NHS
Guy's and St Thomas'
NHS Foundation Trust

Quality Report 2024/25

Contents

Front cover: Amoh Bodje is a registered nurse in our Neighbourhood Nursing Team. She cares for people who are housebound – helping them care for themselves and to be as independent as possible.

Statement on quality from the Chief Executive 2024/25

This report sets out the approach we have taken to improving quality and safety at Guy's and St Thomas' NHS Foundation Trust. As set out by NHS England, the 2024/25 quality account has been prepared as a separate stand-alone document to our annual report.

The Trust's Council of Governors, Board of Directors and the South East London Integrated Care Board have all been consulted on our quality priorities for 2025/26.

Our priority is to provide high quality, safe care for all patients, and to learn from our mistakes if we fall short of these standards. We are committed to driving improvement and a culture of excellence throughout the organisation. Despite the high demand for our services and complex operational and financial challenges the Trust has faced during 2024/25, we have sought to deliver care in accordance with the quality priorities we set ourselves last year. We have continued to work with clinical audit, national audit and organisational learning teams to drive quality improvement.

The first half of the year was overshadowed by the criminal cyber-attack on our pathology partner Synnovis in June, which had a major impact on the delivery of our services. We gradually recovered our services, with full pathology capabilities, including electronic cross-matching of blood, finally being restored in October.

Staff worked tirelessly in extremely difficult circumstances to prioritise the most urgent patients and maintain delivery of safe care. Despite the best efforts of our clinical and administrative teams a significant number of appointments were regrettably cancelled, and we do not underestimate the impact that cancellations or delays have on our patients and their families

Some of our key achievements over the past year include:

- In September we launched our new strategy to 2030: Better, faster, fairer healthcare for all, which has 'delivering healthcare excellence', by providing the very best care and experience to every patient, at it's centre.
- We continue to optimise Epic, our new electronic health record system, to further improve both the safety and quality of care for our patients across the Trust, including our patient portal, MyChart, which is supporting patients to engage in their care.
- In March 2024, we moved to the new Learning from Patient Safety Events (LFPSE) system which replaced the National Reporting Learning System and provides an automatic upload of patient safety incidents to NHS England.
- The Trust has been operating under the Patient Safety Incident Response Framework (PSIRF) for a full financial year, which has enabled us to take a more strategic approach to managing patient safety incidents, identifying priority areas for improvement, and using quality improvement to address our key patient safety themes.
- The number of patient safety incidents reported continues to reflect a positive culture for reporting of incidents.
- We continue to have one of the lowest mortality rates in the NHS and internationally, including in our critical care units, a strong indicator of our relentless focus on quality and safety.

- We achieved a significant improvement in our response rate for the annual NHS staff survey with 57% of staff providing their views on working at the Trust. We were amongst the top 10 trusts nationally for staff agreeing that the care of patients/service users is the organisation's top priority, and scored highly across all the engagement measures. This is important as we know that an engaged workforce has a positive impact on the quality of patient care.
- Our emergency department is consistently amongst the best performing nationally for emergency care. Teams have worked hard to improve the experience of our patients, reduce delays to ambulance handovers and to admissions. The focus on improving care for patients attending the emergency department and requiring specialist mental health care remains a challenge and a key priority.

As part of our commitment to providing safe, high quality care to our patients, it is vital that we have a positive and supportive reporting culture that allows us to share and learn lessons from mistakes, whenever they happen, and to use these to improve the safety of our services and experience of our patients.

Our Learning for Improvement Group is now well embedded and ensures that the Trust Patient Safety Incident Response Plan is delivered through the robust monitoring of incidents and their learning responses; trend and theme analysis; and oversight of progress with improvement plans. The Trust has an executive Risk and Assurance Committee and a Board-level Quality and Performance Committee where all data and information relating to quality of care and patient experience is reviewed.

The Trust employs rigorous information assurance processes including the production of a monthly integrated performance report, local and Trust-wide validation of data and national benchmarking where available. This report is published as part of our public Board papers and is available on the Trust's website.

We publish 'Quality Matters', a regular newsletter which is sent to all staff and which supports the sharing of best practice. Our 'Learning from excellence' system encourages staff to report examples of good practice and things that work well so that they can be recognised and shared across the Trust.

We encourage all our staff to 'speak up' if they have concerns about patient safety or the quality of care we provide and we have an active and well supported network of around 180 'speaking up' champions, a confidential email address and an external phone line.

While there have been many achievements in 2024/25, we are not complacent and recognise that there are areas which require a relentless focus to improve the quality of care and experience of our patients. In particular, we are working extremely hard to reduce the length of time that some patients wait for diagnosis or treatment. This includes waits for cancer patients, where we are working to address complex challenges – both within the Trust and with our partners across south east London.

I am confident that the information in this quality report accurately reflects the services we provide to our patients.

Professor Ian Abbs
Chief Executive Officer 25 June 2025

Our quality priorities for 2025/26

The Trust aims to provide exceptional clinical care, education and research that improves the health of the local community and of the wider populations that we serve. This ambition is reflected in our strategic objectives and is underpinned by our quality priorities and quality goals.

In line with our new Trust strategy 'Better, faster, fairer healthcare for all', we have developed a set of quality priorities for 2025/26 and ensured that these are embedded across the Trust through our executive assurance committees.

Our progress will be monitored through the Trust Risk and Assurance Committee and reported to the Quality and Performance Committee.

How we chose our priorities

Each year the Trust is required to identify its quality priorities. The priorities for 2025/26 were agreed by the Trust Risk and Assurance Committee in March 2025 and the Trust's Quality and Performance Committee in May 2025. We have chosen quality priorities which are reflected under the following 3 key indicators of quality:

Patient safety – having the right systems and staff in place to minimise the risk of harm to our patients, and being open and honest and learning from mistakes if things do go wrong.

Clinical effectiveness – providing the highest quality care with world-class outcomes, whilst also being efficient and cost effective.

Patient experience – meeting our patients' emotional needs as well as their physical needs.

For 2024/25 we are continuing to focus on delivering 2 quality priorities from 2023/24 which will enable us to further improve the experience of our patients through better communications and to progress the implementation of Martha's Rule. We have also identified 3 new priorities which are outlined overleaf.

Our quality priorities for 2025/26

Our quality priorities	What success will look like
Patient safety	
We will introduce a new governance structure for the Operational Safety and Admin Excellence Programme which drives quality improvement to address patient safety risks.	• We will develop an aggregated dashboard to enable increased monitoring of key operational safety metrics for the Operational Safety and Admin Excellence Programme. • We will prioritise improvements and interventions which will improve safety for our patients. • Success will be measured by monitoring compliance with the key operational safety metrics identified.
We will reduce instances of verbal or physical aggression by patients, ensuring that they get the help they need and staff are supported in recognising, dealing and recovering from them.	• Working with our Supporting Positive Behaviours Forum, we will engage with patients and staff in areas of high prevalence to further understand the causes of aggression and identify ways to reduce the number of instances. • We will review the resources and training available to help staff de-escalate and manage instances, as well as the support available to staff when instances have occurred. • Success will be measured by monitoring: the number and type of harm events; the number of exclusions or warnings provided to patients; and the feedback from staff about the support provided when instances occur.
Clinical effectiveness	
We will implement a structured approach to obtain information about a patient's condition directly from patients and their families at least daily.	• We will test a number of methods to determine the most appropriate ways to obtain information relating to a patient's condition directly from patients and their families on a daily basis – and to act on any concern they raise. (Martha's Rule: Component 3) • Success will be measured by the number of concerns raised during the pilot and the action taken as a result.
We will improve our processes for development, review, approval and publication of clinical guidance to align best practice across services and ensure that all patients receive consistent high-quality evidence-based care.	• We will review and standardise processes for the review and approval of all clinical guidance across the Trust in preparation for implementation of a new Document Management System. • Success will be measured by monitoring the number and percentage of clinical guidance documents which have been reviewed within the set timescales.
Patient experience	
We will improve the experience of our patients through better communications and ways to contact the Trust.	• We will improve our ability to address patient queries, working with high volume services to change and optimise the structure of the contact details we publish on our website. • We will improve MyChart functionality so patients can self-schedule (cancel, book, rebook) their appointments. • Success will be measured by monitoring the volume of bookings and cancellations made through MyChart, as well as complaints, Patient Advice and Liaison Service contacts and other patient feedback received about difficulties contacting a clinical area.

