Programme	Stabilisation of the critically ill child	Ongoing
Cleft Registry and Audit Network (CRANE) Database	Cleft Registry and Audit Network (CRANE) Database	N/A
Emergency Medicine QIPs:	a) Adolescent Mental Health	0
Emergency Medicine QIPs:	b) Care of Older People	100
Emergency Medicine QIPs:	c) Mental Health Self Harm	100
Emergency Medicine QIPs:	d) Time Critical Medications	100
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	100
Falls and Fragility Fracture Audit Programme (FFFAP):	a) Fracture Liaison Service Database (FLS-DB)	100
Falls and Fragility Fracture Audit Programme (FFFAP):	b) National Audit of Inpatient Falls (NAIF)	100
Falls and Fragility Fracture Audit Programme (FFFAP):	c) National Hip Fracture Database (NHFD)	100
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	Ongoing
Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal, Newborn and Infant Clinical Outcome Review Programme	Ongoing
Medical and Surgical Clinical Outcome Review Programme	Acute illness in people with a learning disability	75
Medical and Surgical Clinical Outcome Review Programme	Acute limb ischaemia	100

Medical and Surgical Clinical Outcome Review Programme	Rib fractures	Ongoing
Medical and Surgical Clinical Outcome Review Programme	Pleural procedures	100
Mental Health Clinical Outcome Review Programme	Mental Health Clinical Outcome Review Programme	N/A
National Adult Diabetes Audit (NDA):	a) National Diabetes Core Audit. Includes: - Care Processes and Treatment Targets - Complications & Mortality - Type 1 Diabetes - Learning Disability and Mental Health - Structured Education - Prisons and Secure Mental Health Settings	Ongoing
National Adult Diabetes Audit (NDA):	b) Diabetes Prevention Programme (DPP) Audit	Ongoing
National Adult Diabetes Audit (NDA):	c) National Diabetes Footcare Audit (NDFA)	Ongoing
National Adult Diabetes Audit (NDA):	d) National Diabetes Inpatient Safety Audit (NDISA)	Ongoing
National Adult Diabetes Audit (NDA):	e) National Pregnancy in Diabetes Audit (NPID)	Ongoing
National Adult Diabetes Audit (NDA):	f) Transition (Adolescents and Young Adults) and Young Type 2 Audit	Ongoing
National Adult Diabetes Audit (NDA):	g) Gestational Diabetes Audit	N/A
National Audit of Cardiac Rehabilitation	National Audit of Cardiac Rehabilitation	Ongoing
National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)	National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)	N/A
National Audit of Care at the End of Life (NACEL)	National Audit of Care at the End of Life (NACEL)	100
National Audit of Dementia (NAD)	National Audit of Dementia (NAD)	Ongoing
National Audit of Eating Disorders (NAED)	National Audit of Eating Disorders (NAED)	N/A
National Bariatric Surgery Registry	National Bariatric Surgery Registry	100
National Cancer Audit Collaborating Centre (NATCAN):	National Audit of Metastatic Breast Cancer (NAoMe)	100
National Cancer Audit Collaborating Centre (NATCAN):	National Audit of Primary Breast Cancer (NAoPri)	100
National Cancer Audit Collaborating Centre (NATCAN):	National Bowel Cancer Audit (NBOCA)	100
National Cancer Audit Collaborating Centre (NATCAN):	National Kidney Cancer Audit (NKCA)	100
National Cancer Audit Collaborating Centre (NATCAN):	National Lung Cancer Audit (NLCA)	100
National Cancer Audit Collaborating Centre (NATCAN):	National Non-Hodgkin Lymphoma Audit (NNHLA)	100
National Cancer Audit Collaborating Centre (NATCAN):	National Oesophago-Gastric Cancer Audit (NOGCA)	100
National Cancer Audit Collaborating Centre (NATCAN):	National Ovarian Cancer Audit (NOCA)	100
National Cancer Audit Collaborating Centre (NATCAN):	National Pancreatic Cancer Audit (NPaCA)	100
National Cancer Audit Collaborating Centre (NATCAN):	National Prostate Cancer Audit (NPCA)	100
National Cardiac Arrest Audit (NCAA)	National Cardiac Arrest Audit (NCAA)	Ongoing
National Cardiac Audit Programme (NCAP):	a) National Adult Cardiac Surgery Audit (NACSA)	Ongoing
National Cardiac Audit Programme (NCAP):	b) National Congenital Heart Disease Audit (NCHDA)	N/A
National Cardiac Audit Programme (NCAP):	c) National Heart Failure Audit (NHFA)	Ongoing
National Cardiac Audit Programme (NCAP):	d) National Audit of Cardiac Rhythm Management (NACRM)	Ongoing
National Cardiac Audit Programme (NCAP):	e) Myocardial Ischaemia National Audit Project (MINAP)	Ongoing
National Cardiac Audit Programme (NCAP):	f) National Audit of Percutaneous Coronary Intervention (NAPCI)	Ongoing
National Cardiac Audit Programme (NCAP):	g) UK Transcatheter Aortic Valve Implantation (TAVI) Registry	Ongoing
National Cardiac Audit Programme (NCAP):	h) Left Atrial Appendage Occlusion (LAAO) Registry	N/A
National Cardiac Audit Programme (NCAP):	i) Patent Foramen Ovale Closure (PFOC) Registry	Ongoing
National Cardiac Audit Programme (NCAP):	j) Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	Ongoing
National Child Mortality Database (NCMD)	National Child Mortality Database (NCMD)	100
National Clinical Audit of Psychosis (NCAP)	National Clinical Audit of Psychosis (NCAP)	N/A
National Comparative Audit of Blood Transfusion:	Major Haemorrhage Audit 2025	100
National Early Inflammatory Arthritis Audit (NEIAA)	National Early Inflammatory Arthritis Audit (NEIAA)	Ongoing

National Emergency Laparotomy Audit (NELA)	Laparotomy	70.1
National Emergency Laparotomy Audit (NELA)	No Laparotomy	Ongoing
National Joint Registry	National Joint Registry	100
National Major Trauma Registry	National Major Trauma Registry	Ongoing
National Maternity and Perinatal Audit (NMPA)	National Maternity and Perinatal Audit (NMPA)	100
National Neonatal Audit Programme (NNAP)	National Neonatal Audit Programme (NNAP)	100
National Obesity Audit (NOA)	National Obesity Audit (NOA)	Ongoing
National Ophthalmology Database (NOD):	a) Age-related Macular Degeneration Audit	N/A
National Ophthalmology Database (NOD):	b) Cataract Audit	N/A
National Paediatric Diabetes Audit (NPDA)	National Paediatric Diabetes Audit (NPDA)	Ongoing
National Perinatal Mortality Review Tool (PMRT)	National Perinatal Mortality Review Tool (PMRT)	Ongoing
National Pulmonary Hypertension Audit	National Pulmonary Hypertension Audit	0
National Respiratory Audit Programme (NRAP)	a) COPD Secondary Care	Ongoing
National Respiratory Audit Programme (NRAP)	b) Pulmonary Rehabilitation	Ongoing
National Respiratory Audit Programme (NRAP)	c) Adult Asthma Secondary Care	Ongoing
National Respiratory Audit Programme (NRAP)	d) Children and Young People's Asthma Secondary Care	Ongoing
National Vascular Registry (NVR)	National Vascular Registry (NVR)	Ongoing
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	0
Paediatric Intensive Care Audit Network (PICANet)	Paediatric Intensive Care Audit Network (PICANet)	Ongoing
Perioperative Quality Improvement Programme (PQIP)	Perioperative Quality Improvement Programme (PQIP)	Ongoing
Prescribing Observatory for Mental Health (POMH):	a) Improving the quality of valproate prescribing in adult mental health services	N/A
Prescribing Observatory for Mental Health (POMH):	b) Use of clozapine	N/A
Prescribing Observatory for Mental Health (POMH):	c) Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services	N/A
Sentinel Stroke National Audit Programme (SSNAP)	Sentinel Stroke National Audit Programme (SSNAP)	Ongoing
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	100
UK Cystic Fibrosis Registry	a) Cystic Fibrosis - Adults	N/A
UK Cystic Fibrosis Registry	b) Cystic Fibrosis - Children	N/A
UK Interstitial Lung Disease (ILD) Registry	UK Interstitial Lung Disease (ILD) Registry	0
UK Parkinson's Audit	UK Parkinson's Audit	100
UK Renal Registry Chronic Kidney Disease Audit	UK Renal Registry Chronic Kidney Disease Audit	100
UK Renal Registry National Acute Kidney Injury Audit	UK Renal Registry National Acute Kidney Injury Audit	100

National clinical audits - action taken

The reports of 31 national clinical audits were reviewed by St George's University Hospitals NHS Foundation Trust in 2025/26 and we are taking the following actions to improve the quality of healthcare provided.

Project Title	Action
Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	The latest audit findings from the 2025 report highlighted several areas requiring improvement. In response, the clinical leads outlined the following key actions: - Developing a one-stop haematuria assessment: Working with Radiology to coordinate scanning slots, alongside the requirement for same-day reporting to support timely clinical decision-making. - Reduction of Irrigation Fluid Volume: To improve efficiency and reduce waste work is underway to standardise irrigation fluid by working with Endoscopy as well as Procurement. - Embedding a day-case by default approach for TURBT procedures: This will involve reinforcing expectations with Consultants, Registrars, and Clinical Nurse Specialists undertaking flexible cystoscopies to support appropriate patient selection and pathway adherence.
Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices (I-DUNC)	The latest audit findings highlighted a number of key areas for continued optimisation within the management of upper tract urothelial carcinoma. In response, the following actions were outlined: - Timeliness of Treatment Pathway: Ongoing optimisation of diagnostic ureteroscopy (URS) and diagnosis to nephroureterectomy will be supported through continued review and streamlining of cases via the Urology MDT. - Avoidance of Diagnostic URS Where Appropriate: Cases where appropriate testing has been conducted will be identified and reviewed through the Urology MDT to support appropriate decision-making. - Post-Operative Intravesical Mitomycin C (MMC): Work is required to obtain sufficient nursing

