Guy's and St Thomas'
NHS Foundation Trust

Quality Report 2025/26

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Front cover: Thoracic surgeon Stephanie Fraser, wearing protective vest and collar. Stephanie and colleagues are leading a pilot at Guy’s Hospital that combines artificial intelligence with robotic technology, speeding up diagnosis for patients with suspected lung cancer.

Statement on quality from the Chief Executive 2025/26

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 2025/26 Quality Report has been prepared as a separate standalone 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 2026/27.

Our priority is to provide safe, high-quality care for all patients and to share learning and take action when we fall short of these standards. We are committed to driving continuous improvement, delivering value for money and fostering a culture of excellence across the organisation. This includes ensuring timely access to care and addressing health inequalities, so that all patients receive equitable, effective services when they need them.

Despite sustained demand and the complex operational and financial challenges the Trust has faced during 2025/26, we have sought to deliver care in line with the quality priorities we set ourselves last year. We have continued to work closely with clinical audit, national audit and organisational learning teams to support improvement and strengthen the quality of care we provide.

Some of our key achievements over the past year include:

- Our emergency department is consistently among the best nationally for emergency care and we are proud to have received an 'outstanding' rating in our recent CQC service inspection. Teams have worked hard to improve the experience of our patients and reduce delays to ambulance handovers and admissions. Improving care for patients attending the emergency department and requiring specialist mental health care remains a challenge and a key focus.
- We continue to have one of the lowest mortality rates among similar NHS organisations, including in our critical care units, which is a strong indicator of our relentless focus on quality and safety.
- We have continued to optimise how we use Epic, our electronic health record system, to improve both the safety and quality of care for our patients across the Trust. This includes extending the uptake and functionality of MyChart, our patient portal, which is supporting patients to engage in their care.
- The number of patient safety incidents reported continues to reflect a positive reporting culture where staff feel able to report and learn from mistakes, so we can improve the safety and experience of our services.
- Feedback from the NHS Staff Survey continues to show high levels of engagement, with colleagues expressing strong confidence in the organisation as both a place to work and to receive care. We also achieved the highest national score for the 'We are always learning' theme, highlighting our culture of improvement.
- During 2025/26, we delivered more than 1,400 clinical research studies involving over 27,600 participants, making us the second highest recruiting Trust for clinical research in the UK.
- We completed a comprehensive review of our Patient Safety Incident Response Plan (PSIRP) and how it has been implemented over the past 2 years. This identified both key strengths and opportunities for further improvement which have directly informed the development of our updated plan and supporting policy, ensuring they better reflect current needs and learning across the organisation.

Our work to share and learn lessons from mistakes is led by our established Trust Learning for Improvement Group with strong involvement and ownership from clinical groups. This supports the delivery of our updated PSIRP by making sure incidents are carefully monitored, trends are identified and learning is captured and shared.

The Trust has an executive Trust 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. Our Speak Up Guardians and Deputy Guardians are supported by a growing team of volunteer Ambassadors for Speaking Up across the Trust.

While there have been many achievements in 2025/26, 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.

Looking to the year ahead, we are increasing our focus on how we learn from significant events across our large organisation. We have also launched our Future Ready campaign which seeks to create a whole organisation focus on modernising and improving the quality of the care we provide while also being more efficient and reducing the amount of money we spend. Our renamed Future Ready Improvement Programme will be a key feature of this campaign, through which we will embed a consistent approach to quality improvement across the Trust.

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

Dame Amanda Pritchard, Chief Executive Officer
29 June 2026

Our quality priorities for 2026/27

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 Trust strategy to 2030 'better, faster, fairer healthcare for all', we have developed a set of quality priorities for 2026/27 and ensured they are embedded across the Trust through our executive assurance committees.

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

How we chose our priorities

We have identified quality priorities which support the Patient Safety Incident Response Framework (PSIRF) and associated improvement plans and 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 2026/27 we are continuing to focus on delivering 3 quality priorities from 2025/26, which will enable us to further improve the experience of our patients through better communications, improve patient safety by progressing the work on violence and abuse, and to progress the implementation of Martha's Rule. We have also identified 4 new priorities.

The priorities for 2026/27 were reviewed by the Trust Risk and Assurance Committee in March 2026 and the Trust's Quality and Performance Committee in May 2026. They are outlined overleaf.