Progress against our 2024/25 priorities

The following tables show how we have performed against the quality priorities which we identified for 2024/25. The actions we have taken are summarised on pages 5-7:

Our quality priorities	What success will look like	2024/25 Summary
Patient safety		
We will share and embed best practice to support multidisciplinary teams to improve the use of the surgical safety checklist as part of the National Safety Standards for Invasive Procedures.	We will: • Develop a working group to improve the sign-in, time-out, sign-out process within Epic – ensuring specialty specific checks are embedded and can be adapted in line with Local Safety Standards for Invasive Procedures. • Success will be measured by monitoring the number and type of harm events associated with surgical safety checklist related incidents.	We have: • Established a working group to review the surgical safety checklist processes and share best practice across the Trust. Dedicated session held in December 2024 with representation from all clinical groups to agree process improvements required. • Held simulation and engagement sessions with surgical specialties and theatre sites to test the revised checklist content and process, also covered additional checks for each specialty to support education and shared learning. • Developed a new policy and template including Local Safety Standards for Invasive Procedures to align with the revised checklist process. Once finalised, it will be approved via the Trust Surgical Safety Group and Trust Risk and Assurance Committee.

Progress against our 2024/25 priorities

Our quality priorities	What success will look like	2024/25 Summary
Clinical effectiveness		
We will implement Martha's rule to ensure that patients, families, carers and staff have round-the-clock access to a rapid review from a separate care team, if they have a concern.	We will: • Implement Martha's Rule. • Optimise and standardise our processes for patient, family and carer-initiated escalation of a concern or an acute deterioration. • Success will be measured by monitoring the number of concerns raised and the action taken as a result.	We have: • Implemented Martha's Rule across all Trust sites as part of the first phase of national implementation. • Implemented a task and finish group which meets monthly with oversight from the Acutely Ill Patients Group. • Met Component 1 of Martha's Rule: all areas have access to an adult and paediatric outreach response 24/7. • Met Component 2 for all adult services: 'call if concerned' processes are well established. The project was launched for Evelina London Children's Hospital in November 2024. Further work is required to fully embed processes across all specialties and a plan is in place via the Task and Finish Group to support this. • Agreed that we will continue to address Component 3 in 2025/26: this is the most challenging component of Martha's Rule. A specific pilot to test the most appropriate method to obtain information relating to a patient's condition directly from patients and their families at least daily is a quality priority for 2025/26.
We will develop and embed processes to ensure that diagnostic results are reported, reviewed, and responded to in Epic, our new health record system.	We will: • Conduct assurance checks on test results acknowledgement focusing on high-risk tests and specialty reviews to ensure that appropriate action has been taken. • Ensure department leads have access to in-basket management dashboards which highlight results that have not been actioned within recommended timescale. • Success will be measured by monitoring compliance with results requested compared to results actioned.	We have: • Completed assurance checks for critical and unexpected radiology alerted results. • Commenced a pilot using results acknowledgement data to support improvement within paediatrics, rheumatology and diabetes through the Diagnostic and Clinical Results Improvement Group. • Supplemented in-basket management dashboards on Epic with tip sheets (In basket general user guide and manager's guide) for clinical groups. • Started to develop a Trust-wide dashboard providing oversight of results acknowledgement compliance.

Progress against our 2024/25 priorities

Our quality priorities	What success will look like	2024/25 Summary
Patient experience		
We will improve the experience of our patients through better communications and ways to contact the Trust.	We will: • Develop a 'Contacting us' quality improvement project, phased over 2 years, with clear deliverables reflecting the multiple approaches that need improving for our patients. • Start the first phase of deliverables within the first year. • Success will be measured by monitoring the volume of patient queries and complaints received about difficulties contacting a clinical area.	We have: • Developed a multi-year programme to ensure we improve the experience of our patients and our ability to provide more accessible and equitable healthcare across the user journey. • Obtained Charity funding to stand up 2 specialist workstreams and begin programme coordination. • Established a programme management team to start the first 2 work streams.

Statements of assurance from the Board of Directors

This section contains the statutory statements concerning the quality of services provided by Guy's and St Thomas' NHS Foundation Trust. These are common to all quality accounts and can be used to compare us with other organisations.

A review of our services

Guy's and St Thomas' NHS Foundation Trust provides integrated hospital and community services for adults and children. Across our 5 hospitals, and in the community, we provide comprehensive lifelong healthcare – caring for patients from pre-conception and birth, through childhood, adulthood and into old age.

We are one of the largest trusts in England and Wales and during 2024/25 we saw 1,952,000 outpatients, 88,000 inpatients, 106,000 day case patients and 211,000 accident and emergency attendances. We also provided over 692,000 contacts in the community, bringing our total patient contacts to 3.05 million. We employ 23,700 staff. Further information about our services are available on the Guy's and St Thomas', Evelina London and Royal Brompton and Harefield hospitals websites. Detail of the Trust's registered locations and regulated activities is available on our CQC provider page: www.cqc.org.uk/provider/RJ1/services.

Participation in clinical audits and national confidential enquiries

Clinical audits aim to improve patient care by reviewing services against agreed standards of care and making changes where necessary. National Confidential Enquiries into Patient Outcomes and Deaths investigate a specific area of healthcare and recommend ways to improve it.

We are committed to participating in relevant national audits and national confidential enquiries to help assess the quality of healthcare nationally and to make improvements in safety and clinical effectiveness.

Alongside this the Trust has developed a Trust-wide audit plan. This was developed to reflect themes identified through incident reporting, specific risks and core areas for assurance on quality.

Trust-wide audits completed during 2024/25 include the following:

Audit title	The audit demonstrated that:
Consent The objective was to audit the quality of consent form completion in documenting risk and potential complications in accordance with the Trust consent policy.	• Quantified risk, risk of anaesthesia and explanation of alternative treatments is not consistently documented. • Consent form is not always signed. • Almost 33% of consent forms used abbreviations which may not be understood or could be misinterpreted by patients, families and staff. • Actions are required: a plan is being developed to address the key issues highlighted from the audit.
Mental health on the emergency floor The objective was to audit the quality of documentation and monitoring of patients with mental health needs attending our emergency department, and compliance with assigning registered mental health nurses.	• Approximately 60% of patient records had an initial risk assessment recorded in the Emergency Department (ED). While the risk assessment tool is not currently completed for every patient presenting with a mental health problem, ED clinicians still implement a risk management plan for the majority of mental health patients while they wait for further specialist assessment. • Enhanced observations (one-to-one care) were the most commonly recorded intervention. • Actions are required to address key risks. We have developed mental health specific training, including managing suicide risks for ED staff, and we are reviewing the ED and mental health liaison team parallel assessment tool.
Duty of candour The objective was to audit the compliance with documentation of the Trust duty of candour and being open policy on our incident management system in relation to incidents causing moderate or more severe harm to patients.	• Verbal apology compliance improved from 88% (2022/23) to 91% (2023/24). • Written apology compliance decreased from 80% (2022/23) to 71% (2023/24). • Outcome sharing compliance decreased from 60% (2022/23) to 50% (2023/24). • While statutory duty of candour was completed and evidenced, for example, in a patient's clinical records, the Trust's local risk management system had not documented or saved copies of letters in all instances. The sharing of outcomes following investigations was slightly delayed due to the time taken from incident occurring and the learning being identified. • Since the audit, the Trust has introduced a new local risk management system which uploads harm and duty of candour compliance in real time to NHS England. Compliance with duty of candour continues to be monitored via performance metrics and governance committees. All incidents from our previous local risk management systems have now been closed with duty of candour documented as applicable.