	support to administer intravesical MMC following nephroureterectomy. This has been escalated to the Head of Macmillan Nursing, and potential network-level solutions with neighbouring Trusts are being explored. • Adjuvant Chemotherapy: STG is performing above the national average in the administration of adjuvant chemotherapy for patients with $\geq$pT2 disease following nephroureterectomy. This will continue to be supported and optimised through robust MDT processes to ensure eligible patients are appropriately identified and treated.
Case Mix Programme (CMP)	The Case Mix Programme (CMP) is a national clinical audit of patient outcomes from adult critical care, in which STG continues to actively participate. As part of ongoing quality improvement work, focus for the year ahead will include improving the documentation of discharge decisions from ICU. Specifically, work will be undertaken to ensure that the date and time of decisions to discharge from ICU are recorded for more than 85% of eligible patients across all adult ICUs (GICU, CTICU, and NICU). This will involve liaising with ICU Medical Leads, providing regular feedback on progress, and monitoring compliance to support sustained improvement.
Emergency procedures in children and young people: Right Place, Right Time, Right Team	NCEPOD conducted a review of good practice and remediable factors in the delivery of care provided to children and young people under 18 years old undergoing emergency (non-elective) surgery under anaesthetic or sedation. The following recommendations were made: 1) Provide prompt access to emergency surgical and anaesthetic care by specialists with the relevant training and experience in providing care to children and young people. 2) One or more co-ordinators should be in place to ensure that - Children and young people needing emergency surgery have timely access to a theatre - Patients who were not operated on within their prioritisation period are highlighted and the issue escalated to senior management with responsibility for patient safety/governance 3) Prevent children and young people who are waiting for emergency surgery from being fasted for any longer than necessary. The clinical lead has acknowledged the findings and is developing a gap analysis against current care.
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	The latest report was published in July 2025 for Cohort 6 (1 December 2022 – 30 November 2023). The report highlighted that the Trust's district paediatric epilepsy service has a significantly higher rate of children with co-existing mental health conditions compared with national and regional figures. • The Clinical Lead decided that a dedicated paediatric clinical psychologist is needed to support these children. A business case is being developed for a psychologist to cover all three GESH district epilepsy services (Epsom, St Helier, and St George's). • Quality improvement time for the epilepsy lead is below the regional average, this will be discussed at job planning with the Clinical Director. • Leadership time for the district paediatric epilepsy role is below the national average - this will also be reviewed in job planning.
Fracture Liaison Service Database (FLS-DB)	The latest audit findings from the 2026 report have highlighted a number of areas requiring improvement across the Fracture Liaison Service (FLS). In response, the clinical lead has outlined that a business case supported by the Royal Osteoporosis Society is in development to address a number of factors: • Non-Spine Case Identification • Falls Risk Assessment • Strength & Balance Programme Within 16 Weeks • 16-Week Follow-Up and Treatment at First Follow-Up • 1-Year Drug Adherence Monitoring • Assessment Within 90 Days: The funding proposal supports this actions. In addition, a new postcode and catchment policy was implemented from April 2026 to reduce out-of-area referrals.
National Audit of Inpatient Falls (NAIF)	The latest audit report reviewed performance over the past year and highlighted areas for improvement in patient safety and post-fall care. In response, the clinical lead submitted the following action plan for the upcoming year: • Postural Blood Pressure (BP) Monitoring: Revise BP electric documentation and provide targeted postural BP training for inpatient physiotherapy and occupational therapy staff across medicine, senior health, ortho-geriatric, surgery, and rehabilitation wards, aiming for a recording rate of 60% of eligible patients. • Delirium Screening: Utilise the live delirium dashboard to monitor screening rates in real time at ward, speciality and divisional levels, with the aim of achieving a 65% screening rate. • Timely Analgesia for Fall-Related Injury: Draft and introduce a new section in the Grey Book to improve the time to analgesia for patients following fall-related injuries.
National Hip Fracture Database (NHFD)	The Trust performed within expected limits for several key metrics in the latest report, with some areas identified for further improvement. To address these the clinical lead developed the following action plan: • Timely Admission & Nerve Block (KPI 1): Ensure site management prioritises hip fracture patients for transfer to Trauma & Orthopaedic wards, with a continued focus on improving delivery of nerve blocks in the Emergency Department. • Orthogeriatric Review Within 72 Hours (KPI 2): Maintain strong weekday performance and continue monitoring provision over long weekends. • Prompt Surgery Within 36 Hours (KPI 3): Undertake governance reviews and local audits to better understand theatre delays, including the balance between capacity constraints and patient medical stability. • Early Mobilisation Post-Surgery (KPI 4): Re-establish regular meetings with therapy leads, review cases where mobilisation has not occurred, and consider local audit of relevant audit subcategories to drive improvement.

	• Post-Operative Delirium (KPI 5): Reinforce key nursing interventions, including pain assessment, bowel monitoring, and early mobilisation, in collaboration with the Trauma & Orthopaedic matron. • Return to Original Residence (KPI 6): Maintain current good performance, which remains above the national average, through continued focus on discharge planning. • Bone Health & Follow-Up (KPI 7): Review how this metric is measured and clarify processes, recognising that while most patients have a treatment plan, follow-up is not fully embedded within the current service model. • Mortality: Continue reviewing 30-day mortality outcomes through quarterly governance meetings, with a focus on pathway improvements. • Pressure Ulcers: Sustain progress through ongoing collaboration with nursing teams, particularly around patient repositioning and mobilisation.
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	The Learning Disability (LD) Improvement Plan was reviewed and the clinical lead confirmed that ongoing work and assurance for the year ahead include: • Electronic record Integration for Early Identification: Patients attending ED will be identified earlier through triage by introducing an additional question on learning disability status, alongside existing dementia and delirium screening questions. • Learning Disability Wristbands: Sky blue wristbands have been introduced in ED to support visible identification of patients with learning disabilities. Standard Operating Procedure (SOP) for wristband use is currently under review for approval to ensure consistent implementation and governance. • Training and Communication: A structured training programme will be delivered covering the wristband SOP, documentation requirements, and alert systems. Training will be extended to the wider multidisciplinary team to ensure consistent awareness and application of reasonable adjustments. • Hospital Passport Review and Communication Needs: The Learning Disability passport will be reviewed where available, with emphasis on identifying communication needs, sensory preferences, and known triggers to support personalised care planning. • Reasonable Adjustments in Care Delivery: Staff will ensure appropriate adjustments are made, including allowing additional time for assessments, using simple language and visual aids, and minimising environmental stressors such as noise and bright lighting to improve patient experience and engagement. • Pain Assessment for Non-Verbal Patients: Pain will be assessed using appropriate tools, supported by observation of non-verbal cues including facial expressions and body language to ensure accurate assessment and management. • Documentation and Handover: Key adjustments and interventions will be clearly documented in patient records, with communication of LD-related needs included in multidisciplinary handovers to ensure continuity of care. • Use of TEACH Communication Principles: Staff will apply structured communication approaches including speaking slowly and clearly, breaking information into steps, checking understanding, and maintaining a calm environment to support effective patient interaction. • Escalation and Specialist Support: Staff will be encouraged to seek support from senior ED clinicians and liaise with the Learning Disability Team or LD Champions where additional guidance or specialist input is required.
Maternal, Newborn and Infant Clinical Outcome Review Programme	The latest MBRRACE Perinatal Mortality Surveillance findings have identified key areas for improvement in neonatal and perinatal care. The clinical lead reviewed the reports and submitted the following action plan: • Increase NICU Capacity for Extremely Preterm Babies (<24 weeks): Recruit additional medical staff and expand nursing training, including Qualified in Specialty (QIS) development, to support increased demand and improve care provision. • Strengthen Review of Stillbirths and Neonatal Deaths: Implement enhanced external clinical review processes through network-level collaboration to ensure robust and consistent learning. • Implement British Association of Perinatal Medicine Optimisation Pathway: Audit compliance with optimal cord management and improve wider perinatal optimisation measures, including admission temperature, administration of antenatal steroids, early colostrum, and use of perinatal passports. • Reduce Health Inequalities: Develop and introduce a perinatal passport with language support to improve communication and accessibility for families, and implement a parental census for families visiting the Neonatal Unit to better understand and address inequalities at both organisational and national levels.
Acute Limb Ischaemia: Risking Life and Limb	NCEPOD reviewed the care of patients who were admitted to a vascular hub as an emergency to improve the care of patients with acute limb ischaemia (ALI). The following recommendations were made: 1) Raise awareness of acute limb ischaemia, how to recognise it and what actions to take to reduce delays in the treatment pathway. 2) Risk stratify and refer/transfer patients with symptoms of acute limb ischaemia and new sensory or motor impairment directly to a vascular hub. 3) Organise vascular networks to provide timely access to vascular specialists skilled in treating people with acute limb ischaemia. 4) Develop a national guideline for the management of acute limb ischaemia. 5) Support the national vascular registry to capture focused data on acute limb ischaemia, and to report on procedures and outcomes for patients with ALI The clinical lead reviewed the findings and conducted a gap analysis against all appropriate recommendations.
Blood Sodium: A Balanced Solution	NCEPOD carried out a review of the quality of care provided to adults in hospital identified as having hyponatraemia (low blood sodium levels) or hypernatremia (high blood sodium levels). The report outlined the following recommendations:

	1) Implement processes to reduce variation in the assessment and management of abnormal blood sodium levels. 2) Develop clear standards and tools for the assessment and recording of fluid status in all patients with abnormal blood sodium levels including, when appropriate, the use of point-of-care ultrasound. 3) Integrate point-of-care testing results into patient electronic records. 4) Develop a national standard for the use of hypertonic saline in the management of hyponatraemia. 5) Raise awareness of the importance of documenting and communicating all medication changes made in hospital to primary care as well as the patients and their family/carers. The clinical service has reviewed the findings and the project lead is producing a gap analysis against existing care.
Rehabilitation Following Critical Illness: Recovery Beyond Survival	NCEPOD reviewed the quality of rehabilitation care provided to patients following an admission to an intensive care unit. The report laid out a number of recommendations: 1) Improve the co-ordination and delivery of rehabilitation following critical illness at both an organisational level and at a patient level. 2) Develop and validate a national standardised rehabilitation screening tool to be used on admission to an intensive care unit. 3) Undertake and document a comprehensive, holistic assessment of the rehabilitation needs of patients admitted to an intensive care unit at risk of physical and/or non-physical morbidity. 4) Ensure that multidisciplinary teams are in place to deliver the required level of rehabilitation in intensive care units and across the recovery pathway. 5) Standardise the handover of rehabilitation needs and goals for patients as they transition from the intensive care unit to the ward and ward to community services. 6) Provide patients and their family/carers with clear information about their admission to an intensive care unit, impact of critical illness and likely trajectory of recovery. The clinical lead responded to the findings with a gap analysis against appropriate findings for the current care provided.
National Audit of Dementia (NAD)	The was no report published in 2025/26, however the clinical lead has been reviewing local data flows and shared the following ongoing work: • Enhance Dementia Identification: Conduct a Training Needs Analysis and develop an education plan with an options appraisal; standardise Tier 2 dementia training across STG; update the patient incident reporting system to capture dementia and delirium in relevant incidents (e.g. falls, violence, pressure sores). • Improve Person-Centred Care: Increase the use of hospital passports ("This is me"); roll out the Alzheimer's Society "Forget Me Not" scheme; review ward local audit criteria to strengthen person-centred care standards. • Strengthen Monitoring and Oversight: Implement a dementia and delirium reporting dashboard to support performance monitoring; monitor screening and compliance through monthly heatmaps to identify areas for improvement. • Enhance Carer Involvement and Experience: Relaunch John's Campaign and carer passports to improve carer engagement; update the carer survey with input from community carers to strengthen feedback and support. • The Trust has signed up to participate in a national census day audit in 2026.
National Bariatric Surgery Registry	The latest results indicate that clinical performance and data accuracy has improved across all bariatric procedures entered. The clinical lead identified key areas for improvement: • Ensuring organisational understanding of the lag between data entry and publication of registry reports, as upcoming reports may still reflect historical performance. In addition, there is a need to improve consistency in data entry among consultants, particularly where tasks have not been delegated. Historical gaps in data have also been identified due to Fellows leaving early without appropriate handover, and processes are being put in place to ensure delegation in such instances going forward. • Risks have been identified in relation to the expected lag in registry reporting, which may continue to show apparent non-compliance despite recent improvements. There are also concerns regarding incorrectly coded procedures and low procedural volumes for some consultants, which may require further review. The lead provided assurance that audit results demonstrate clear improvement compared to previous years, and ongoing monitoring will be undertaken through regular review of unit data at biannual service meetings to ensure sustained compliance with data entry requirements.
National Audit of Primary Breast Cancer (NAoPri)	The National Audit of Primary Breast Cancer 2025 report indicated that the Trust's performance continues to be strong across key metrics. The clinical lead confirmed ongoing work and assurance for the year ahead includes: • Triple Diagnostic Assessment (TDA): Ensure patients have access to TDA in a single visit. This is fully achieved through the One Stop Clinic model. • Neo-Adjuvant Chemotherapy (NACT): Continue to review use in patients with triple negative and HER2+ early invasive breast cancer. STG is performing above national expectations, ensuring eligible patients are offered NACT in line with guideline recommendations. • Immediate Breast Reconstruction (IBR): Maintain high rates of IBR and continue offering this option to all women as part of balanced shared decision-making, except where contraindicated by comorbidity or adjuvant therapies. Performance remains well above the national average. • Re-Operation Following Breast-Conserving Surgery (BCS): Monitor local protocols to maintain low re-operation rates. STG continues to perform better than the national average. • Breast MDT Data Quality: Ensure full tumour characterisation, ER/HER2 status, performance status, NABCOP fitness assessment (aged 70+), TDA, and CNS contact are recorded contemporaneously at weekly MDTs. Validation by individual clinicians and processing by the

	Cancer Services Data Team ensures high-quality national data submission, with recent COSD performance confirming completion.
National Bowel Cancer Audit (NBOCA)	The latest review of performance informed the following actions which were developed by the clinical lead in collaboration with the clinical audit and data teams: • Review Performance Against KPIs: Analyse performance against the 2024 NBOCA KPIs, including collection and review of data from major resections to identify areas for improvement. • Improve Data Quality: Work with the data team to ensure that data are accurately and consistently captured across all databases used for NBOCA submission. The clinical lead also received positive feedback from NBOCA, noting that STG is a positive outlier for the percentage of patients with an unclosed ileostomy 18 months after anterior resection (SGH 13.7% vs national 38%).
National Kidney Cancer Audit (NKCA)	The clinical lead developed an action plan in response to the latest results: • Improve Access to Renal Biopsy Diagnostics: Review access to timely CT and ultrasound guided renal biopsy pathways to increase the proportion of people with small kidney cancers receiving histological confirmation and to support shared decision making. • Review Higher-Risk RCC Pathways: Continue to monitor pathways for people with higher-risk renal cell carcinoma (RCC) to ensure system-level delays are minimised and that patients are prioritised appropriately to meet national treatment timelines. • Maintain Surgical Assessment for Eligible Patients: Continue to ensure that people with stage T1b–3NX RCC are considered for surgical treatment wherever appropriate. The clinical lead noted that the Trust benefits from a highly specialised high-risk anaesthetic service and extensive anaesthetic expertise, making it uncommon for patients to be deemed unsuitable for surgery. • Maintain Specialist MDT Review for T1 RCC: Continue to ensure that all people with stage T1aNOm0 RCC are discussed at specialist multidisciplinary team (MDT) meetings to support consistent consideration of nephron-sparing surgery (NSS) where feasible. • Maintain Oncology Review for Metastatic RCC: Continue to ensure that people diagnosed with metastatic RCC are reviewed by a medical or clinical oncologist with expertise in renal cancer management to support appropriate consideration for systemic anti-cancer therapy (SACT).
National Lung Cancer Audit (NLCA)	The clinical lead developed an action plan in response to the latest results: • Review Small Cell Lung Cancer (SCLC) Data Submission: Liaise with Cancer Services to access data on SCLC diagnoses for 2024. Where more than 10 cases are identified, work with SACT pharmacists to review how many patients received systemic anti-cancer therapy (SACT). • Assess Emergency Presentation Rates: Liaise with Cancer Services to obtain data on the route of presentation for lung cancer patients in 2024, with a focus on those presenting via the Emergency Department as their first point of diagnosis. • Evaluate Early-Stage NSCLC Treatment Pathways: Work with Cancer Services to identify patients with early-stage (I–II), good performance status (0–2) non-small cell lung cancer. Review medical notes and MDT outcomes to determine decision-to-treat (DTT) timelines and identify patterns in reasons why patients did not receive curative treatment.
National Non-Hodgkin Lymphoma Audit (NNHLA)	The latest State of the Nation Report 2025 outlined several recommended actions, the clinical lead reviewed and provided the following local position: • Emergency Presentations of Non Hodgkin Lymphoma (NHL): No direct actions identified at Trust level, as this is primarily a system-wide issue led by NHS England, Primary Care, and Cancer Alliances. • Timely Treatment Within 62 Days: Current performance is above the national average, with no immediate actions required. Improved outcomes reflect enhanced data completeness and submission. • Radiotherapy Following systemic anti-cancer therapy (SACT): STG is compliant with national requirements, with consistent clinical oncology representation at MDT meetings and quorate standards met. Established clinic provision further supports timely radiotherapy planning; therefore, no additional actions are required at present. • Clinical Trial Participation: All eligible patients are approached for trials available at STG. However, expansion of trial activity is limited by Trust-wide research funding and staffing constraints, which sit outside the department's control.
National Oesophago-Gastric Cancer Audit (NOGCA)	The Oesophago-Gastric (OG) Cancer audit recommendations were reviewed, and actions agreed to support continued improvement in early diagnosis, pathway efficiency, treatment decision-making and patient support: • Early Diagnosis and Emergency Presentations: Medical teams encouraged to utilise Acute Oncology Service (AOS) support to aid early diagnosis and provide oncology input for inpatients presenting as emergencies. Cases where delays in AOS referral have impacted management will be reviewed. In addition, 'radiology red flags' will continue to be discussed at MDT; any missed or delayed flagging resulting in treatment delays will be reviewed by the MDT lead and escalated to radiology for shared learning. • Diagnostic and Decision-Making Pathways: MDT leadership will ensure appropriate clinical cover to minimise delays in decision-making. Current reliance on limited surgical and clinical oncology representation will be reviewed to ensure that absences do not delay treatment planning or initiation. • Palliative SACT Decision-Making and Review: Monthly morbidity and mortality (M&M) meetings will continue, with a focus on reviewing all patients who die within 30 days of receiving palliative systemic anti-cancer therapy. Early dietetic referrals will be embedded, ideally prior to oncology review, to optimise patients before treatment. Nutritional status will also be routinely reviewed at MDT as an additional safeguard. • Clinical Nurse Specialist (CNS) Access: Access to Upper GI CNS support will be monitored. Where gaps are identified, this will prompt consideration of a business case to expand CNS

	provision to ensure timely patient access. • Pathology Data Capture: Ensured that this metric is not incorrectly attributed to STG as this responsibility for audit and reporting remaining with the local specialist cancer hospital.
National Early Inflammatory Arthritis Audit (NEIAA)	The latest audit report covered data from April 2024 to March 2025. In response an action plan was developed by the clinical lead: • Improve capture of cases by recruiting from all consultant's clinics • Improve access to assessment by recruiting other consultants to in review EIA patients, reducing reliance on a single clinician. • Improved access to AS services by increasing the number of AS clinic slots. • Improved time to diagnosis by providing urgent ultrasound slots specifically allocated for EIA patients. • Develop an EIA protocol to improve consistency across consultants, then write the protocol and distribute it.
National Emergency Laparotomy Audit (NELA)	The latest audit report reviewed recent performance and identified key areas for improvement across the patient pathway. The clinical leads confirmed that work for the year ahead will focus on improving communication, documentation, and multidisciplinary input with the following actions: • Radiology and Clinician Communication: Improve documentation of communication regarding critical CT findings by circulating guidance to radiologists to ensure details of discussions are consistently included in reports. • Timely Antibiotic Administration: Strengthen processes to ensure antibiotics are administered within one hour by liaising with SpRs and SHOs, and improving coordination between clinical teams and the Emergency Department. • Geriatrician/POPS Review: Increase rates of specialist review for eligible patients by engaging divisional management to enhance POPS and Geriatrics support, including consideration of tariff implications. • ICU Input Documentation: Improve recording of ICU involvement by exploring the introduction of a NELA checklist within CEPD theatres. • Post-Operative Risk Scoring: Reinforce completion and documentation of post-operative NELA scores through engagement with SpRs and SHOs.
National Joint Registry (NJR)	The clinical lead outlined key areas for improvement and contextual considerations arising from the audit findings, with the following actions and reflections: • Patient Consent for NJR Submission: A dedicated administrative process has been introduced, including the appointment of an NJR administrator to cross-check consent status and follow up directly with operating clinicians where required. Retrospective consent is being obtained in line with NJR guidance, with the aim of achieving full compliance. • Hip Arthroplasty Revision Rates: The unit remains in outlier status for 5-year revision rates; however, this reflects the highly specialised, high-risk case mix managed at the centre. The majority of standard elective total hip arthroplasty cases are undertaken at a separate elective orthopaedic centre, while STG manages complex and high-risk patients, including those with significant comorbidities and trauma-related indications. These patient groups are well evidenced to have higher revision rates. • Tertiary Centre: The outlier status is consistent with other tertiary centres managing similar case complexity. This has been reviewed through multidisciplinary discussions and is considered an expected outcome given the nature of the service. Despite this, outcomes within these high-risk cohorts are reported to be within acceptable ranges, supporting the continuation of this specialist service. • Risk Mitigation and Clinical Pathways: A range of targeted interventions are in place to minimise modifiable risks and optimise surgical outcomes. These include the use of implants with strong long-term survivorship data, availability of advanced prosthetic options, and robust infection prevention measures. In addition, established clinical pathways for patients with complex conditions (e.g. haematological disorders, lymphoedema, and poorly controlled diabetes) are in place, with multidisciplinary input to optimise patients pre- and post-operatively. • Multidisciplinary Oversight and Governance: Complex cases are routinely reviewed through specialist MDT forums involving multiple consultant specialties. Furthermore, all revision cases undergo structured review at dedicated governance meetings to identify themes related to technical or biological failure and inform learning. • Ongoing Audit and Service Improvement: As part of continued quality improvement, a focused audit of pelvic and acetabular fracture revisions is planned to assess whether any additional modifiable risk factors can be addressed. This will support further refinement of clinical pathways and risk reduction strategies.
National Maternity and Perinatal Audit (NMPA)	The lead reported that the focus of actions for the year ahead will centre on sustaining early access to maternity care, strengthening data quality, and improving oversight of clinical outcomes through enhanced governance and data reporting. Key areas of progress and planned actions include: • Timely pregnancy booking - Booking before 10 weeks remains strong, at above 70%, which is higher than the national average (above 50%), providing assurance of effective early engagement with maternity services. • Changing trends in maternity care and outcomes - An updated maternity dashboard has been developed and is awaiting go-live. This will improve the ability to monitor local performance and benchmark against national data. • Rising induction of labour and caesarean section rates have been noted with a review of care in theatre guidance, including escalation processes and use of a second theatre team where required; An ongoing induction of labour (IOL) improvement project to support pathway optimisation. • Unwarranted variation - Ongoing work is in place to reduce variation in outcomes, particularly