Our quality priorities for 2026/27

Our quality priorities	What success will look like
Patient safety	
We will reduce instances of verbal or physical violence and abuse by patients. We will ensure that patients get the help they need and that staff are supported in recognising, dealing with and recovering from these incidents. **This priority addresses both patient safety and staff safety in their experience of violence and abuse.** This continues to be a priority for 2026/27 because it remains one of the highest reported incident categories and builds on the programme of work started last year. During the past year, our Patient Safety Partner led an in-depth review. The recommendations from review being taken forward this year with oversight from the Trust Supporting Positive Behaviours Forum.	• We will review the Trust communications to staff, patients and members of the public related to violence and abuse. • 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 abuse and identify ways to reduce the number of instances. The forum is attended by a Patient Safety Partner to ensure that patient viewpoints are considered and included. • We will take forward 6 of the 12 recommendations made by the Patient Safety Partner review of violence and aggression within the Trust (the remaining 6 recommendations are already in progress). • We will review and standardise training for our staff to help de-escalate and manage instances of violence or abuse. We will improve staff skill and knowledge on how to best support themselves, and other staff and patients, when exposed to violence and abuse whilst also ensuring patient care. • We will work to improve the support provided to staff who experience violence or abuse. • Success will be measured by monitoring the number and type of harm events; the number of exclusions or warnings provided to patients; and staff feedback about the support provided when instances occur.
We will improve procedural safety through Trust-wide initiatives to strengthen surgical safety and improve governance across the Trust.	• We will pilot the revised version of the WHO surgical safety checklist, along with adaptions to the way teams carry this out, within key surgical areas of the Trust. • We will use the feedback gained from the pilot to confirm the changes to our surgical safety processes and begin a wider roll out across the Trust. • We will introduce adapted versions of the surgical count discrepancy checklist to areas outside of theatre settings who perform interventional procedures. • We will develop a new Trust-wide Surgical Safety Policy with stakeholders from all clinical groups, to ensure standardisation in practice across the organisation. • Success will be demonstrated by the completion of the pilot rollout and publication of the new Surgical Safety Policy, increased WHO surgical checklist training and continued improvement in surgical count compliance audits.

Our quality priorities for 2026/27

Our quality priorities	What success will look like
Clinical effectiveness	
We will implement a structured approach to obtaining information about a patient's condition directly from patients and their families at least daily, which will align with Martha's Rule Component 1 requirements. We will also pilot Martha's Rule in areas other than inpatients. This continues to be a priority for 2026/27 because, after devising and testing the process, we now need to embed this practice across the organisation.	• We will design a digital solution for Martha's Rule Component 1, which will be implemented across all adult inpatient areas. This tool will obtain information relating to a patient's condition directly from patients and their families daily, so that the clinical team caring for the patient can act on any concerns. • We will continue to pilot Martha's Rule in the community wards, focusing initially to optimise and standardise our processes for staff, patient, family and carer-initiated escalation of a concern or an acute deterioration (Martha's Rule Component 2 and Component 3). • Success will be measured by the successful rollout of a digital solution for Martha's Rule Component 1, and completion of the pilot for Component 2 and 3 in our community wards.
We will transform ambulatory care, reduce variation, and use a data-led approach to ensure excellent care is provided consistently and at the right time to all patients.	• We will optimise our outpatient activity through the review of our clinic templates and implementing new models of ambulatory care (Patient Initiated Follow-Up, Straight-to-Test, Advise and Guidance). • We will use a data-led approach to prioritise waiting lists by patient risk, to see the patients who most need it first. • We will deploy Remote Care technology and pathways to shift more activity out of our hospitals and into the community. • We will embed best-practice care and clinical guidelines within Epic workflows. • Success will be measured by reduced wait times for outpatients.
We will maximise the use of functionality within our electronic health record (Epic) by strengthening staff knowledge, training, and digital competency.	• We will pilot new training materials and methods to train staff (including in-person support sessions) to refine digital training approach and impact. • We will improve the visibility of training sessions and measure attendance. • We will deliver targeted refresher sessions. • We will identify and train digital leads to cascade and embed training locally. • We will promote consistent, high quality use of Epic to support safer care, better outcomes, and improved operational effectiveness by improving consistency in documentation. • Success will be measured by: o uptake and delivery of Epic refresher training sessions o increased number of digital leads in local areas o improved staff satisfaction technology surveys (e.g. KLAS research).