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Trust-wide audits completed during 2024/25 include the following:

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Audit title	The audit demonstrated that:
Surgical safety checklists This audit was conducted to help identify changes required to the surgical safety checklist process	• Following the launch of Epic, our new electronic health record system, some checklists were merged with checklists from King's College Hospital NHS Foundation Trust which resulted in additional or missing checks that specialties had requested to support their practice. These were checks in addition to the minimum criteria. • The critical changes were addressed and future changes are in progress as part of the surgical safety checklist improvement programme. • A survey was conducted to gather feedback from relevant staff groups regarding the checklist's functionality to look to simplify the checklist model.
Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) and associated treatment escalation plans The aim was to audit the appropriate documentation and assessment of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders for in patients.	• All DNACPR decisions were felt to be clinically appropriate. • A senior clinician was involved in all new DNACPR decisions with only a few examples of community DNACPRs or existing forms being reinstated by junior members of the team without senior supervision. However, all previous DNACPR decisions had been made with senior clinician involvement. • The documentation of rationale for decision-making was reasonable in the majority of cases although not always clearly included within the DNACPR form itself. Those forms which were reinstating an existing form or community DNACPR frequently did not include the initial rationale for the decision.

The Trust-wide audits planned for 2025/26 are:

Audit title	Audit objective
Consent	• Audit the quality of consent form completion in documenting risk and potential complications in accordance with the Trust consent policy.
Duty of Candour	• Audit compliance with the Trust duty of candour and being open policy in relation to incidents causing moderate or more severe harm to patients.
Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) and associated treatment escalation plans	• Audit the appropriate documentation and assessment of DNACPR orders for inpatients.
Safe discharge	• Audit compliance with the Trust discharge policy and managing patient choice in discharge.

Participation in national clinical audits 2024/25

In 2024/25, we participated in 43 national clinical audit programmes, which included 89 individual national clinical audits and 5 national confidential enquiries.

The national clinical audit programmes and national confidential enquiries that we participated in during 2024/25 are shown in the tables which follow. The information provided also includes the number of cases submitted to each audit programme or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Submitting data to national audit programmes is an important responsibility for the Trust, however, the participation in these audits requires substantial clinical and administrative time. We continue to enhance the use of Epic, our new electronic health record system, to integrate national audit data collection and there are a total of 11 national clinical audits now operational. It will provide increased automation of data collection, validation and engagement, enabling clinicians to focus on the outcomes from our audit data to further improve patient care.

Audit programme title	Participation	% of cases submitted
Adult Respiratory Support Audit	Yes	100%
BAUS Urology Audits	Yes	100%
Breast and Cosmetic Implant Registry	Yes	100%
British Hernia Society Registry	Yes	Data collection on-going
Case Mix Programme (CMP)	Yes	Data submitted. Awaiting publication
Cleft Registry and Audit Network (CRANE)	Yes	100%
Elective Surgery (National PROMs Programme)	Yes	Data submitted. Awaiting publication
Emergency Medicine QIPs	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP)	Yes	100%
Gestational Diabetes	Yes	Data submitted. Awaiting publication
Kidney Audits	Yes	100%
Learning Disability and Autism Programme	Yes	Data submitted. Awaiting publication
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	Data collection on-going
Mothers and Babies: Reducing Risk through Audit and Confidential Enquires (MBRRACE)	Yes	100%
National Adult Diabetes Audit (NDA)	Yes	Data submitted. Awaiting publication

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Audit title	Participation	% of cases submitted
National Audit of Cardiac Rehabilitation	Yes	Data submitted. Awaiting publication
National Audit of Care at the End of Life (NACEL)	Yes	Data collection on-going
National Audit of Dementia	Yes	Data collection on-going
National Cancer Audit Collaborating Centre (NATCAN)	Yes	Data collection on-going
National Cardiac Arrest Audit (NCAA)	Yes	Data submitted. Awaiting publication
National Cardiac Audit Programme (NCAP)	Yes	100%
National Child Mortality Database (NCMD) Programme	Yes	100%
National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy12)	Yes	100%
National Comparative Audit of Blood Transfusion	Yes	100%
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	100%
National Joint Registry	Yes	Data submitted. Awaiting publication
National Lung Cancer Audit (NLCA)	Yes	Data collection on-going
National Maternity and Perinatal Audit (NMPA)	Yes	Data submitted. Awaiting publication
National Major Trauma Registry Network	Yes	100%
National Neonatal Audit Programme (NNAP)	Yes	100%
National Obesity Audit (NOA)	Yes	100%
National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	Data collection ongoing
National Ophthalmology Database Audit (NOD)	Yes	100%
National Paediatric Diabetes Audit (NPDA)	Yes	100%
National Respiratory Audit Programme (NRAP)	Yes	100%
National Vascular Registry (NVR)	Yes	Data submitted. Awaiting publication
Paediatric Intensive Care Audit Network (PICANet)	Yes	100%
Perinatal Mortality Review Tool (PMRT)	Yes	Data collection on-going
Perioperative Quality Improvement Programme (PQIP)	Yes	Data collection on-going
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Yes	100%
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS)	Yes	Data collection on-going

Please note: 'Data collection on-going' indicates that the national clinical audit period for data collection is still open for submissions.

Participation in national clinical audits 2024/25

Below are examples of national audit findings and improvement actions for our Trust:

National Respiratory Audit Programme (NRAP): Pulmonary Rehabilitation Workstream

This is a UK-based initiative that collects and analyses data on pulmonary rehabilitation services for patients with chronic respiratory conditions, like Chronic Obstructive Pulmonary Disease (COPD). Its goal is to assess the quality and accessibility of pulmonary rehabilitation, identify areas for improvement, and ensure that patients receive effective care to improve their breathing and quality of life. The audit helps guide healthcare professionals and inform policy decisions related to respiratory care.

Reviewing the data shows that Guy's and St Thomas' has done well in the following categories:

- **Assessments**: Completion of the Medical Research Council (MRC) Dyspnoea Scale consistently meets or exceeds the national average of 87%-100%.
- **Waiting times**: For non-acute exacerbations our waiting time is 43 days, meeting the national target of 90 days.
- **Walk tests**: Walk tests at assessment and discharge: We consistently meet the national average (100% vs. 90% nationally).

We identified that an important area for improvement was to increase the percentage of patients completing discharge assessments. Our Trust score fluctuates between 52% to 88% but does not consistently meet the national quality improvement target of 70%. However, 100% of patients with a discharge assessment did receive a written plan. Actions to improve consistency of discharge assessments include developing a new community service to improve patient travel and access, and a telephone-based programme for patients who do not attend in person.

National Audit of Percutaneous Coronary Intervention (NAPCI)

This audit, which collects data on Percutaneous Coronary Interventions (PCI) performed in the NHS and selected private hospitals across the UK, tracks activity related to angioplasty procedures. PCI, or angioplasty, is a medical procedure used to treat obstructions in the heart arteries, which supply blood to the heart muscle and can cause chest pain (angina). When symptoms cannot be controlled with medication, PCI is used to improve blood flow by overcoming these blockages. An alternative treatment for severe cases is coronary artery bypass grafting (CABG).

Reviewing the data shows that the Trust has done well in the following categories:

- Intracoronary imaging was used in 78.5% of PCI procedures of the unprotected left main stem, which is greater than 75% recommended benchmark.
- Median call-to-balloon time for patients treated with Primary PCI (PPCI) for ST-elevation myocardial infarction (STEMI) is 139 minutes, which is well within the recommended benchmark of less than 150 minutes.
- Median door-to-balloon time for patients treated with PPCI for STEMI is 61 minutes, which is well within the recommended benchmark of less than 90 minutes.