	postpartum haemorrhage (PPH) rates, supported by an action plan and enhanced monitoring through the updated maternity dashboard to enable comparison with similar Trusts. • Data definitions and data capture - continued work is underway to improve electronic data capture, including Ensuring mandatory fields are consistently completed; Improving documentation quality and completeness; Strengthening system use across clinical teams. • Data quality optimisation - Ongoing efforts are focused on improving overall data quality through standardisation of data entry practices; reinforcement of mandatory documentation requirements, and monitoring compliance and improvement.
National Neonatal Audit Programme (NNAP)	The audit lead reports that the neonatal team continues to actively engage with network governance processes, mortality reviews and quality improvement initiatives to support safe, effective and equitable neonatal care. Key areas of focus for the year ahead include: • Regular review of mortality, perinatal optimisation and breastmilk feeding data through network and local governance structures, • Ongoing use of NNAP dashboards and Badgernet data to monitor performance, support benchmarking and inform quality improvement activity, • Strengthening data quality and demographic recording through improved ethnicity documentation processes and mandatory staff training, • Collaborative working with neonatal networks, obstetric teams and perinatal workstreams to reduce variation in care and improve neonatal outcomes, • Development of local action plans and participation in network-level reviews and improvement programmes to address identified areas for improvement. The audit lead provided assurance that neonatal audit findings are routinely reviewed through local and network governance arrangements, with learning shared across multidisciplinary teams and quality improvement initiatives implemented to support ongoing service development and re-audit.
National Perinatal Mortality Review Tool (PMRT)	The latest Perinatal Mortality Review Tool (PMRT) report was published in November 2025. Key actions for the year ahead include: • Parental Engagement: Ensure all parents are contacted and offered the opportunity to provide their perspectives and questions, supported by trained staff using PMRT engagement materials. • Adequate Staffing for PMRT Reviews: Review and update job plans to include protected time for staff to attend and contribute to PMRT meetings, ensuring review teams are fully resourced. • Incorporation into Job Plans and Role Descriptions: Include PMRT responsibilities in consultant job plans and relevant role descriptions, formally assigning senior clinical leadership. • External Clinician Participation: Establish arrangements and allocate resources to ensure independent external clinicians are invited, supported, and consistently present at all PMRT meetings. • Prioritising Improvement Activities: Integrate PMRT summary reports and MBRRACE-UK data into quality improvement planning to prioritise and allocate resources to key areas requiring action. • System-Level Quality Improvement: Develop and implement system-level actions from PMRT findings, and establish robust processes to monitor, audit, and evaluate their impact on service quality.
National Vascular Registry (NVR)	The clinical lead reported that the focus of actions for this coming year will focus on improving the accuracy of coding within the National Vascular Registry. Work is being undertaken to develop clearer guidance for the coding of: • Thoracic Endovascular Aortic Repair (TEVAR) procedures for Type B Aortic Dissection, to distinguish these from TEVAR performed for aneurysms, and • Fenestrated Endovascular Aortic Repair (FEVAR) procedures for juxta- or supra-renal aneurysms. Targeted education and guidance will be provided to registrars and surgeons entering data to ensure consistent and accurate use of coding across the service.
Paediatric Intensive Care Audit Network (PICANet)	The clinical lead highlighted areas for ongoing monitoring and service development with the following actions and considerations: • Low Acuity Admissions: A significant proportion of Level 0 and 1 admissions continue to impact PICU capacity. This has been recognised in GIRFT reviews, and further work is required at divisional level to support service reconfiguration and ensure appropriate use of PICU beds. • Long Stay Patients: The unit continues to manage a growing cohort of long-stay patients with complex needs, including those requiring long-term ventilation. Ongoing monitoring will ensure this remains in line with national trends and does not adversely affect capacity. • Mortality and Outcomes: Crude mortality remains low compared to peer units, and the standardised mortality ratio is within expected limits. Continued review is required to understand the influence of case mix, particularly low acuity admissions, on these outcomes. • Readmission Rates: Emergency readmissions within 24 hours are very low. While positive, this may reflect cautious discharge practices or delays in discharge and will be reviewed to ensure optimal patient flow. • Accidental Extubations: Rates have fluctuated slightly, with a small increase noted in the most recent year. All incidents are reported and reviewed patient incident reporting, with ongoing monitoring to identify trends and learning. • Data Quality and Submission: Data submission rates are above the national average, supported by a dedicated data manager. Continued focus on data quality will ensure accurate benchmarking and audit reporting.

Sentinel Stroke National Audit Programme (SSNAP)	The clinical lead reports that the focus of actions for the year ahead will centre on strengthening stroke service delivery following the SSNAP re-set in October 2024, with the team successfully adapting to the new dataset and webtool. Key areas for improvement include addressing workforce pressures within the SSNAP audit team, improving therapy staffing, and reviewing nursing levels and ratios on the Acute Stroke Unit, and improving patient flow on Acute Stroke Unit.
UK Renal Registry Chronic Kidney Disease Audit	The clinical service reviewed the latest findings; from these results the audit lead reports that priorities for the coming year: • Strengthening data collection processes through the introduction of structured onboarding routines for new staff • Ensuring consistent and accurate data capture across the service.

*Based on information available at the time of publication

Local clinical audits

The reports of 10 local clinical audits were reviewed by St George's University Hospitals NHS Foundation Trust in 2025/26 and we intend to take the following actions to improve the quality of healthcare provided.

Local Clinical Audit	Action
Bereavement Survey - End of Life Care	This audit project gathers information on bereaved people's views on the quality of end-of-life care provided to their friend or relative. The project lead reported that the survey is now available online via a QR code and hosted on an external website, alongside a printed version. An issue was identified whereby the printed version did not correspond with the online survey; this has now been resolved. Continued work is required with feedback from responses now being shared with wards, and work is ongoing to increase response rates. A poster is currently being designed for display in waiting areas to encourage participation.
Falls prevention audit	The biannual falls prevention audit provides a snapshot of performance across the organisation and supports continuous improvement through regular review and oversight. Wards are encouraged to monitor their performance using this audit, with findings reported to the Falls Steering Group, Nursing Board, and Patient Safety and Quality Group. The most recent audit highlighted improvements across eight key metrics compared to the previous cycle. The audit lead confirmed that falls prevention teaching remains a key pillar for improvement and continues to be delivered across the Trust through a mix of structured programmes and targeted sessions. Falls related content is included in some MAST, as well as Nurse and Healthcare Support Worker inductions. Targeted local teaching also continues across wards to support staff awareness and practice.
NatSSIPs Theatres Audit	This audit takes place quarterly and examines theatre procedures for adherence to NatSSIPs2 standards. The audit lead confirmed that speciality results are reviewed locally with specific actions drawn up to address shortfalls in performance. For the corporate level report there has been a renewed focus on improvement across the Trust, with NatSSIPs being named a quality priority across the Group. The focus for the year ahead will be to standardise the data collection tools across gesh and to expand reporting into qualitative data.
Non-Theatre LocSSIPs Audit	This audit topic has been identified as a quality priority across the Group. In response the project lead has begun to scope all clinical areas that have LocSSIPs in place, to assess them against the NatSSIPs2 guidance for proportionality and will work with the central audit team to ensure that a new audit is put in place with robust methodology to reflect the diverse landscape of procedures across the Trust.
Consent Audit	This corporate audit assesses the quality of surgical consent by different health professionals in the Trust and identifies areas for improvement. The project methodology has received an update to its methodology in 2025-26 with the first round of renewed project in progress at the time of this report. The audit lead confirmed that actions for the year ahead include: • Working with clinical trainers to review specific patients and ensure consent forms are completed appropriately. • Devolving responsibility of data collection to individual clinical specialities to promote greater engagement and action planning. • Ensuring reporting is completed by divisional leadership to increase oversight and reporting centrally. • Developing benchmarking pages for clinical specialities, divisions and corporate accountability.
VTE Prevention Audit	This audit is conducted quarterly with results and actions monitored by the Hospital Thrombosis Group (HTG). In 2025-26 workforce pressures have led to a delay in reporting of 9 months, however the audit indicated that improvements were required across the Trust to meet the key metrics of the study. A Group wide audit plan was developed in order to standardise methodology and improve performance - the group also highlighted VTE prevention as a quality priority for the coming year. VTE champions have been appointed across clinical divisions but the audit lead highlighted the risk to the Trusts VTE Exemplar Status if these performance figures are not addressed. The following actions were highlighted as key next steps in this process: • Digital improvements: reviewing risk assessment (RA) forms; investigate other digital tools that can be adapted to drive VTE prevention; map out how to report 'clock start' at true decision to admit.