Our quality priorities for 2026/27

Our quality priorities	What success will look like
Patient experience	
We will improve the experience of our patients through better communications and ways to contact the Trust through the 'Contacting Us' improvement programme. This continues to be a priority for 2026/27 because the first phase of actions identified through the 'Contacting Us' Programme need to be completed. Dissatisfaction from patients contacting the Trust continues to be one of the main causes for concerns across the Trust.	• We will complete the first phase of deliverables for the 'Contacting Us' Programme, including: 1. Find Information: we will seek to find digital solutions to improving patient contact into the organisation, aiming to reduce our current reliance on analogue technologies. 2. Manage My Care: We will establish specialist teams that can work directly with services in ensuring their Epic templates are robust, optimised, and require little to no staff management. • Success will be measured by monitoring the volume of complaints, Patient Advice and Liaison Service (PALS) contacts and other patient experience feedback received about difficulties contacting a clinical area. We will also monitor: o call data from phone lines where specific interventions have occurred o MyChart usage data from specific services where interventions have occurred o patient feedback gathered during the pilots o staff feedback gathered during the pilots.
We will improve patients' experience of attending clinics by providing clear information and updates about expected waiting times.	• We will review patient feedback about delays in clinics and how we communicate waiting time updates, to identify where we face the greatest challenges in keeping patients informed. • We will ask each clinical group to identify 3-4 outpatient clinics to conduct targeted improvement work in this area and expand into additional areas in the second half of 2026/27. • We will identify and trial different methods of keeping patients informed about delays in clinics and share information on the most successful methods with colleagues within and across clinical groups. • Success will be measured by monitoring local outpatient surveys, results of mystery shopping observations, by clinical group patient experience reports at local performance review meetings and via the Trust's quarterly patient experience report.

Progress against our 2025/26 priorities

The following tables show how we have performed against the quality priorities which we identified for 2025/26:

Our quality priorities	What success will look like	2025/26 summary
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 & 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.	• An operational processes dashboard has been developed to support oversight at clinical group, directorate and specialty level. It provides high level reporting on unsigned visits, referral triaging, work queues, data quality and validation, and is the primary source for performance reporting to the Elective Recovery Board and Trust Operations Board. • Key administrative risks, including Epic implementation challenges and data quality issues, are reported to the Trust Risk and Assurance Committee, alongside targeted improvement programmes. • In 2025/26 there was a 14% decrease in the total number of incidents reported relating to administrative pathways, appointments and clinics, and a 17% reduction in harm incidents, compared to the previous financial year. • Unsigned visits remain a significant risk, with more than 70,000 recorded at the end of 2025/26. Clinical action is required to reduce the backlog, with the Unsigned Visits Task and Finish Group continuing to oversee progress and escalate areas of concern.
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.	• Senior leadership support has been established across our workforce, nursing and medical teams, to drive the Trust's violence and aggression agenda. • A Trust-wide review, commissioned by the Learning for Improvement Group and informed by a Patient Safety Partner, has been agreed for implementation through relevant governance committees. • Extensive staff engagement - including a Trust-wide survey, focus groups and roadshows - has informed a refreshed violence and aggression communications campaign which launched in May 2026. • Work is also underway to develop a new Trust Exclusion Policy, with ongoing Trust-wide oversight of violence and abuse risk maintained through directorates and clinical groups. • In 2025/26 there was a 10% increase in the total number of reported incidents relating to patient aggression, conduct and abuse towards others compared to the previous year. This increase relates to an improved reporting culture for these types of incidents but indicates that there is more work to do in this area. Rates of patient and staff physical and psychological harm are comparable with the previous financial year.

Progress against our 2025/26 priorities

Our quality priorities	What success will look like	2025/26 summary
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 – renamed Component 1 by NHS England). • Success will be measured by the number of concerns raised during the pilot and the action taken as a result.	• Awareness and implementation of Martha's Rule have been strengthened through updates to the Trust website, refreshed ward-based posters across all inpatient sites, and new roller banners in hospital entrances. Multilingual materials are being developed to support accessibility for patients and families. • Component 1 has been piloted successfully in adult wards using a Patient Wellness Questionnaire, with positive staff feedback and a working group established to develop a long term Epic solution. • In children's services, enhancements to the Paediatric Early Warning Score workflow have been implemented and are overseen by a dedicated task and finish group. • Bespoke training has been developed and delivered for listening and responding to parents. Community services have joined the national pilot, with Components 2 and 3 live and plans in place to pilot Component 1. • Data shows very low volumes of Martha's Rule calls across all hospital sites, with 2 calls relating to acute deterioration.
We will improve our processes for development, review, approval and publication of clinical guidance to align best practice across all relevant services.	• 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.	• The governance of our clinical guidance has been improved, and the approval of adult non-medicines guidance has been devolved to clinical groups and directorates. The governance of medicines guidance is now agreed through the Drug and Therapeutics Committee, supported by a new Chair. • A Trust-wide document alignment approach has been approved to standardise content, reduce document length and address overdue guidance. • A planned upgrade to the clinical guidance database has improved access, and development of a new Document Management System is underway for 2026/27. • Progress has been made to reduce the number of clinical guidelines and standard operating procedures which are past their review date; however, 29% remain overdue and further action is required to reduce this.