We have identified 2 key areas for improvement to the current PCI procedures. First, only 64.6% of elective PCI procedures are being performed as a day case, which is 10.4% below the recommended standard of 75%. Second, newer P2Y12 antiplatelet drugs, such as Ticagrelor or Prasugrel, were only used in 63% of STEMI patients treated by PPCI, which is also below the recommended 75% standard.

Participation in National Confidential Enquiries into Patient Outcome and Death 2024/25

We participated in 5 NCEPOD studies in 2024/25. We await the final reports and recommendations for review.

Audit title	Participation	% of cases submitted
ICU rehabilitation following critical Ilness	Yes	100%
Abnormal blood sodium	Yes	100%
Paediatric emergency surgery	Yes	88%*
Acute limb ischaemia	Yes	100%
Acute illness in people with a learning disability**	Yes	Data collection on-going

* A total of 22 cases were submitted. The Trust was unable to submit 3 cases due to clinician capacity to complete the questionnaires by the deadline.
** This study is about to start and we have provided provisional data.

Local clinical audit

A total of 1,466 local clinical audits were registered in 2024/25. These audits were proposed by clinical and non-clinical staff for various reasons including measurement of compliance against guidelines and to support quality improvement initiatives. Prior to undertaking a project, the audit proposer discusses their plan with their local audit lead, following which the project is registered and approved via the Trust's audit database. Below are examples from across the Trust that demonstrate some of the actions taken to improve the quality and safety of our services following audit findings.

Therapies and rehabilitation

An audit was undertaken to improve the pathway for nerve conduction studies by allowing first contact practitioners (FCPs), who are physiotherapists in GP practices, to make direct referrals to the neurology department. Previously, FCPs could not order these studies directly, leading to an inefficient process and delays. The first cycle included scoping sessions with stakeholders such as FCPs, GPs, patients, and the nerve conduction department, resulting in a co-produced referral pathway that allowed direct FCP referrals. This change reduced test waiting times from 67 to 21 days and improved satisfaction, efficiency, and capacity.

Transplant, renal and urology

An audit on short-notice cancellations in adult living donor transplantation revealed that 19 out of 60 living donor transplants (1 in 3) were cancelled within 5 days of the scheduled surgery. These cancellations posed significant logistical challenges, including donor and recipient rearrangement and theatre time wastage. Of these cancellations, 12 were deemed preventable, and 3 occurred at external units. Following collaborative work and implementation of interventions, the number of short-notice cancellations (within 5 days) was reduced significantly from 37.5% to 4.5%. This marked a notable improvement in patient care, donor logistics, and service efficiency.

Cardiovascular services

An audit of heart failure ward round information was undertaken to measure the quality of clinical information available on handover as it as felt that there were areas for improvement. Baseline data was collected from 20 heart failure patients using 20 parameters (e.g. date, lead consultant, problem list, ejection fraction, weight trends, medication details, key blood markers, and discharge plans), which showed variations in documentation – while some parameters, such as the care plan, were frequently recorded, others, such as weight trends and heart failure medications, were noted in only about 50% of cases. As a result, the team designed a ward round checklist that captured 20 key parameters specific to heart failure which resulted in a significant improvement, with up to 85% of parameters now being recorded.

Our participation in clinical research

Guy's and St Thomas' is committed to carrying out pioneering research to find the best treatments for some of the most complex conditions, to benefit patients locally, nationally and internationally. A number of our teams are leading national and international research.

During 2024/25, the Trust had 2,051 studies open across its research portfolio comprising 1,348 non-commercial clinical studies and 703 commercial clinical studies. We have recruited 25,240 participants to these research studies. The Trust has exceeded its target for the patient research experience survey carried out on behalf of the Clinical Research Network, with 1,423 participants completing the survey during 2024/25. In 2024/25 Guy's and St Thomas' moved up from 8th to 6th highest recruiting Trust to research studies in the UK.

Over the past year the King's Health Partners Centre for Translational Medicine has strengthened our research collaborations, and we've continued to support the regional network as host of the new South London Regional Research Delivery Network. The King's College London and Guy's and St Thomas' Joint Research Office has been launched to foster collaboration, improve research efficiency and support innovative projects across both Trusts. We were selected to host one of 14 new Commercial Research Delivery Centres across England that aims to enhance the speed and efficiency of commercial clinical research delivery in south London.

Our Commissioning for Quality and Innovation (CQUIN) performance

NHS England have 'paused' the CQUIN programme for 2024/25 and have published a refreshed non-mandatory list of CQUIN indicators for Integrated Care Systems and Trusts to integrate into their current quality and performance metrics, and align with local priorities. Contractually, these indicators are without an embedded financial risk. To date, no further action has been taken to collaborate across south east London on the delivery of a shared CQUIN.

Statements from the Care Quality Commission

Guy's and St Thomas' NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'registered without conditions or restrictions'. The CQC has not taken enforcement action against Guy's and St Thomas' NHS Foundation Trust during 2024/25.

The Trust's last full inspection and assessment by the CQC was in April and May 2019. We were pleased to have maintained an overall rating of 'good' and that our community services for adults were rated as 'outstanding'. This was a significant achievement given the size and complexity of the Trust, and reflects the dedication of our staff. The Trust was rated 'outstanding' for caring services and for being well-led, 'good' for effective and responsive services, and 'requires improvement' for safe services.

Royal Brompton and Harefield hospitals were last assessed by the CQC in October and November 2018, when they were rated as 'good' overall. The Trust has not had a full Trust-wide inspection since the merger of Guy's and St Thomas' NHS Foundation Trust with Royal Brompton and Harefield NHS Foundation Trust in 2021.

Summary of ratings from the last Trust-wide inspection, April - May 2019:

The CQC's quality inspection framework has moved to a more frequent service-specific inspection model and assesses trusts against new 'quality statements'. This will result in more frequent inspections of NHS services, but fewer trust-wide service inspections.

The CQC last carried out a service-specific inspection in September 2022 focused on our maternity service at St Thomas' Hospital. The service was rated 'good' overall with positive findings, and there were no immediate actions required or changes to the Trust's overall CQC ratings as a result. It is disappointing that our maternity services were rated 'requires improvement' under the safe domain, and improvement actions are underway.

As part of our ongoing 'Good to outstanding' programme, we have increased both midwifery and medical staffing levels in the Maternity Assessment Unit, and continue to improve the environment for women, families and staff. The plan continues to be monitored by our Women's and Children's Clinical Group, with oversight by our Trust Executive. Improvement actions aim to be completed in financial year 2025/26.

We continue to focus on a range of actions to meet the well-led requirements and to provide assurance of our compliance with the Health and Social Care Act 2008 (Regulated Activities) and Regulations 2010, as set out in the CQC's guidance for providers. These include a well-established ward accreditation programme and quality self-assessments supported by a developing programme of quality reviews and visits in line with the new CQC quality statements, which replaced the former 'Key Lines of Enquiry' in 2023/24.

Previous reports and full details of the inspections of Guy's and St Thomas' NHS Foundation Trust are available on the CQC website (www.cqc.org.uk/provider/RJ1).

Our data quality

Good information governance means keeping the information we hold about our patients and staff safe. The 'Data Security and Protection Toolkit' is used to evidence our compliance with national data protection standards. All NHS organisations are required to make an annual submission to demonstrate compliance with data protection and security requirements.