	• Clinical leadership and workflows: work with medical & nursing leadership to drive & maintain improvements; map out patient pathways and clinical workflow to identify opportunities for improvement. • Training: review MAST training modules across gesh; revise who should be trained; review local induction training for resident doctors & nursing staff. • Using data well: review the data sources and reporting across the group; review process to monitor patients waiting >12 hours for admission from ED for RA and treatment.
Controlled Drugs Audit	This audit is carried out quarterly and ensures that controlled drugs are correctly stored and secured across the Trust, and that an adequate record is kept with complies to guidance. The audit lead confirmed that performance across the year has been largely positive. A focus for 2025-26 was adopting a standardised methodology across the gesh group, with 14 new standards adopted. The plan for 2026-27 will be to adopt this Group wide approach and for timely benchmarking data to be made available to drive improvements in areas where attention is required.
Human Tissue Act (HTA): Human Application License Audit in Theatres	The central clinical audit team supported a one-day data collection exercise for this independent audit, which assessed compliance with HTA standards and protocols relating to human tissue storage and application. This included reviewing SOPs for musculoskeletal allografts and Human Application in Theatres. Positive results were recorded across document review, consent, storage, and knowledge. The audit lead welcomed these results and is working to draw up a local audit plan to monitor these metrics over the coming year.
Nutritional Screening Audit	This audit forms part of the wider Fundamentals of Care workstream. The clinical lead presented the latest results to the central quality meeting and reported the following actions: • Aim to provide interventions to specific areas to target full nutritional screening within 24hrs. Specifically targeting BMI, % weight loss, and acute disease effect. • Work with clinicians to ensure accuracy of entries - this work centres around ensuring the % weight loss is captured and carried forward. • Review of patient pathways to ensure barriers to appropriate referrals to dieticians are completed. • Weekly review of patients and referrals are maintained for oversight and training purposes.
Protected Mealtimes Audit	This audit forms part of the wider Fundamentals of Care workstream. The clinical lead presented the latest results to the central quality meeting and reported the following actions: • Training awareness to all medics, including students and residents, to ensure that only medically urgent mealtime interruptions are carried out. • Reordering the mealtime service to ensure that all special meals, including allergens, are issued first in line with the Group wide Nutrition & Hydration policy.

*Based on information available at the time of publication

2.2.3 Our participation in clinical research

Research is core to the purpose of St George's. It enables us to contribute to the development of future treatments, offer our patients access to new therapies, and continually enhance the quality of our clinical care. Our research activity spans all major clinical specialties and is supported by dedicated research teams and our Clinical Research Facility.

Our current research priorities sit within the wider GESH CARE strategy, which sets out a group-wide commitment to delivering high-quality care, strengthening partnerships, and promoting innovation. A specific Group Research and Innovation strategy is currently being co-designed with patients and staff, due for completion in June 2026. This year we were awarded over £248k of external funding to support research pharmacy and a validated electronic research file system.

Participation in NIHR-approved clinical studies remains one of the key ways we bring new treatments into practice by ensuring research is patient-centred and aligned with NHS priorities. Our research recruitment activity remains strong, with 261 of studies and 10,453 recruited to NIHR clinical research and trials in 2025/26.

Our partnership with City St George's, University of London continues to be essential in supporting joint research priorities. Together we have established four Clinical Academic Groups, enabling clinicians, academics and scientists to collaborate in areas of shared expertise. The gesh Translational and Clinical Research Institute (TACRI), launched in 2020, further strengthens this partnership by funding competitive fellowships that support clinicians to develop research proposals. This year TACRI has supported the development of 3 new research groups at St George's, in addition to those previously funded, which aim to develop research capability in clinical areas. TACRI provides funding to ringfence time for clinical

staff from all professions to develop competitive research and fellowship proposal. This year it has funded 5 Senior Fellowships for senior clinicians and 7 Chief Nurse Research Fellowships for nurses and allied health professions.

Increasing research capacity and capability (the ability to carry out research) in Health and Care Professionals (HCPs) remains a key objective and we support the UK ambition to double the number of our clinical academic HCPs - posts that combine research with clinical practice. Under the leadership of the Group Director for HCP Research, the number of HCPs undertaking funded research fellowships has continued to increase. In 2025, five HCPs were awarded external funding totalling more than £200,000 to undertake research fellowships. A new 'Research Champion' scheme was launched to widen participation in research and increase opportunities for patients to participate in research, with 40 champions from wards and departments taking part.

2.2.4 Our Commissioning for Quality and Innovation (CQUIN) performance

There were no CQUIN schemes in 2025-26.

2.2.5 Our registration with the Care Quality Commission (CQC)

The Care Quality Commission (CQC) is the regulator for all health and social care services in England and is the organisation that checks that our services meet the appropriate standards for care. St George's University Hospitals NHS Foundation Trust is required to register with the Care Quality Commission, and its current registration status is "registered without conditions or restrictions".

Ratings for St George's Hospital:

	Safe	Effective	Caring	Responsive	Well-led	Overall*
Urgent and emergency services	Requires improvement ↑ Dec 2025	Good Dec 2019	Good Dec 2019	Requires improvement Dec 2019	Requires improvement ↑ Dec 2025	Requires improvement Dec 2025
Medical care	Requires improvement Dec 2019	Requires improvement Dec 2019	Good Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019
Surgery	Requires Improvement ↓ Dec 2025	Good Dec 2019	Good Dec 2019	Requires improvement Dec 2019	Requires Improvement ↓ Dec 2025	Requires Improvement ↓ Dec 2025
Critical care	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Maternity	Requires Improvement ↑ Dec 2025	Outstanding Nov 2016	Good Nov 2016	Good Nov 2016	Requires Improvement ↑ Dec 2025	Requires Improvement ↑ Dec 2025
Services for children and young people	Good Dec 2019	Good Dec 2019	Outstanding Dec 2019	Outstanding Dec 2019	Good Dec 2019	Outstanding Dec 2019
End of life care	Requires improvement Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016	Requires improvement Nov 2016	Requires improvement Nov 2016
Outpatients	Good Dec 2019	Not rated	Good Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019
Overall*	Requires improvement Dec 2025	Requires improvement Dec 2019	Good Dec 2019	Requires improvement Dec 2019	Requires improvement Feb 2025	Requires improvement Feb 2025

Ratings for Queen Mary's Hospital Roehampton

	Safe	Effective	Caring	Responsive	Well-led	Overall*
Surgery	Good ↑ Jan 2025	Requires improvement Dec 2019	Good Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019	Requires improvement Jan 2025
Outpatients	Requires improvement Jul 2018	Not rated	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Overall*	Requires improvement Jan 2025	Requires improvement Dec 2019	Good Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019	Requires improvement Jan 2025

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

On 28 March 2025 following the inspection of Maternity and Midwifery Services as part of the national inspection programme focusing on the key lines of enquiry Safe and Well-led, the CQC issued the Trust with a section 29A Warning Notice. The Trust immediately commenced a targeted improvement plan to address the issues highlighted by the CQC.

Maternity Services were rated Inadequate in the Safe and Well led domains overall. The Trust has provided assurance on the completion of the improvement actions.

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

- January 2025, Surgery at St George's and Queen Mary's Hospitals
- February 2025, Well Led inspection
- December 2025, Maternity Services
- December 2025, Urgent and Emergency Care
- January 2026, Urgent and Emergency Care

Surgery at St George's were rated Requires Improvement for Safe and Well Led.

Surgery at Queen Mary's Roehampton was rated Good for Safe and Well Led.

Maternity Services were rated Requires Improvement for Safe and Well Led.

Urgent and Emergency Care were rated Requires Improvement for Safe and Well Led in March 2026.

The inspection reports can be viewed on the CQC website at www.cqc.org.uk

2.2.6 Participation in special reviews or investigation by the CQC

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

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

2.2.7 Our data quality

SGUH

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

- 99.6% for admitted patient care (against 99.7 % national average)
- 99.6 % for outpatient care (against 99.8 % national average)
- 98.8 % for accident and emergency care (against 98.5% national average)

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

- 99.8% for admitted patient care (against 99.8 % national average)
- 99.7 % for outpatient care (against 99.6 % national average)
- 99.8 % for accident and emergency care (against 99.1% national average)

2.2.8 Our Information Governance Assessment Report

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

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

The DSPT has been developed in response to The National Data Guardian Review published in July 2016 and the government response published in July 2017.

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

The submission date for the year 2025/26 is 30 June 2026.

St George's University Hospitals NHS Foundation Trust Data Security and Protection Toolkit for 2024/25 was submitted as 'Standards Not Met'. The Trust aims to obtain "Standards Met" for the 2025-26 submission.

The Data Security and Protection Toolkit managed by NHS England is available at <https://www.dstoolkit.nhs.uk/> where an organisations compliance status can be viewed.

2.2.9 Payment by results

St. George's Hospitals was not subject to the Payment by Results clinical coding audit during 2025/26.

2.2.10 Learning from deaths

During 2025/26 1376 of St George's University Hospitals NHS Foundation Trust's patients died. This comprised of the following number of deaths which occurred in each quarter of this reporting period:

- 364 in the first quarter
- 307 in the second quarter
- 353 in the third quarter
- 352 in the fourth quarter

By 31 March 2026, 125 case record reviews have been carried out in relation to 9.1% of the deaths included.

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

- 47 in the first quarter
- 26 in the second quarter
- 24 in the third quarter
- 28 in the fourth quarter

3 (representing 0.22%) of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter this consisted of:

- 1 representing 0.27% of the number of deaths which occurred in the first quarter
- 0 representing 0% of the number of deaths which occurred in the second quarter
- 1 representing 0.28% of the number of deaths which occurred in the third quarter
- 1 representing 0.28% of the number of deaths which occurred in the fourth quarter

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

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

There were no (0) case record reviews and no (0) investigations completed after 30 April 2025 which related to deaths which took place before the start of the reporting period.

What we have learnt, and action taken

In addition to completing structured judgement reviews (SJR) in individual deaths several investigations have been conducted, responding to both external alerts and internally derived signals. We have continued to review a proportion of deaths, as described by our Learning from Deaths policy. In the course of these investigations and reviews, issues were highlighted for local reflection and learning, including instances where excellent practice was observed. Examples of this work are summarised below. NHS Blood and Transplant (NHSBT) visited the St George's renal transplant unit in April 2025 as the final stage of a structured investigation of an alert triggered by 2 kidney losses and 2 deaths within 30 days of implantation. The visit was conducted according to the Organ and Tissue Donation and Transplantation (OTDT) standard operating procedure, whereby an in-person visit is triggered in response to a mortality alert. The aim of the visit was to identify any potential systemic issues and was intended to be supportive, enabling reflection by the team, and to find ways in which the NHSBT Organ and Tissue Donation and Transplantation team could help.

The panel met with the multiprofessional team, including surgeons, nurses and managers and senior leaders from the Trust. They also reviewed the unit's response to all deaths and graft losses which triggered the alert, plus any new cases since the initial alert. The panel saw evidence of prospective detailed review and confirmed adherence to Trust governance standards for Mortality and Morbidity (M&M) meetings.

Comparison data for peer centres was considered, and relevant unit protocols and process documentation were reviewed. An overview of outcomes found that graft survival at 1 year is average, and patient survival is average. 5-year graft survival is just below average and 5-year patient survival is above average. Overall, there is average 1-5 years graft and patient survival. The panel commented that results overall were good and do not indicate any systemic concerns.