Progress against our 2025/26 priorities

Our quality priorities	What success will look like	2025/26 summary
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.	• Work is underway to reduce reliance on phone and email communications through digital and self service solutions. A call reason audit identified that 70% of patient calls relate to appointments. This informed plans to pilot callback technology and patient initiated messaging via MyChart. • Messages to encourage patients to use alternative information sources have been developed. • We have expanded the use of self scheduling tools to 34 services and 884 clinic codes; however, online booking remains limited (1.5% of appointments) due to capacity constraints and voluntary uptake by services.

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 reports 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 2025/26 we saw 2,055,000 outpatients, 86,000 inpatients, 110,000 day case patients and 207,000 accident and emergency attendances. We also provided over 639,000 contacts in the community, bringing our total patient contacts to 3.1 million. We employ 23,900 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. The National Confidential Enquiry into Patient Outcome and Death programme investigates 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 2025/26 include the following:

Audit title	The audit demonstrated that:
Duty of candour The objective was to audit compliance with the Trust duty of candour and being open policy in relation to incidents causing moderate or more severe harm to patients.	• written duty of candour compliance was 97% for 2024/25 • only 29% of cases reviewed had a written duty of candour letter document attached to the incident report on the local risk management system which is a policy requirement, and 71% had an outcome sharing duty of candour letter attached • the quality of written duty of candour documentation was variable • actions to improve compliance include: explore the barriers to completing and uploading written letters; raise the awareness and use of the statutory duty of candour leaflet; review and update the Trust duty of candour policy to provide further support and guidance; raise the awareness of and use of the Trust statutory duty of candour policy.
Safe discharge The objective was to audit compliance with the Trust discharge policy and managing patient choice in discharge.	• more than 80% of cases had high levels of patient/family communication documented (out of 290 audited) • follow-up and aftercare was included in most discharge letters • low readmission rate • actions to improve compliance include: reinforce mandatory estimated date of discharge documentation in Epic and monitor compliance by directorate; ensure formal capacity assessments are completed and documented where required; strengthen discharge communication recording, with standardised documentation fields; aim for 100% pharmacy review of discharge medications, supported by Epic alerts.
Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) and associated treatment escalation plans (TEP) The objective was to audit the appropriate documentation and assessment of DNACPR orders for inpatients.	• 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 • the documentation of rationale for decision-making was good in the majority of cases although not always clearly included within the DNACPR form itself • actions to improve compliance include: Include a free text box on Epic for capacity decisions to allow space to summarise decision making; Include an option to document TEP discussion in situations where a formal TEP decision is not reached.
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.	• data collection for this audit finished on 31 May 2026 and analysis of data is underway.

The Trust-wide audits planned for 2026/27 are:

Audit title	Audit objective
Procedural safety	• Audit to support standardisation in how surgical counts are performed and communicated throughout the Trust.
Multi-disciplinary team (MDT) working	• Audit the documentation of MDTs to ensure clear roles, supervision, and coordinated care to maintain patient safety and quality outcomes.
Safe discharge	• Audit compliance with the Trust discharge policy and managing patient choice in discharge.
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.
Consent	• Audit the patient and family experience of the consent form process in accordance with the Trust consent policy.

Participation in national clinical audits 2025/26

In 2025/26, we participated in 42 national clinical audit programmes, which included 77 individual national clinical audits and 4 national confidential enquiries.

The national clinical audit programmes and national confidential enquiries that we participated in during 2025/26 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 electronic health record system, to integrate national audit data collection and there are a total of 19 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
BAUS Urology Audits	Yes	100%
Breast and Cosmetic Implant Registry	Yes	Data collection on-going
British Spine Registry	Yes	100%
BTS UK Interstitial Lung Disease (ILD) Registry	Yes	100%
Case Mix Programme (CMP)	Yes	100%
Child Health Clinical Outcome Review Programme	Yes	88%*
Cleft Registry and Audit Network (CRANE)	Yes	100%
Emergency Medicine QIPs	Yes	100%
Learning from Lives and Deaths of People with a Learning Disability and Autistic People (LeDeR)	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	Data collection on-going
National Acute Kidney Injury Audit	Yes	100%
National Audit of Cardiac Rehabilitation	Yes	100%
National Audit of Care at the End of Life (NACEL)	Yes	Data collection on-going
National Audit of Dementia (NAD)	Yes	Data collection on-going
National Audit of Pulmonary Hypertension	Yes	Data collection on-going
National Cancer Audit Collaborating Centre (NATCAN)	Yes	Data collection on-going
National Cardiac Arrest Audit (NCAA)	Yes	Data collection on-going
National Cardiac Audit Programme (NCAP)	Yes	100%

*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.