Our latest full audit against the clinical coding element of the overall Data Security and Protection Toolkit was completed in March 2025. 200 episodes were audited from 6 specialities with discharge dates between May and July 2024. A summary of the findings is presented in the table below:

Data Security and Protection Toolkit assessment

	Score (March 2025)	Quality of coding
Primary diagnosis	86.0%	Met the mandatory standards
Secondary diagnosis	90.5%	Standards exceeded
Primary procedure	88.0%	Met the mandatory standards
Secondary procedure	90.5%	Standards exceeded

Clinical coding

Overall quality of coding meets the mandatory standards but decreased compared with the 2023/24 audit results. Coding quality was affected by:

- The merger with Royal Brompton and Harefield led to disparate structures and working methods across the Trust. A restructure of the clinical coding department took place during 2024 to address this.
- The transition to Epic exacerbated the backlog of coding work and led to a decrease in productivity as teams adapted to the new system.

Learning from deaths

Deaths at the Trust are recorded in line with the national approach through a local risk management system and using our mortality review process. This enables review and discussion at service and directorate morbidity and mortality meetings. A proportion of deaths also undergo a more detailed review.

Our 'Learning from Deaths' policy is based on the framework set out in the National Quality Board's (NQB) publication 'National guidance on learning from deaths' published in March 2017.

Detailed case record review is undertaken using the Royal College of Physicians' Structured Judgement Review (SJR) methodology for any adult death meeting one of the defined categories below.

- A patient with a learning disability or autism
- A patient being treated for severe mental illness
- A patient not expected to die (including an elective patient or unexpected death)
- Significant concerns raised relating to quality of care by family, carers or staff
- Death in a service or specialty, particular diagnosis or treatment group where an alarm has been raised
- Death where learning will inform existing or planned quality improvement work (including PSIRF priorities).

Services may also undertake additional detailed case record reviews as part of their own mortality review processes and feed any lessons learned from these to the central quality and assurance team for wider learning. In addition, while the Royal College of Physicians SJR methodology and the NQB guidance on learning from deaths only relate to the episode of care where their death occurred, services may include previous episodes of care in their case review if they feel that this will enhance learning.

Maternal deaths are reportable to the MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK. This covers the deaths from pregnancy up to one year postnatal. The Maternity and Newborn Safety Investigations (MNSI) national programme investigates when mothers die whilst pregnant or within 42 days of the end of their pregnancy.

The Trust has a robust and comprehensive system in place to implement the national statutory and operational guidance for child death reviews. This covers the deaths of all babies receiving neonatal care, children and young people from 22 weeks gestation up to their 18th birthday, regardless of location of care.

Sharing of learning

Learning from reviews of deaths, including those reviewed by detailed case record review, is discussed and shared through local service and directorate mortality meetings. Themes from these meetings are shared at the monthly Trust Mortality Surveillance Group, Trust Risk and Assurance Committee with the Trust Board. Learning from child death reviews is shared locally, regionally and nationally via multi-disciplinary Child Death Review Meetings, Child Death Overview Panels and the National Child Mortality Database.

During the period April 2024 to March 2025

	Q1	Q2	Q3	Q4	Total
Number of adult inpatients patients who died	287	301	292	292	1,172
Number of paediatric inpatients who died	20	17	19	22	78
Number of adult inpatient deaths subjected to Structured Judgement Review or investigation	46	44	58	35	183
Estimate of the number of deaths thought to be more likely than not due to problems in the care provided	1	0	4	0	5

Themes that have emerged from reviews of deaths at the Trust include: sepsis, nasogastric tube management and treatment escalation planning. Actions to address these issues are presented in the below table:

Thematic learning

Thematic learning	Summary of completed action(s)	Summary of planned actions and/or sharing of thematic learning
Sepsis	• Sepsis quality improvement project rolled-out across inpatient wards using the sepsis screening tool in Epic. • Sepsis screening high and moderate latest results now available on storyboard (patient's health record landing page) • Implemented processes to ensure that patients, families, carers and staff have round-the-clock access to a rapid review from a separate care team, if they have a concern.	• Implement the 60-minute timer on Epic to help with sepsis management. • Review Epic documentation of NEWS scores to ensure a visual flag is provided when score is concerning. • Implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily (Martha's Rule: Component 3)
Nasogastric tube (NG) management	• Standardised training, competencies and policies to describe how processes are carried out by different staff groups. • Reviewed x-ray reporting times. • Embedded use of the Epic handover function to record clinical events and key information between shifts.	• Review Trust mandatory training resources to ensure fully aligned to policy and guidance. • NG tube imaging requests are not immediately obvious to radiologists, therefore develop an escalation process if the volume of work is too high. • Review handover process between members of the multi-disciplinary team to ensure the process is robust.
Treatment Escalation Panning (TEP)	• Trust standard agreed: TEP to be recorded for all inpatients with DNACPR order. • TEP documentation now available on storyboard (patient's health record landing page). • Standardised documentation of TEP conversations. • Updated ward accreditation process, it now includes a question for all patients who have DNACPR – do they also have TEP as expected?	• Review documentation to ensure mental capacity, discussion with patient/carer and evidence of supporting information provided is included within the TEP navigator. • Monitor ward accreditation audit results. • Improve usage of London Universal Care Plan.

Freedom to Speak Up

At Guy's and St Thomas' NHS Foundation Trust we are committed to creating a culture where everyone feels able and confident to speak up. The Trust's 'Showing we care by speaking up' initiative encourages all staff to speak up about concerns they may have about patient safety or the way the Trust is run. The initiative is led by a team of 3 full-time and 2 part-time Freedom to Speak Up guardians, supported by a large network of around 180 'speaking up' champions across the Trust. The guardians play an active and visible role in raising awareness, developing staff and dealing with concerns. They ensure that our governance processes are robust and effective, and report on their work and key themes to the People, Culture and Education Committee and Trust Board on a regular basis.

The Trust scores above the national average in the NHS Staff Survey in relation to staff feeling safe and confident in raising concerns about unsafe clinical practice, which demonstrates a positive speaking up culture. During 2024/25, 370 contacts were made to the guardians, and key themes are shared with the National Guardian's Office on a quarterly basis and published on the public website. Additional metrics are recorded to help understand which services and staff groups contact the service. Ethnicity and other diversity data are also used to help target the promotion of the service to ensure an open and transparent culture where all staff feel able to raise concerns.

The National Guardian's Office training modules are available on our College of Healthcare Learning Hub, and Trust guardians encourage all staff to compete their relevant training. The Freedom to Speak Up service works closely with the Trust mediation service, which may be able to resolve concerns without the need to raise a formal grievance or initiate a disciplinary process. The speak up guardians also work with the Equality, Diversity and Inclusion team and staff networks to promote the training and education offered to staff and to increase awareness of bias, including the impact of micro-aggressions and frameworks for calling out inappropriate behaviour safely and effectively.

Resident doctor rota gaps

Resident Doctors (post graduate doctors/doctors in training) are allocated to the Trust by Health Education England (HEE). In 2024/25, we had a total of 132 vacancies as confirmed by Health Education England with an average of 11 gaps per month over the 12-month period.

Any unfilled posts from HEE are recruited to with local Trust grade posts as directed by the respective recruiting manager. The Trust does not keep a central record of rota gaps but any specific issues are reviewed by the medical workforce, the local clinical group human resources team and the office of the Guardian of Safe Working teams.

The Trust continues to experience recruitment difficulties in common with the rest of the NHS, particularly for middle-grade posts and in a number of specialties – including anaesthetics, paediatrics and paediatric intensive care roles. However, the Trust medical workforce and anaesthetics teams implement a Certificate of Eligibility of Specialist Registration rotation with partners University College London Hospitals NHS Foundation Trust, and Lewisham and Greenwich NHS Trust, in order to attract and retain middle grade doctors.

Paediatrics and anaesthetics remain a particular area of concern across London and, while the Trust supports initiatives such as flexible working, the need for staff to achieve better work/life balance continues to present a problem in some specialties.