The panel recognised the committed participation of the team in the review process. A number of suggestions for local improvement, including reinforcement of supervision and support for new and locum consultants, were put forward by the panel. They reiterated that no systemic issues had been revealed and acknowledged the team had learned from the cases which triggered the alert and made changes where needed. The clinical team did not raise any specific issues and reflected that the review had been a useful process for examining transplant patient care in more detail.

Following this alert it was agreed that transplant mortality data should be reported annually to the Trust's Mortality Monitoring Group (MMG), as a means of providing internal oversight of data submitted externally. The first report was presented in February 2026 and MMG were assured of the quality of care and governance processes.

Mortality is monitored internally at diagnosis group level and considered each month by MMG. In this period investigations of alerts have been completed for two groups and are briefly outlined below. These alerts, which are derived from proactive consideration of our data compared to the national average, do not necessarily indicate clinical concern but are used as a prompt to look closer at both data and outcomes.

Leukaemias diagnosis group

20 deaths that were observed between July 2024 and May 2025 were clinically reviewed. This included a small number of paediatric cases, who generally have a lower baseline mortality risk, which may have contributed to the signal being triggered. Most patients were in the palliative phase of treatment or had multi-organ disease at the time of death. No concerns regarding the quality or timeliness of care were identified.

Coded data was accurate but doesn't distinguish between primary and relapsed leukaemia, which may carry different risks of mortality. Additionally, pre-admission palliative care cannot be coded which may under-represent the severity of illness. These coding limitations alongside inclusion of paediatric cases, were felt to have contributed to the alert. MMG was assured that care was good with a focus on major complications of the disease or its treatment and closed the investigation.

Aortic; peripheral; and visceral artery aneurysms

39 deaths were included in this group, which covered a wide range of diagnoses within vascular surgery, cardiothoracic surgery and renal. The majority of the deaths related to acute aortic dissection or aortic rupture.

The deaths were independently reviewed by a senior consultant member of MMG. The acuity of the patients was noted, and no clinical concerns were identified. Clinical records evidenced strong teamwork with shared discussions taking place in relation to complex patients. Good, sensitive discussions with patients and families was also observed. An audit of clinical coding found that the large majority of cases were coded correctly.

The main clinical teams, cardiac surgery and vascular surgery, were engaged in the next stage of the review. Around the time of the alert the cardiac surgery team had been added back on to the Type A dissection rota. As part of routine governance outcomes were prospectively reviewed and benchmarked to provide assurance and no concerns were identified; therefore, this investigation focused on vascular surgery.

The vascular surgery team considered the independent clinical review and the coding audit alongside their routine M&M activity. They considered 26 cases, which fell into four groups. There were 2 deaths following elective admission, 4 deaths of patients with ruptured aneurysms who underwent surgery, 12 patients with ruptured aneurysms who didn't undergo surgery (including several previously turned down for elective surgery) and 8 other cases. The different pathology of aneurysms within this grouping and therefore the variation in treatment and mortality risk was highlighted.

All patients with a ruptured aneurysm that did not undergo surgery were palliated appropriately and no concerns in care were identified. Learning from M&M discussions of the ruptured aneurysm operated deaths was noted, particularly around transfer and case selection for surgery. However, it was acknowledged that nationally and internationally there is an expected mortality rate of 40% for ruptured aneurysm surgery, highlighting that mortalities are not unlikely. It was felt that the risk adjustment did not adequately reflect the actual risk for a large number of the patients in the alert, particularly those with a ruptured aneurysm that cannot be treated.

The alert has resolved and MMG was assured by the multiple levels of review that there is no problem of clinical care. The investigation has been closed, and the grouping will continue to be monitored as part of routine processes. Any future investigation will explore risk adjustment used in more detail and benchmark against peer organisations.

Well established mortality review using structured judgement reviews has continued. Reviews are shared with clinical teams regardless of findings, so good practice is shared in addition to flagging concerns. A summary of SJRs and associated learning is also included in the quarterly quality and safety report for each division. Over the year there have been a number of reviews completed that have contributed to positive change, a selection of which are outlined.

- Contributed to a PSIRF learning response focused on improving the management and holistic care of long stay patients which is being taken forward by a task and finish group.
- Collaboration with colleagues at ESTH regarding imaging for a transferred patient prompted engagement with radiology to promote better access to imaging in an emergency situation.
- Acute medicine are compiling a comprehensive list of rapid access, outpatient pathways and how these can be accessed by acute medical teams.

In addition to using the SJR methodology to look at specific cases we have utilised this approach to investigate cohorts of patients. This year we completed a review of deaths on a ward where concerns had been raised by a family, and a review of deaths that followed transfer from another Trust.

Ward Quality Review

Ongoing mortality monitoring had not revealed any concerns and deaths had not been observed as significantly higher than usual. An SJR was completed for each death on the ward during Q1 2025/26.

The SJR process focuses on different phases of care, from admission to end of life. Care was assessed as good in the majority of cases, and across all phases. Excellence was noted in a number of instances. There was no poor or very poor care, and the lowest rating was adequate ongoing care in one instance.

Reviewers also look for problems in defined aspects of healthcare and assess whether or not these problems led to harm. A total of 9 problems in healthcare were identified, but in no instances were these found to have led to harm.

In 15 cases the death was judged to be 'definitely not avoidable'. There was one death that was felt to be 'possibly avoidable, but not very likely (less than 50:50)'. In this case the reviewer asked the clinical team to complete a mortality review. The specialty review answered the questions posed, and no further action was required.

A large portion of the deaths were in relation to patients that had significant co-morbidities prior to their admission and had limited treatment options. Several of these patients were for conservative or palliative management. No concerns about the care provide on the ward were identified and MMG agreed that the special review should be closed.

Patient transfers

This cohort was selected as it included a range of specialties and diagnoses and was not in response to any concerns. During this period 12 cases were reviewed. The transferring hospitals were Kingston, Ashford & St Peters, St Helier, Epsom, East Surrey and Royal Surrey. Transfers were made to all divisions and patients were cared for across several wards with the most common being critical care.

Of the 12 patients, 10 cases were graded as having good overall care and two were graded as having received excellent overall care. In 11 cases the death was judged to be unavoidable, and in one case as possibly avoidable but not very likely. This case was shared with the clinical team, who had already reported and reviewed the incident confirming effective governance processes are in place.

The investigation did not highlight any themes or trends with transferred patients during this period. Several of the reviews complimented the patients care, documentation and MDT discussions.

Summary of action taken in 2025/26 and plans for 2026/27

This year there has been continued support for mortality governance with admin resource used to facilitate M&M meetings. We have defined clear meeting standards and strengthened the analysis and dissemination of learning. This progress is regularly reviewed and monitored through the trust level MMG.

We have launched an infographic which provides a consistent standard and clear expectations for high-quality learning and meaningful actions. This has been approved by MMG and widely shared at senior clinical leadership meetings, divisional meetings, and with specialty groups. Over the next year this will underpin the development of standard operating procedures (SOPs) for each specialty group's M&M meeting. This work will help to further embed structured M&M meetings that prioritise quality learning, reflective discussion, and identification of service improvement opportunities. They will also encourage the use of self-audit and peer review to strengthen internal assurance, allowing the central M&M team to shift their focus to synthesising learning and improvement actions.

Further progress has been made with supporting divisional learning and the triangulation of data sources. This approach has been successfully piloted within the two divisions, with ongoing evaluation of the strengths and gaps in the information shared. Reporting has developed to include divisional M&M themes, trends, and learning which enables clearer visibility of patterns over time. As reporting continues to mature, it will support the identification of recurring themes across months and years, and across divisional boundaries. The M&M team has also initiated this data-driven approach across specialty groups to support learning and service improvement. SJRs, Medical Examiner (ME) data, and M&M learning continue to be shared quarterly across all three divisions via the Patient Safety Quality Group. During 2026/27, our aim is to have fully embedded this triangulated learning model across all divisions.

During this period, we have made some changes to the structure of the central learning from deaths team. Towards the end of the year the tenure of the clinical lead came to an end and the resource was redirected to strengthening governance at a divisional level. Alongside this the review team is developing a strategy to engage clinicians in the utilisation of SJRs as a learning tool within divisions. This will be supported by training, with oversight provided centrally to ensure mandated reviews continue to be completed. Working with the newly appointed Divisional Safety Leads the intention is to maximise the benefit of the SJR methodology, whilst allowing the independent central team to focus on complex cases. With our mortality monitoring and investigation processes, including M&Ms and diagnosis group investigations, well established it is felt that this redirection of investment will make a positive contribution to wider patient safety and quality governance.

2025/26 represents the first full year of the statutory Medical Examiner (ME) service. The ME service hosted by St George's is responsible for scrutinising all deaths in Merton and Wandsworth, both in-hospital and in the community, that are not investigated by a coroner. Quarterly reporting to the National ME has confirmed that all key performance indicators were met for the year. Since the introduction of the statutory system the ME service has delivered an out of hours provision on every weekend and mandated bank holidays. Extending the service has facilitated the rapid release of deceased patients, particularly where there is a specific religious requirement.

Throughout the year we have continued to collaborate with our colleagues at Epsom & St Helier across all aspects of mortality governance from investigation methodology, sharing SJRs and developing M&M approaches. We continue to share ideas and spread best practice between the organisations and during 2026/27 we will bring all of this together in a group learning from deaths policy.

2.2.11 Standards for Seven Day Services

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

- Standard 2 – Time to first consultant review

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

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

We are compliant with reference to standard 6.

With reference to standard 8 and 7-day equitable access to MRI scanning, the service is not yet resourced to fully provide this, and priority is given to the most urgent conditions and clinical presentations.

Hospital SITREP data continues to show a similar length of stay for non-elective admissions over 7 days, with no significant weekend disparity. The average length of stay is 9.5 days – ranging from 8.9 days for Monday admissions to 10.0 days for Friday admissions. Saturday and Sunday admissions stay on average just below 10 days. Elective admissions on a Sunday seem to have a longer length of stay but activity numbers are comparatively small and are likely to represent specific cohorts of patients. The percentage of discharges occurring at the weekend continues to be lower than weekday activity, but this pattern for discharge activity is similar to regional and national benchmark data. Specialities identified due to variance with benchmark data are different to the previous year, apart from general & colorectal surgery, where further quality improvement will be supported.

2.2.12 How our staff can speak up

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

Staff are encouraged in the first instance to raise issues with their line manager; often concerns can be resolved at this level. However, it is recognised that some staff may not feel comfortable in taking this route, especially if the concern being raised pertains to their line manager or has already been raised and unresolved.