Continues on next page

Participation in national clinical audits 2025/26

Audit title	Participation	% of cases submitted
National Child Mortality Database (NCMD)	Yes	100%
National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes	100%
National Comparative Audit of Blood Transfusion	Yes	Data collection on-going
National Diabetes Audit (NDA - adults)	Yes	Data collection on-going
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Data collection on-going
National Emergency Laparotomy Audit (NELA)	Yes	100%
National Falls and Fragility Fracture Audit Programme (FFFAP)	Yes	100%
National Joint Registry	Yes	100%
National Major Trauma Registry	Yes	Data collection on-going
National Maternity and Perinatal Audit (NMPA)	Yes	100%
National Neonatal Audit Programme (NNAP)	Yes	Data collection on-going
National Obesity Audit (NOA)	Yes	Data collection on-going
National Ophthalmology Database Audit (NOD)	Yes	100%
National Paediatric Diabetes Audit (NPDA)	Yes	100%
National Perinatal Mortality Review Tool (PMRT)	Yes	Data collection on-going
National Respiratory Audit Programme (NRAP)	Yes	Data collection on-going
National Vascular Registry (NVR)	Yes	100%
Paediatric Intensive Care Audit Network (PICANet)	Yes	100%
Perioperative Quality Improvement Programme (PQIP)	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Yes	Data collection on-going
UK Cystic Fibrosis Registry	Yes	100%
UK Parkinson's Audit	Yes	Data collection on-going
UK Renal Registry Chronic Kidney Disease Audit	Yes	100%

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 2025/26

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

National Audit of Care at the End of Life (NACEL)

This audit looked at how well the Trust cared for adults who were nearing the end of their life while in hospital. It aimed to understand and improve the care people receive in their final days and how well families and carers are supported.

The findings showed that most people received kind, compassionate, and respectful care at the end of life. Families and carers were generally very positive about their experiences, often rating the overall quality of care as good or excellent. Many felt that staff treated their loved one with dignity, managed pain and symptoms well, and communicated in a sensitive and caring way. Families also frequently reported that they were supported emotionally, practically, and, where needed, spiritually or culturally, both before and after their loved one died. These results were often better than the national average, suggesting that compassionate care is a strong feature of services across all hospital sites.

Pain relief and comfort were highlighted as particular strengths. Most families felt that their loved one received enough pain relief and that symptoms such as breathlessness or distress were well managed. Support with eating and drinking was also commonly reported. In many cases, medications were prescribed in advance to help prevent discomfort in the final days of life, which helped staff respond quickly if symptoms developed.

The report also identified areas where care can be improved. One key issue is recognising earlier when someone is likely to be in the last days or hours of life. Earlier recognition helps staff plan care more effectively, have important conversations, and ensure that patients' wishes are understood and respected. In some parts of the Trust, this recognition happened later than the national average.

Another important area for improvement is documentation. Although families often felt that staff had discussed drinking, hydration, and care options with them, these conversations were not always clearly documented in medical records. Improving how these discussions are recorded would give better reassurance that patients and families are involved in decisions and that their views are clearly understood by everyone caring for them.

Planning ahead for future care was also identified as an area needing further work. Not all patients had clear, recorded conversations about their wishes for care before they became very unwell. Having these conversations earlier can help ensure that care at the end of life reflects what matters most to each person.

In response to these findings, the Trust has set out a programme of actions to further improve care. These include strengthening staff education and training, improving how care plans and conversations are recorded, encouraging earlier recognition of dying, and increasing opportunities for people to discuss their wishes in advance. Work is also underway to improve fairness and consistency of care across all hospital sites and patient groups.

National Congenital Heart Disease Audit (NCHDA)

This audit checked how accurate and complete the Trust's records are for children and adults who had procedures for congenital (from birth) heart conditions in 2024/25. It included work carried out at Evelina London Children's Hospital, Guy's, St Thomas', Royal Brompton and Harefield hospitals.

Between 1 April 2024 and 31 March 2025, the Trust reported almost 2,000 heart procedures. These included operations, catheter-based procedures (where tubes are passed through blood vessels), and a small number of other types of procedures. This shows that the service continues to treat a large number of patients across several hospital sites. This was also the first full year using the Epic electronic patient record system, which was introduced in late 2023.