National core set of quality indicators

All acute Trusts are required to report their performance against a set of 8 quality indicators with the aim of making it possible for a 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 this data is available. The key indicators are detailed below.

Mortality

The summary hospital level mortality indicator (SHMI) is a mortality measure that takes account of a number of factors, including a patient's condition. It includes patients who have died while having treatment in hospital or within 30 days of being discharged from hospital.

The SHMI score is measured against the NHS average which is 100. A score below 100 denotes a lower than average mortality rate and therefore indicates good, safe care. Data is collated internally and then submitted on a monthly basis to NHS Digital via the Secondary Uses Service. The mortality indicator is then calculated by NHS Digital, with results reported quarterly on a rolling year basis.

We believe our performance reflects that:

- the Trust has a process in place for collating data on hospital admissions, from which the SHMI is derived
- the Trust's mortality rate is consistently 'lower than expected', which is a quality indicator of safe patient care
- the Trust reported a high percentage of records with missing data for the Sex field following the launch of Epic, which contributed to an increased SHMI during the April 2023 to March 2024 period. Missing data for the Sex field has been resolved from April 2024 onwards.

Summary hospital-level mortality indicator

	April 18 - March 19	July 18 - June 19	April 19 - March 20	Nov 20 - Oct 21	April 21 - March 22	April 22 - March 23	April 23 - March 24
SHMI	71	73	76	75	71	78	88
Banding	3	3	3	3	3	3	3
% deaths with palliative care coding	56.2%	56.2%	56.1%	53.0%	54.0%	50.0%	50.0%

Source: NHS Digital (data updated quarterly on a rolling basis) SHMI Banding
3 = mortality rate is lower than expected

Patient reported outcome measures

Patient reported outcome measures (PROMS) look to measure quality from the patient's perspective, and seek to calculate the health gain experienced by patients following either a hip replacement or knee replacement. The most recent publication of these measures in England is April 2023 to March 2024.

Patients who have had these procedures are asked to complete a short questionnaire which measures their health status or health related quality of life at a moment in time. The questionnaire is completed before, and then some months after surgery, and the difference between the 2 sets of responses is used to determine the outcome of the procedure as perceived by the patient. This provides a score between 0 and 1 based on how improved the patient's health is post-operation; and a score closer to 1 (or 100%) is best.

We are a specialist referral centre and we often treat patients with complex treatment needs whose perception of health gain may be influenced by other health factors.

In 2023/24 there were 702 eligible hospital episodes and 525 pre-operative questionnaires returned – a participation rate of 74.8% (69.3% in England). Of the 236 post-operative questionnaires sent out, 236 have been returned – a response rate of 100% (47.6% in England).

Clinicians regularly review scores at a service and Trust-level to ensure that what we learn from patient feedback is incorporated into our quality improvement programmes.

We believe our performance reflects that:

- the Trust has a strong process in place for collating data on patient reported outcomes, with high participation
- data is compared to peers, highest and lowest performers, and our own previous performance, as set out below and overleaf.
- our scores show the Trust having one of the lowest perceptions of health gain for patients having primary hip and knee replacements, and we are working to improve this. Local department PROMs data demonstrates that the Trust has higher than reported positive health gains for the same time period, we will working with NHS England to understand why there is a difference between local gathered data and NHS England published data.

Adjusted Average Health Gain (EQ-5D) Primary hip replacement	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Guy's and St Thomas'	0.44	0.45	0.43	0.37	0.38	0.36
National average	0.46	0.45	0.47	0.46	0.46	0.46
Highest performing Trust	0.55	0.53	0.57	0.53	0.55	0.58
Lowest performing Trust	0.33	0.37	0.39	0.37	0.36	0.35

Adjusted Average Health Gain (EQ-5D) Primary knee replacement	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Guy's and St Thomas'	0.29	0.31	Data unavailable	0.26	0.27	0.23
National average	0.34	0.33	0.32	0.32	0.33	0.32
Highest performing Trust	0.41	0.45	0.40	0.42	0.41	0.41
Lowest performing Trust	0.25	0.21	0.18	0.25	0.24	0.23

Readmission within 28 days of discharge

Using data from the Healthcare Evaluation Data (HED) system, we are able to access full year information for 2023/24 and part-year (M1-M9) for 2024-25. The HED system provides national average performance rates, and the capacity to benchmark our performance against peers.

Data is collated internally and then submitted on a monthly basis to NHS Digital via the Secondary Uses Service (SUS). This data is then used by the Healthcare Evaluation Data system to calculate readmission rates.

We believe our performance reflects that:

- The Trust has a process in place for collating data on hospital admissions, from which the readmissions indicator is derived.
- The introduction of Epic, in October 2023, provided the opportunity for us to align with national guidance and to exclude Same Day Emergency Care (SDEC) patients from the Trust's readmission data outlined in Table 1. As a result, the information provided below demonstrates an artificial decrease in the calculated emergency readmission rate in comparison to the levels seen before the implementation of Epic.
- A year-on-year reduction to the emergency readmission rate since 2021/22 has been demonstrated by a piece of analysis conducted by the Trust excluding SDEC patients over this same period.

Readmissions	2022/23			2023/24			2024/25 (Jan – Sept)		
	Under 16	16 & Over	Total	Under 16	16 & Over	Total	Under 16	16 & Over	Total
Discharges	33,127	283,089	316,216	32,549	275,028	307,577	24,694	208,176	232,870
28 day readmissions	1,865	14,616	16,481	1,743	12,626	14,369	1,154	8,036	9,190
28 day readmission rate	5.6%	5.2%	5.2%	5.4%	4.6%	4.7%	4.7%	3.9%	4.0%

Source: Healthcare Evaluation Data

The Trust will further refine its focus and strategy for reducing the number of patients requiring readmission by:

- Further refining readmission data, including improved granularity of information, and integration into the Trust performance framework to allow for the most effective approach to be adopted in managing this target.
- Continuing to work with the elderly care team to improve our ability to review all cases at a multidisciplinary team meeting and in turn to further support improvement in clinical practice.
- Improving the working relationship with primary care and community teams to better manage patients who are regularly readmitted to secondary care.

Patient experience

The NHS Outcomes Framework Indicator 'Responsiveness to personal needs' is a composite of several questions from the Adult Inpatient Survey. The NHS Outcomes Framework not published a composite score published since 2020/21.

The Care Quality Commission (CQC) publish results from each question individually but the composite cannot be calculated from this data. Therefore, scores for each individual question are included below.

A summary of results from individual questions from the Adult Inpatient Survey 2023 is included below. The Trust scores for the answers to these questions were rated as 'about the same' as other trusts of a similar size and type, except for the question about medicines which was rated as 'somewhat better than expected'.

Adult Inpatient Survey 2023	**Question 25** To what extent did staff looking after you involve you in decisions about your care and treatment?	**Question 27** Did you feel able to talk to members of hospital staff about your worries and fears?	**Question 28** Were you given enough privacy when being examined or treated?	**Question 41** Thinking about any medicine you were to take at home, were you given any of the following information?	**Question 43** Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?
Guy's and St Thomas'	7.2	7.7	9.6	4.9	7.9
Highest	8.3	9.1	9.9	6.5	9.7
Lowest	6.3	6.8	9.1	4.9	6.1

Source: Care Quality Commission

Staff recommendation to friends and family

We highly value staff feedback from the national Staff Survey, particularly regarding their willingness to recommend our Trust to their friends and family. Strong staff engagement is reflected in both the NHS Staff Survey and the Quarterly Pulse Survey, which consistently show a highly positive perception of our services. Staff recommendations serve as a key indicator of the quality of care provided and in 2024 we scored 4th nationally and 2nd in London for staff recommending the Trust to a friend or relative as a place to receive care or receive treatment.

The Trust partners with an external contractor, Quality Health/IQVIA, to manage data collection for these surveys. The results are then submitted to NHS England and benchmarked against the 'Acute, Acute and Community Trusts' category. Our organisation's performance is detailed in the table below.