Staff can raise concerns with:

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

Staff can raise concerns in different ways such as:

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

Staff are also advised how they can raise concerns externally if they are unhappy with using any of the internal routes for raising concerns or if they indicate that after raising a concern

they do not feel the concern was investigated in line with the Trust policy. These external routes include the Care Quality Commission and recognised professional or union body. Staff with concerns about potential fraud are encouraged to raise concerns with our Local Counter Fraud Specialist or with NHS Counter Fraud.

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

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

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

A Group-wide FTSU team is now well established and actively supports staff across the St George's, Epsom and St Helier University Hospitals and Health Group, and as such will have a wider reach and more flexibility when supporting teams and groups of staff members. In 2025/26, the Group-wide Freedom to Speak Up team comprised one Group FTSU Guardian and four Group Deputy FTSU Guardians roles covering all the sites and services across the hospital Group.

2.2.13 Guardian of safe working

In 2025-26 there were 602 Exception reports compared to the 352 submitted in 2024-25. This was a substantial increase which from the second quarter, which coincided with the rotation of the largest cohort of resident doctors in August 2025, the reasons for Exception reporting is seen below.

The most significant event in this year was the adoption of the changes in terms and conditions to the Resident Doctors contract of 2016 on February 9th, 2026, which led to a redefinition of Exception report types. The hours based exceptions changed to two types: late starts and late finishes. The majority of exception reports are hours based, in acute specialties such as acute medicine or surgery at junior grade rosters.

Exception Reporting for 2025/26	
Total number of exception reports received	602
Number relating to immediate patient safety issues	15
Number relating to hours of working	547
Number relating to missed breaks (February 2026 onwards)	23
Number relating to educational opportunities	7
Number relating to service support available to the doctor	6

Note: Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support has the option of specifying if it is an Immediate Safety Concern (ISC). ISC is not an exception type by itself.

Exception reports continue to provide excellent insight into the challenges working in our services and provide a means of feedback. Strategically, it is possible that a framework for feedback will be provided by the BMA, to ensure safe space reporting.

ISCs are a good indicator of inadequate skill mix or clinical business that outstrips what an individual can provide in terms of clinical care and are a marker of areas that would benefit from staffing review.

Specialty trainee and LED vacancies within Trust

Specialty	Grade	Apr-Jun 2025	Jul-Sep 2025	Oct-Dec 2025	Jan-Mar 2026	Total gaps (average WTE)
Medicine	FY1-2, CT1-3/ST1-8	0	2	0	0	0.5
Surgery/ T&O/ Urology	FY1-2, CT1-2, ST3+	0	0	0	0	0.0
Clinical Services	ST1-8	0	0	0	0	0.0
Women and Childrens	All grades	0	0	0	0	0.0
Renal	ST3+	0	0	0	0	0.0
Anaesthetics/ITU	ST1 - 8	1	0	0	2	0.8
Total		1	2.0	0.0	2	1

Issues arising

- Rota Gaps are in some part predictable, and HR are informed of the grids 12 weeks prior to the commencement of roles, this includes GPVTS trainees, because a matching process has to take place, there is little sway in the timescale.
- ISC's have risen again from 9 (2024-2025 to 15 (2025-2026).
- Exception reporting has risen in line with resident doctor's striving for better conditions of work.

The new terms of the Resident Doctors' Contract have been ratified and agreed with BMA representatives and also with the LNC. The LNC agreed that geolocation was not adopted.

Actions taken to resolve issues

- HR engages with residents to join the bank when they are already substantively employed to assure good quality locum cover where the need arises; assuring improved and safer working environments. This is the first time that combined data for both LEDs and HEE employed trainees have been available which is a improved reflection of gaps overall. Anecdotal reports from LFGs seem positive about good quality locum cover.
- ISCs are a measure of whether residents feel unsafe in their work place. These concerns were discussed directly with the DMDs and CDs of the departments prior to the February changes where these have occurred. After this time, the ISCs have been escalated to the local teams but the guardian has given the doctors the opportunity to discuss issues. The HR representative responsible for those areas/ wards have also been informed of ongoing complaints where these can be summarised in a way not to breach confidentiality. For example naming a problem on an FY2 roster where there is only one or two FY2 residents employed.)
- The Guardian views rises in reporting not as an 'issue' but identified as a significant change. The new tool is designed to automatically identify breaches via the organisations reporting system when it is used with eroster. The GOSW continues to encourage exception reporting where it is appropriate.

2.3 Reporting against Core Indicators

National Core Set of Quality Indicators

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

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

2.3.1 Mortality

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

The SHMI for the last reporting period is as expected, which is consistent with previous reporting periods between to October 2024 to September 25.

Summary hospital level mortality indicator (SHMI)									Nov-23 to Oct-24	Oct-24 to Sep-25
SHMI									0.87	0.8896 Banding 2
Banding	Lower than expected	Lower than expected	Lower than expected	Lower than expected	As expected	As expected	As expected	As expected	Lower than expected	Lower than expected
No of deaths with palliative care coded at either diagnosis or specialty level	49%	48%	47%	49%	54%	54%	58%	56%	55%	55%

Source [Summary Hospital-level Mortality Indicator \(SHMI\) - Deaths associated with hospitalisation - NHS England Digital Percentage of deaths with palliative care coding Oct24-Sep25.xlsx](#)

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

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

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

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

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

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

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

2.3.3 Readmission within 30 days of discharge

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

30 days Readmissions (30 days in 2024-25)	2019		2020		2021		2022		2023		2024		(Mar) 2025 Published Nov 25	
	0-15	16+	0-15	16 +	0-15	16+	0-15	16+	0-15	16+	0-15	16+	0-15	16+
Number of provider spells	20498	132936	13703	97043	16152	112266	16390	111037	13660	97050	4651	37050	4270	38785
30 day readmissions (30 days in 2024-25)	1558	11659	900	8421	1064	8187	1008	7356	740	6513	360	5575	395	6225
30 day readmissions rate (30 days in 2024-25)	7.60%	8.77%	6.57%	8.68%	6.69%	7.29%	6.15%	6.62%	5.42%	6.71%	8.40%	15.10%	9.25%	16.05%

Source: [I02040 Compendium Readmissions Dataset \(Main\) 2025.xlsx](#)

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

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

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

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

2.3.4 Patient experience

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

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

Source: <https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current/domain-4-ensuring-that-people-have-a-positive-experience-of-care-nof/4-2-responsiveness-to-inpatients-personal-needs>
[https://nhssurveys.org/all-files/02-adults-inpatients/05-benchmarks-reports/2021/Question 49 – Overall Experience](https://nhssurveys.org/all-files/02-adults-inpatients/05-benchmarks-reports/2021/Question%2049%20Overall%20Experience)

We have reviewed a related section in the national CQC inpatient survey (2023/24). This section is made up of several questions relating to personal care, food, and assistance with eating.

Patient Experience	2021	2022	2023	2024
St George's University Hospitals	8.0	8.1	8.1	8.3

Source: [St George's University Hospitals NHS Foundation Trust - Care Quality Commission \(cqc.org.uk\) St George's University Hospitals NHS Foundation Trust.pptx \(live.com\)](#)
[RJ7 St George's University Hospitals NHS Foundation Trust.pptx](#). The above score is pulled from the CQC report looking at "Overall Experience" *2025 data has not been published at the time of submitting this report. This data will be included in the Quality Report 2026

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

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

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

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

2.3.5 Staff recommendation to friends and family

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

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

The data for 2025/26 shows a 3.57% reduction in staff who would recommend St George's to their friends and families when compared with the previous year.

Staff recommendation	2021	2022	2023	2024	2025
St George's University Hospitals	58.45%	58.53%	59.54%	63.09%	59.52%
Average for Acute	58.40%	56.46%	60.53%	60.90%	57.77%
Highest Acute Trust	77.87%	75.26%	77.14%	79.37%	79.40%
Lowest Acute Trust	38.40%	40.90%	44.01%	35.43%	34.20%

[2025 NHS Staff Survey Benchmark Report - Question 25c](#)

NHS Staff Survey dashboard (nhssurveys.co.uk) Local results for every organisation | NHS Staff Survey (nhsstaffsurveys.com)

[NHS Staff Survey dashboard](#) [Local results for every organisation](#) | [NHS Staff Survey](#)

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

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

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

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

2.3.6 Patient recommendations to friends and family

Our patients are very positive about our inpatient services in 2025/26 with 95% of our Inpatients saying they would recommend our services to their friends and family.

Due to the significant demand for Emergency Department (ED) services and the associated waiting times 78.3% of those visiting our ED said they would recommend our services to their friends and family, which was an improvement of 0.6% when compared with the previous year.

Friends and Family Test	2021-22		2022-23		2023-24		2024-25		2025-2026	
St George's University Hospitals	A&E	Inpatient	A&E	Inpatient	A&E	Inpatient	A&E	Inpatients	A&E	Inpatient
Response rate	12.82%	32.71%	12.43%	29.17%	11%	29%	13.8%	31%	10.46%	31.46%
% would recommend	77.86%	97.70%	74.42%	98.42%	80%	98%	77.7%	98.6%	78.38%	97.59%
% would not recommend	12.82%	0.60%	17.24%	0.41%	13%	0.49%	14.8%	0.52%	4.62%	0.55%
National comparison positive response rate										
National comparison as at March 2020 % would recommend										
National comparison as at March 2020 % would not recommend										

[NHS England » Friends and Family Test data – December 2024](#)

[NHS England » Friends and Family Test data – December 2025](#)

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

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

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

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

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

2.3.7 Venous thromboembolism

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

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

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

- This data is validated through the Trust's informatics and reporting processes. It should be noted that the VTE risk assessment data submission to NHS England Digital now requires assessments to be completed within 14 hours, in line with NICE standards. As a result, performance in 2025-26 has been impacted.

VTE Assessments	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
St George's University Hospital	96.18%	96.80%	97.00%	96.10%	58.80%	82%
National Average	95.33%	N/A	N/A	N/A	90.40%	
Best Performing Trust	100%	N/A	N/A	N/A	100%	100%
Worst Performing Trust	77.16%	N/A	N/A	N/A	13.70%	

[Venous Thromboembolism \(VTE\) Risk Assessment Data Provision Notice - NHS England Digital](#)

[Statistics » VTE risk assessment 2025/26](#)

[Quality & Performance Report for Trust Board: Patient Safety - Tableau Server](#)

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

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

2.3.8 Infection control

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

Clostridium Difficile	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Trust apportioned cases due to lapses in care	41	43	60	41	60	51
Trust bed-days	225,244	278,832	290,474	267,252	291,471	283,411
Rate per 100,000 bed days	16.03	13.74	20.3	15.34	20.6	18.0
National average	53	63	27.51	73	84	**
Worst performing trust	211	245	98.8	275	288	**
Best performing trust	0	0	0	0	0	**

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

**Data showing National, Worst and Best performing Trust included all CDiff data- not published at the time of this report- will be added in the 26-27 report

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

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

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

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

2.3.9 Patient safety incidents

Patient Safety Incidents	Apr 21-Mar 22	Apr 22-Mar 23	April 23-Mar 24	April 24-Mar 25	April 25-Mar 26
Total reported incidents	13092	13880	14741	13622	13728
Rate per 1000 bed days	51.7	55.0	55.16	63.44	48.44
*National average (acute non-specialist)	As of April 2019 NHS Digital no longer publishes data on the national averages for patient safety incidents				
*Highest reporting rate					
*Lowest reporting rate					

Used bed days of 283411 as in infection control numbers

Patient Safety Incidents	Apr 21-Mar 22	Apr 22-Mar 23	Apr 23-Mar 24	April 24- Mar 25	April 25-Mar 26
Incidents causing severe harm or death	46	28	25	36	Not available at time of reporting
Rate per 1000 bed days	0.35%	0.10%	0.08%	0.13%	

Source: Datix

NHS England previously published official statistics using patient safety incident data from the National Reporting and Learning System (NRLS). The Learn from Patient Safety Events (LFPSE) service has fully replaced NRLS since June 2024. Patient Safety Incidents are reported to LFPSE directly from the Trust's Incident Reporting System. Statistics are published on a quarterly basis.