Overall, the audit found that just over 94% of the information submitted was correct. While this was slightly lower than in the previous 2 years, it is still considered a high standard, especially given the recent merger of services, the introduction of a new IT system, and the large number of patients seen. Basic information about patients, such as age and sex, was recorded very accurately. Some areas were less consistent, particularly details about other health conditions, who carried out the procedure, devices used, and some outcome information.

When patient records were reviewed, most information was found to be accurate, clear, and easy to access. The audit did identify a small number of cases where procedures may have been missed, recorded twice, or included incorrectly.

The report highlights that the Trust has strong systems in place to manage and check its data. These include regular internal checks, submitting data on time, making good use of Epic templates, and a strong culture of clinical audit. The Trust meets national staffing standards for managing congenital heart audit data. However, as the service continues to grow and become more complex, staff capacity may need to be reviewed to ensure data quality remains high.

Some ongoing challenges were identified, including inconsistent recording of device and radiation information, and a need for clearer responsibility for specific pieces of information – especially around recording causes of death and patient outcomes.

National Paediatric Diabetes Audit (NPDA)

This audit looked at how well children and young people with diabetes are being cared for. It includes patients looked after by the Evelina London children's diabetes team, as well as young people aged 16–19 who are seen in the Young Adult Clinic (YAC). Many of these young people have complex needs. A large proportion are older teenagers, many live in areas of higher social deprivation, and more patients now have higher blood sugar levels compared with last year.

Overall blood sugar control remains a concern. The average HbA1c level (a measure of long-term blood sugar control) was 64 mmol/mol. This is only a small improvement on last year and is still worse than the national and London averages. Fewer patients are reaching recommended blood sugar targets, with the poorest results seen in older teenagers attending the YAC.

The audit also reviews whether key health checks are being completed. These checks are carried out reasonably well in the children's clinic, with around two-thirds completed. However, when YAC patients are included, completion drops sharply to around one-fifth. Young people in the YAC are also much less likely to see a dietitian or receive psychological support, which is likely to contribute to poorer outcomes.

Use of diabetes technology shows mixed results. It is positive that many patients are using continuous glucose monitoring devices, however, fewer are using insulin pumps compared with national and London averages. Pump use is particularly lower among young people from more deprived backgrounds and some ethnic minority groups, highlighting ongoing inequalities.

The audit shows clear strengths in the children's diabetes service, especially in teamwork and use of technology. However, it also highlights significant difficulties for young people as they move from children's to adult services. The findings underline the need to reduce inequalities, improve support for teenagers and young adults, and strengthen care for those at highest risk.

Both the children's and adult diabetes teams are taking action. Priorities include improving blood sugar control across all patients, offering extra support soon after diagnosis, targeting help for those with very high HbA1c levels, and reviewing hospital admissions related to high blood sugar and diabetic ketoacidosis. Other planned actions include helping families make better use of home monitoring data, increasing access to diabetes technologies, testing new ways to engage young people who are struggling, and improving how the children's and Young Adult services work together to better support 16–19-year-olds.

Participation in National Confidential Enquiries into Patient Outcome and Death 2025/26

We participated in 4 NCEPOD studies in 2025/26. We await the final reports and recommendations for review.

Audit title	Participation	% of cases submitted
Acute Illness in People with a Learning Disability	Yes	100%
Stabilisation of the Critically Ill Child	Yes	Data collection on-going*
Pleural Procedures	Yes	Data collection on-going*
Rib Fractures	Yes	Data collection on-going*

* Data submission deadlines are in Quarter 1 of 2026/27 for the 3 studies with data collection on-going

Local clinical audit

A total of 1,272 local clinical audits were registered in 2025/26. 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.

Children's community services

2 complementary clinical audit projects were undertaken to strengthen transition arrangements for young people with special educational needs and disabilities (SEND), addressing known gaps in compliance with NICE guidance and the NHS Long Term Plan. Together, these projects demonstrate measurable improvements in preparedness, confidence and system integration for a highly vulnerable population.

Project 1: Special Educational Needs (SEN) Transition Checklist

NICE recommends that young people with SEND have a written, developmentally appropriate transition plan in place from age 14 to support their transition to adult services; however, this was not embedded in routine practice. Audit findings identified that the existing Ready Steady Go checklist was used by only 29% of local families and was not perceived as suitable for young people with SEND.