Staff recommendation	2021	2022	2023	2024
Guy's and St Thomas'	86%	82%	81%	82%
Average for combined acute/community trust	67%	62%	63%	62%
Highest combined acute/community trust	90%	86%	89%	90%
Lowest combined acute/community trust	44%	39%	44%	40%

Source: : NHS staff surveys

Patient recommendation to friends and family

We believe that patient recommendations to their friends and family is a key indicator of the quality of care we provide. For 2024/25 the Trust has provided a breakdown of the Friends and Family Test for maternity, emergency care, inpatient and outpatient services, as well as comparison to the national average. Data is collated internally and then submitted on a monthly basis to NHS Digital. NHS England does not publish response rates for individual areas of care.

We believe our performance reflects that:

- The Trust has a process in place for collating and analysing data from the Friends and Family Test
- The Trust scores for A&E, inpatient, maternity birth and community postnatal care are better than national average scores
- Data is comparable to the national average for outpatients
- Positive scores for maternity antenatal and postnatal ward are markedly below the national average; inconsistent capture of responses has affected the scores for 2024/25. As a result, increasing the volume of feedback captured from women, and making improvements based on their feedback, is a core element of the Good to Outstanding Programme being delivered by our maternity services in 2025/26.

Friends and Family Test 2024/25							
Guy's and St Thomas'	A&E	In-patient	Out-patient	Maternity Antenatal	Maternity Birth	Maternity Postnatal Ward	Maternity Postnatal Community
% Positive response	84.7%	96.5%	93.9%	89.7%	94.2%	87.4%	93.2%
National average*	78.6%	93.0%	94.0%	91.6%	92.3%	92.3%	92.7%
% Negative response	9.6%	1.0%	3.1%	6.5%	1.9%	4.3%	6.1%
National average*	13.9%	4.0%	3.0%	6.0%	5.4%	4.9%	4.3%

Source: Trust information system and NHSE website

*National average scores for each area of care are currently based on an average of 10 months of data from April 2024-Jan 2025 as there is a 2-month time lag with publication of national data.

Friends and Family Test 2023/24							
Guy's and St Thomas'	A&E	In-patient	Out-patient	Maternity Antenatal	Maternity Birth	Maternity Postnatal Ward	Maternity Postnatal Community
% Positive response	82.7%	94.2%	92.7%	86.7%	93.1%	83.3%	97.7%
National Average	79.5%	94.3%	93.9%	91.4%	93.8%	92.3%	92.3%
% Negative response	10.1%	1.9%	3.9%	7.3%	3.0%	7.6%	0.0%
National Average	13.5%	2.8%	3.0%	4.9%	3.7%	3.9%	3.7%

Source: Trust information system and NHSE website

Venous thromboembolism

Venous thromboembolism (VTE) or blood clots, are a major cause of death from hospital admission. Over 50% of blood clots due to hospital admission can be prevented by early assessment of the risk for each patient. The Trust continues to assess more than 95% of patients for risk of thrombosis and bleeding on admission to hospital.

Our clinical staff remain at the forefront of venous thromboembolism care, both nationally and internationally, including through clinical research and service development.

In October 2023 the Trust moved to the Epic electronic health record system which did not include a hard stop to complete a VTE risk assessment for inpatient wards which led to risk assessment completion rates being significantly below the required rate. A solution for inpatient areas (with clinically appropriate exclusions) was implemented in Epic on November 2024. This resulted in significantly improved performance including a drastic reduction in the time to completion for inpatient admissions).

Data is collated internally and then submitted on a monthly basis to the Department of Health and Social Care.

We believe our performance reflects that:

- The Trust has a process in place for collating data on venous thromboembolism assessments
- The transition to Epic resulted in a significant fall in completed VTE risk assessment within 14 hours
- The VTE prevention team are working to improve performance and utilising the Epic infrastructure to meet our targets.

VTE assessments	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Guy's and St Thomas'	96.2%	96.6%	97.9%	97.7%	97.4%	89.1[1]
National average	96%	96%	Data not available – national reporting suspended			
Best performing Trust	99%	99.7%				
Worst performing Trust	89%	87.5%				

[1] Data from October 2023 incorporates reporting across all Trust sites, including Royal Brompton and Harefield, following the implementation of Epic.

Infection control

The Trust continues to implement a range of measures to tackle infection and to improve the safety and quality of our services. These include a strong focus on prevention and antibiotic stewardship and improved environmental hygiene, supported by continuous staff engagement and education. The Trust has continued to report mandatory data via UK Health Security Agency.

The Trust is below the threshold for all Gram-negative blood stream infections, but above the threshold for C. difficile. The threshold for healthcare-associated cases of C. difficile for 2024/25 was no more than 60 cases (set by NHS England based on Trust data from the preceding 12 months). The Trust has exceeded this threshold, reporting a total of 66 healthcare-associated cases for 2024/25. However, the Trust has the lowest C. difficile rate in the Shelford group for the 12th consecutive year, and we have not declared any 'lapse in care' in 2024/25.

- The Trust has a process in place for collating data on C. difficile cases
- Data is collated internally and submitted on a regular basis to UK Health Security Agency
- Effective systems are in place to review cases and improve practice to reduce the risk of C. difficile.

C. Difficile cases	2021/22	2022/23	2023/24	2024/25
Hospital and community onset cases	58	60	62	66
Rate per 100,000 bed-days	15.7	14.7	21.7	Data not available yet
National average	25.2	26.7	46.7	Data not available yet
Best performing trust	0	0	0	Data not available yet
Worst performing trust	78.6	92.8	131.2	Data not available yet

Please note: Data is not comparable with previous years due to a combination of changing national definitions over time.

Patient safety incidents

In March 2024 the Trust moved to the new Learning from Patient Safety Events (LFPSE) system, which replaced the National Reporting Learning System and provides an automatic upload of patient safety incidents to NHS England the day after they are reported. The system is a national database designed to promote learning. It is mandatory for NHS trusts in England to upload all patient safety incidents to NHS England via the LFPSE. All incidents resulting in severe harm or death are reported on the LFPSE, which then informs the Care Quality Commission (CQC), meeting the statutory requirement of notifying the CQC of any serious harm or fatal incident.

There is no nationally established and regulated approach to reporting, categorising and validating patient safety incidents, so different trusts may choose to apply different approaches. These judgements may differ between professionals, so data reported by different trusts may not be directly comparable. Equally, levels of harm or patient outcomes may not be known at the time of first reporting an event, so the final level of harm caused by an incident can change overtime and be reuploaded to the LFPSE system.

The way we receive analysis from NHS England about our patient safety incident data changed in 2023/24. Data from NHS England is now annually, as opposed to 6-monthly, and the first annual report from the new LFPSE system is still awaited for 2023/24. NHS Digital's official benchmarking data for 2023/24 was not available at the time of publishing this report. Our figures below can therefore only be updated with published benchmarking data for April 2022 to March 2023 (2 years in arrears). However, we have provided our internal patient safety incident reporting rates and harm levels for transparency whilst we await the official benchmarking data.

The number of patient safety incidents reported continues to reflect a positive reporting culture and we remain one of the top reporters of patient safety incidents in the NHS. It is worth noting that the number of reported Patient Safety incidents is significantly higher in the last financial year, due to an improved reporting form which is linked to Epic. For the periods where comparators are available, the number and percentage of incidents resulting in severe harm or death remains consistently around the national average.

We believe our performance reflects that:

- the Trust has a robust process in place for collating data on patient safety incidents and reporting them to NHS England and the CQC as required.
- data is now submitted on a daily basis direct to the LFPSE System and our reporting rates show a strong safety culture, and our harm rates remain comparable to previous years
- our total number of incidents increased in 2024/25 following the introduction of the LFPSE due to our improved incident reporting software, bringing together all our services onto one reporting system for the first time since our merger with Royal Brompton and Harefield in 2021.