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

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

2.3.9.2 In 2025/26 there were 7 Never Events. In line with the Patient Safety Incident Response Framework (PSIRF), the Trust applied proportionate responses to these Never Events, utilising a variety of systems-based learning responses or improvement plans. Learning has been identified to make improvements to work systems and processes.

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

- Continue to work towards enhancing existing mechanisms throughout 2026/27. These include: risk management input into training programmes, increased frequency of Patient Safety Incident Investigation training, increased involvement from all staff in following up incidents, a bi-monthly patient safety newsletter and a quarterly analysis report and thematic learning
- Implemented of the new Patient safety Incident reporting Framework (PSIRF) in line with the new National Patient Safety Strategy.

Part 3

3.1 Our performance against the Single Oversight Framework

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

In October 2024 two new targets were introduced:

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

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

Key performance indicators

SGUH	SGUH Metric	Target	Annual Performance						
			2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Referral to treatment times	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	>=92%	78.79%	71.80%	75.97%	67.14%	65.91%	61.30%	62.20%
	Number of 52-week breaches	0	3	829	193	517	853	1,162	728
ED access	78% of patient wait less than 4 hours	>=78%	85.60%	90.05%	83.51%	74.22%	75.90%	79.60%	79.00%
Cancer access	62-day treatment standard: commence treatment within 62 days of being referred or consultant upgrade	>=70%			85.32%	85.78%	90.18%	81.40%	72.40%
	Faster Diagnosis Standard: a diagnosis or ruling out of cancer within 28 days of referral	77%			78.20%	79.80%	83.70%	84.80%	84.40%
Diagnostic waits	Maximum 6 week wait for diagnostic procedures	95%	83.50%	93.20%	93.40%	90.00%	96.22%	94.80%	94.02%

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

3.2 Our performance against our Quality priorities in 2025-26 – All needs review

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

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

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

1.0 Patient Safety			
Our quality priorities	What will success look like?	How did we do in 2025/26?	How our performance compared with 2024/25
1.1 We will focus on improving the delivery of fundamentals of care for: • Pressure ulcer prevention • Venous Thromboembolism (VTE) risk assessment • Falls prevention • Delirium assessment	We will get the basics right every time and consistently complete risk assessments in line with expected standards of performance	We did not achieve this.	There were 8 category 4 pressure ulcers.
		There were 7 category 4 pressure ulcers against the annual threshold of 0. There were 94 category 3 pressure ulcers against the annual threshold of 89. We developed a consistent approach to data capture for VTE. The agreed reporting standards commenced from April 2025. Compliance against new guidance was 82% We developed a consistent approach to Delirium assessment data capture across the Group and reporting commenced in January 2026. Trajectories have been agreed for the next financial year.	There were 95 category 3 pressure ulcers. We achieved 65.9% of VTE assessment within 14 hours of admission against the 95% performance target.
		There were 28 falls with moderate and above harm against the threshold of 31. The total number of falls by 1000 bed days was 0.77 compared with the previous year of 0.10.	There were 29 falls with moderate and above harm against the threshold of 17. The total number of falls by 1000 bed days was 0.11 compared with the previous year of 0.12.

2.0 Patient experience			
Our quality priorities	What will success look like?	How did we do in 2025/26?	How our performance compared with 2024/25
We will improve flow in the Emergency Department to reduce overcrowding and long waits for treatment	We will maintain the proportion of patients who wait for more than 12 hours from arrival in our emergency department at or below 2024/2025 levels. We will deliver the 4 hour performance target of 78% of patient attendances being seen and discharged or admitted within 4 hours of their arrival.	We did achieve this?	79.0% of patient attendances were seen and discharged or admitted within 4 hours (against the target of 78%)
		Within ED, front door pathways and paediatric access have been strengthened, streaming capacity strengthened with daily oversight driving performance.	We continued to exceed 4 Hour national target of 78% achieving 79% in 2025/26 compared to 79.6% in 2024/25. Compliance achieved against increasing attendances to the department (+1.9% compared to 2024/25) The proportion of 12 hours waits was on average 10% across 2024/25 which exceeded plan
3.0 Effectiveness and Outcomes			
Our quality priorities	What will success look like?	How did we do in 2025/26?	How our performance compared with 2024/25

3.1 We will ensure our Maternity Services are safe.	We will strengthen the governance and quality of our Maternity Services	We did achieve this.	N/A
---	---	-----------------------------	-----

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

A1.1 Statement from South West London Integrated Care Board

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

During 2025/26, many healthcare organisations experienced increased demand, significant operational pressures, and sustained high levels of clinical complexity and acuity. In addition, the Trust underwent a Well-Led inspection by the CQC and is taking actions to improve. A more recent Urgent and Emergency Care inspection noted improvements, although further time is needed for changes to embed. Against this backdrop, the ICB recognises that achieving the quality priorities set at the start of the year has been challenging.

However, there have been several areas of improvement and focus. The Trust reported positive trends in the 2025 NHS Staff Survey, including significant improvements at St George's and progress across the People Promise indicators. The 2024 CQC Maternity Survey results showed performance in line with national averages and highlighted areas of strong practice, including kindness after birth, mental health support, partner involvement, staff communication, and postnatal support. In addition, the Trust has launched iClipPro, a shared electronic patient record system that improves continuity of care by providing clinicians with real-time access to integrated patient information.

The ICB welcomes the 2026/27 priorities and looks forward to seeing continued progress:

- **Priority 1 – Improve patient safety:** ensuring the right systems and staffing are in place to minimise the risk of harm and to support openness and learning when incidents occur. The focus on VTE and surgical safety, including improving safety checklist compliance, is appropriate.
- **Priority 2 – Improve patient experience:** addressing patients' emotional as well as physical needs. Reducing corridor care will be critical to improving patient experience and reducing risk.
- **Priority 3 – Improve effectiveness and outcomes:** delivering high-quality, efficient care with excellent outcomes. The focus on Martha's Rule implementation, recognising deterioration, and using standardised data sets is welcomed.

We look forward to seeing how these initiatives develop and to continuing our collaborative and transparent working relationship with the Trust in 2026/27.

A1.2 Statement from Healthwatch Wandsworth

Healthwatch Wandsworth has continued to work to support quality improvements through our Healthwatch Appointed Governor and other projects and collaborations. At the time of writing this statement, we did not have sight of the Quality Account for 2025-6 so we are not able to comment on the detail of the achievements and areas that continue to be a challenge for the Trust's quality improvement plans.

Over the year we have observed a clearer and more proactive approach to looking at health inequalities and disparities in patient experience and quality of services provided. This is very important and we hope to see this level of analysis reflected in quality monitoring and reporting. New arrangements to ensure there are flags on patient records that assist the Trust to meet communication and access needs will be embedded in 2026 and we hope this also reduces disparities in access, patient experience and outcomes.

Another positive improvement has been a strategic approach to key safety and quality issues through governance, including through the Quality and Safety Committee.

We continue to see more activities to identify and support unpaid carers and look forward to seeing continued impact on patients and their carers of this work.

Areas that we would highlight for continued focus and improvement:

We've recently completed a report about patient experiences of contacting and getting support from PALS (Patient Advice and Liaison Service), a vital route for patient voice and concerns. Senior staff at the hospital have supported us to undertake this project and have responded constructively to draft recommendations that will be available on our website once the Quality Account has been published. We look forward to hearing more about how improvements will be made to the PALS service and in supporting patients to be heard. As a related route for patient voice and concerns, we hope that the Quality Account will demonstrate the impact of concerns raised via Martha's Law procedures. Last year we asked that information about this is available in accessible formats and to patients and carers who may not have a good understanding of written English.

CQC reports continue to identify areas for improvement. We see the Trust working on action plans and with the CQC to resolve issues, and this clearly becomes a significant focus for staff to improve quality.

Organisationally, there has been a considerable change in personnel at senior level, which has the potential to bring focus and speed up improvements. We hope that financial challenges will not impact the range and quality of services for the Wandsworth community and that quality oversight will be able to support changes.

One suggested service change that has attracted concerns from the community is a proposal to close the Carmen Birthing Suite. We have been told that any changes will be made after consultation with staff and patients.

We hope our comments are useful to support reporting progress on quality improvement and quality measures.

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

- Provision of comments is voluntary – not requested

A1.4 Our response to our stakeholders

The Trust is grateful for the considered responses from all our stakeholders and their input in developing our Quality Account. These responses have been helpful and will be considered with the relevant stakeholders in developing the Quality Account for 2026-27.

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

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

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

Not required

Annex 2:

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

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

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

- the content of the quality report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2021/22* and supporting guidance *Detailed requirements for quality reports 2021/22*
- the content of the quality account is not inconsistent with internal and external sources of information including:
 - board minutes and papers for the period April 2025 to March 2026
 - papers relating to quality reported to the board over the period April 2025 to March 2026
 - feedback from the Integrated Care Board
 - feedback from Governors
 - feedback from local Healthwatch organisations (voluntary)
 - feedback from overview and scrutiny committee (voluntary)
 - the Trust's complaints report 2025-26 published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
 - the latest national patient surveys for Adult Inpatients; Urgent and Emergency Care; Children and Young People; and Maternity Services
 - the latest national staff survey
 - the Head of Internal Audit's annual opinion of the Trust's control environment dated [Not required]
 - the CQC inspection reports published on the [CQC website](#)
- the quality account presents a balanced picture of the Trust's performance over the period covered
- the performance information reported in the quality account is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality account, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality account has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporate the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality account.

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

By order of the board.



Sir Mark Lowcock
Chair

24 June 2026



Matthew Shaw
Chief Executive Officer

24 June 2026