In response, a new SEN Transition Checklist was co-produced with parents, young people, and a multidisciplinary team including speech and language therapy, physiotherapy, dietetics, occupational therapy, psychology, and nursing. The checklist was designed to be holistic, accessible, and developmentally appropriate.

Post-implementation feedback demonstrated the checklist had a strong impact:

- 100% of parents reported the checklist to be beneficial
- 94% of parents felt it would adequately prepare their young person for transition to adult services
- 93% of young people with learning disabilities rated the checklist as "good".

Critically, the service moved from not meeting any of the 5 NICE transition recommendations to full compliance with all 5 standards following implementation. This represents a significant quality improvement and provides assurance against national guidance.

Project 2: Joint GP Paediatrician Transition Clinics

Young people with complex learning disabilities, Trisomy 21, and physical disabilities frequently face significant transition challenges due to a lack of equivalent adult specialist services. This population also experiences a markedly reduced life expectancy (14–18 years lower than the general population), highlighting the need for early, preventative, community-based support.

Aligned with the NHS Long Term Plan, joint GP Paediatrician Transition Clinics were piloted across Lambeth and Southwark to support continuity of care, build GP confidence, and broaden the focus beyond acute healthcare needs.

Survey feedback from parents and GPs showed substantial improvements:

- confidence in managing overall wellbeing and independence increased from 54% pre-clinic to 100% post-clinic (ratings 4–5/5)
- perceived developmental appropriateness of care improved from 45% pre-clinic to 100% post-clinic
- 100% reported improved discussion of mental health and wellbeing and would recommend the service
- 100% reported increased signposting to non-healthcare support services.

These projects collectively demonstrate improved compliance with national standards, enhanced experience for young people and families, and strengthened system-wide transition arrangements.

Cardiology

This audit looked at how quickly patients received a follow-up appointment after being treated for a heart attack with a procedure called coronary angioplasty. Early follow-up after this treatment is important because it helps patients recover safely, manage their medicines, return to everyday life, and avoid complications or unnecessary emergency visits.

The team reviewed the care of 100 patients treated between July and October 2025 across all hospital sites. They compared current follow-up times with previous audits from 2023 and 2016. To improve care, several changes had already been put in place, including better staff education, clear reminders to arrange follow-up, improved clinic capacity, and additional checks to make sure no patient was discharged without a clear follow-up plan.

The audit showed a clear improvement. On average, patients were now seen for follow-up within 7 weeks, compared with around 13 weeks in previous audits. There was also a large reduction in emergency visits while patients were waiting for follow-up appointments. These improvements reflect better teamwork between ward staff, nurses, doctors and administrative teams, and a more reliable follow-up process for patients after treatment.

Overall, the audit shows that the changes made have led to faster follow-up, fewer emergency visits, and a safer, more supportive recovery for patients after a heart attack. The teams plan to continue these improvements and repeat the audit regularly to make sure standards remain high.

Surgery

An audit of skin cancer operation reports was completed to identify variations in documentation compared to Royal College of Surgeons standards and British Association of Dermatologists (BAD) audit requirements. Some deficiencies in documentation were noted, including which prophylaxis was being used, pre-surgery indication, lesion measurements, peripheral margins and specimen details or numbers. A new smart phrase on Epic was implemented to prompt the required information with education to improve awareness of standards with the clinical team. Statistical analysis of re-audit results after one month identified a positive overall outcome for the audit, with several areas showing significant improvements, particularly documentation of lesion size measurements, adding diagrams, documentation of antibiotics given and recording of any intraoperative complications.

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 2025/26, the Trust had 1,418 studies open across its research portfolio comprising 1,020 non-commercial clinical studies and 398 commercial clinical studies. We have recruited 27,618 participants to these research studies. We recruited more patients in 2025/26 compared with 2024/25, resulting in us moving up from the 6th to the 2nd highest recruiting Trust in the UK.

Significant work is being undertaken across the organisation to allow us to open studies and recruit patients into these studies much more quickly, allowing our patients even earlier access to research trials. The Trust has exceeded its target for the patient research experience survey carried out on behalf of the National Institute for Health and Care Research (NIHR) Research Delivery Network, with 953 participants completing the survey during 2025/26.

We continue to offer patients, both adult and children, the chance to participate in innovative studies, including those delivering gene and cell therapies and those integrating the latest imaging technology, through our NIHR Clinical Research Facilities which have expertise in delivering novel and innovative research studies. Regionally we continue to support the South London Research Delivery Network as the host organisation and we have also been able to strengthen research links with our NIHR Commercial Delivery Centre partners, Lewisham and Greenwich NHS Foundation Trust and Oxleas NHS Foundation Trust.