Reported patient safety incidents	April 2022 – March 2023	April 2023 – March 2024	April 2024 – March 2025
Total reported incidents	26,740	26,806	33,211
Rate per 1,000 bed days	74.5	–	–
National average (acute non-specialist)	58.2	–	–
Highest reporting rate	120.2	–	–
Lowest reporting rate	21.5	–	–
Incidents causing severe harm or death	**April 2021 – March 2022**	**April 2022 – March 2023**	**April 2022 – March 2024**
Total incidents causing severe harm or death	71	51	106
% incidents causing severe harm or death	0.3%	0.2%	0.3%
National average (acute non-specialist)	0.4%	–	–
Highest reporting rate	2.3%	–	–
Lowest reporting rate	0	–	–

Source: NHS Digital (2022/23 only) and our Local Risk Management System (Datix and Radar)

Patient Safety Incident Response Framework

In December 2023, we adopted a new investigation methodology under the Patient Safety Incident Review Framework (PSIRF). Under PSIRF the Trust identified 8 patient safety priority areas and published our Patient Safety Incident Response Plan (PSIRP) to address these:

- Medication incidents relating to omitted and delayed medicines, wrong dose administration of medicines, and dispensing delays.
- Inpatient fall-reported Incidents
- Pressure ulcers acquired whilst under Trust care
- Surgical errors as a result of systemic failure to conduct safety checklist
- Failure to identify and act on sepsis or systemic failure to identify the deteriorating patient
- Failure to follow-up and act on the result of diagnostic test
- Patient administration incidents from systemic failure to refer or act on referral from internal or external request
- Paediatric extravasation injury

The Trust will be undertaking a review of all PSIRP priority areas in 2025/26 as well as any new or emerging trends from our new incident reporting system.

Statements

Statement of directors' responsibilities in respect of 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 England 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 2024/25 and supporting guidance
- the content of the quality report is consistent with internal and external sources of information including (non-exhaustive):
  - Board minutes and papers for the period April 2024 to March 2025
  - papers relating to quality reported to the Board and the Trust Executive over the period April 2024 to March 2025
  - national audit publications for the period April 2024 to March 2025
  - feedback from the South East London Integrated Care Board in June 2025
  - feedback from Governors in March 2025
  - feedback from executive and non-executive committee members in May 2025
  - the 2024 national staff survey published March 2025
  - CQC inspection reports dated July 2019 for Guy's and St Thomas' NHS Foundation Trust
  - CQC inspection reports dated September 2022 for maternity services at St Thomas' Hospital
- the quality report presents a balanced picture of the NHS Foundation Trust's quality performance over the period covered. Some quality indicators have been delayed or suspended from external sources and have been stated where non-available and why
- the performance information reported in the quality report is reliable and accurate
- there are internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS England's annual reporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the Board

Charles Alexander, Chairman
25 June 2025

Professor Ian Abbs, Chief Executive Officer
25 June 2025

SEL ICB's Guy's and St Thomas' NHS Foundation Trust 2024/2025 Quality Account Statement.

SEL ICB wishes to thank Guy's and St Thomas' NHS Foundation Trust for sharing their 2024/2025 Quality Account with us and welcomes the opportunity to provide a commissioner statement. We are pleased that the working relationship between SEL ICB and the Trust continues to flourish particularly around quality and the implementation of the national Patient Safety Incident Response Framework (PSIRF) and their move to the Learning from Patient Safety Events (LfPSE) platform, which supports the Trust to take a proportionate approach to patient safety incidents. We confirm that we have reviewed the information contained within the Quality Account and, where possible, information has been cross referenced with data made available to commissioners during the year.

Firstly, SEL ICB would like to congratulate the Trust on their continued optimisation of the Epic electronic patient record which they launched in October 2023, including the launch of their patient portal, MyChart. Their dedication on quality and safety for all patients is demonstrated in their achievement of being a Trust with one of the lowest mortality rates both nationally and internationally despite it being one of the largest trusts in England and Wales.

The ICB would like to thank the staff and management of the Trust for their response in working across the healthcare system to maintain quality and patient safety during the Synnovis Cyber Attack.

The ICB recognises the work undertaken by the Trust to ensure equality and diversity is embedded as business as usual and it's encouragement for all staff to be able to 'speak up' if they have any concerns about patient safety. Its implementation of Martha's rule ensure patients, families, carers and staff will have 24 hours access to a rapid review from a separate care team, should they have any concerns about a patient's condition.

The Trust has continued with its improvement journey, as highlighted in previous years Quality Accounts. It is to be commended on its continued work to improve reduce the length of time some patients are waiting for diagnosis or treatment and its work with partners across south east London.

The ICB acknowledges the achievements made against the quality priorities set for 2023/2024 and for maintaining their overall CQC rating as 'good' overall and for achieving 'outstanding' for their community services for adults.

The ICB would like to acknowledge the part the Trust has played in developing a SEL approach to quality through participation in the SEL System Quality Group (SQG). The ICB welcomes the ongoing commitment of the Trust to improve patient safety across the system during 2025/26 and looks forward to our continued partnership over the coming year.

Paul Larrisey
Interim Chief Nurse
Caldicott Guardian
NHS South East London Integrated Care System

GSTT proposed Quality Priorities 2025-26: Healthwatch Lambeth Response

Thank you for asking Healthwatch Lambeth to provide feedback on the trust's priorities for 2025-6. We appreciate working closely with GSTT to improve services for residents and to make sure their voices, especially those from underrepresented groups, are heard and are central to the Trust's continuous quality improvement.

Quality priority – Patient Safety

Governance and administrative risks impacting patient safety

Administrative issues such as lost referrals or lack of follow-up are a frequent theme in the feedback we receive from patients, which can have an impact on patient safety and outcomes. Therefore, we strongly support this priority. However, we are unclear from what has been presented, what metrics you will use to measure success.

Reducing verbal and physical aggression

This is an important area for both staff and patients, and we welcome the Trust's commitment to supporting staff in this area. Some patients may respond in this way because they are unwell or do not feel they are being listened to. We therefore support plans to listen to both staff and patients in areas where aggression is common. We would like to suggest training staff in communication and trauma informed approaches, understanding the needs of patients with, for example, mental health conditions or other complex needs such as experiencing homelessness and having a dual diagnosis, to help staff feel more prepared.

Quality priority – Clinical effectiveness

Martha's rule – Patient and family input- component 3

We recommend piloting different methods (spoken, written or digital) to gather feedback. This would greatly enhance early detection of deterioration and empower carers and relatives to raise concerns safely and confidently.

Quality priority – Patient experience

Better communication and ways to contact the trust

This priority is of particular importance to our residents. Poor communication is often behind patients and carers having less positive experiences of care when engaging or trying to engage with hospital services. Patients often tell us that they feel frustrated when they can't easily reach hospital teams—whether it's to ask a question, rearrange an appointment or follow up on a referral. We are therefore pleased that the Trust will continue prioritising improvements to patient communication.

We are encouraged by the Trust's plan to improve both the website and the MyChart digital system. Features like being able to self-schedule appointments are very welcome and could save time for both patients and staff given the above-mentioned difficulties. However, it is important that these digital tools are inclusive and not the only option. Many people — particularly older adults, people with disabilities, carers, and those without internet access— still rely on phone calls or in-person support and therefore the ability to contact the Trust must be inclusive. Patient support to use MyChart will also be beneficial.

Healthwatch Southwark were given the opportunity to review and comment on the Trust's quality priorities for the 2025/26 financial year but were unable to submit a response on this occasion. Healthwatch Southwark expressed appreciation for the insights shared and the continued effort to foster closer working relationships.

Guy's and St Thomas' NHS Foundation Trust

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