Statements from the Care Quality Commission

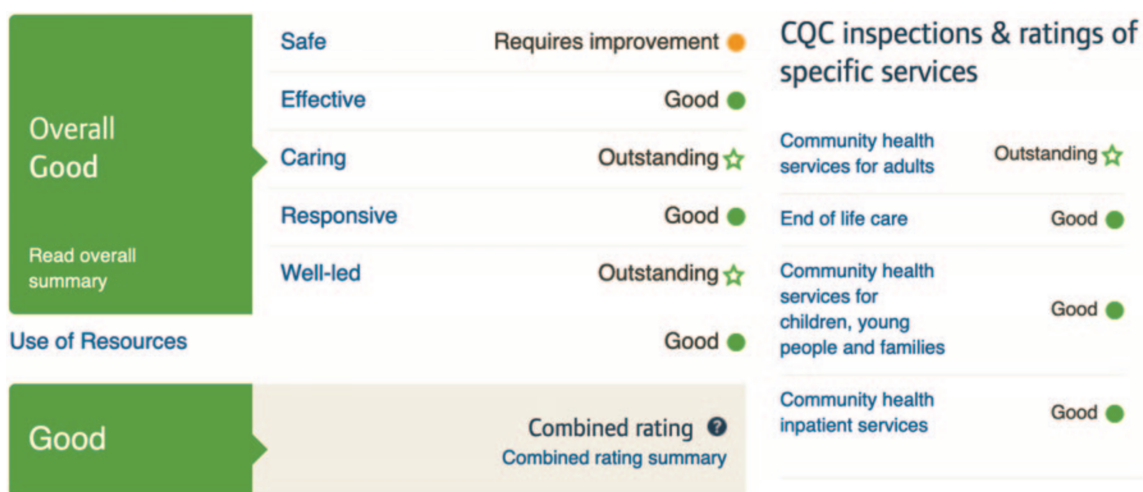
Guy's and St Thomas' NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'registered without conditions or restrictions'. The CQC has not taken enforcement action against Guy's and St Thomas' NHS Foundation Trust during 2025/26.

Trust-wide inspections

The Trust's last full inspection and assessment by the CQC was in April and May 2019, when we maintained an overall rating of 'good' and 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:



Urgent and emergency care

CQC carried out a service-specific inspection of the adult and children's urgent and emergency care services on 10 and 11 March 2026. The emergency department at St Thomas' maintained its 'outstanding' rating and our urgent care centre at Guy's maintained its 'good' rating. The inspection found both sites' services had made significant progress in the caring category, with each of their ratings in this area upgraded from 'good' to 'outstanding'.

The CQC report highlighted that leaders ensured people felt safe raising concerns, including staff. They investigated when things went wrong and made changes to improve care. Inspectors also found that some patients with mental health needs experienced long stays, due to extended waits for transfer to specialist mental health services. However, the reports noted that the Trust's leadership was working proactively with mental health partners to address this.

Maternity services

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.

2 outstanding CQC maternity inspection actions from 2022 remain in progress: improvements to the Maternity Assessment Unit (MAU) estate and the expansion of maternity theatre capacity. The MAU estate full business case was approved, and we await regulatory approvals. Work continues to identify the most feasible option for a third obstetric theatre, with multiple estate options under review and executive oversight in place.

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 quality reviews and visits, as well as CQC readiness inspections, which are based on the CQC quality statements.

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 2026. 200 episodes were audited from 5 specialties with discharge dates between October and December 2025. A summary of the findings is presented in the table below:

Data Security and Protection Toolkit assessment

	Score (March 2026)	Quality of coding
Primary diagnosis	95.5%	Standards exceeded
Secondary diagnosis	93.3%	Standards exceeded
Primary procedure	95.8%	Standards exceeded
Secondary procedure	93.1%	Standards exceeded

Clinical coding

Overall, the coding department has achieved a high standard of coding accuracy in 2025/26, exceeding the mandatory standards and increasing compliance when compared with the 2024/25 audit results. Coding quality was improved because:

- the coding department is operating under revised monthly deadlines. Current performance requirements include completion of 70% of all monthly episodes by flex date (deadline by which coded episodes must be submitted for payment and data-quality reporting) and the application of the full range of clinically relevant codes to each episode to increase coding depth
- services have adapted well to the Epic electronic health record system, identifying additional locations within Epic in which relevant information is recorded
- we have recruited more trainee coders and a new Director of Clinical Coding has been appointed to lead the department
- a new AI tool called Epic Coding Assistant has been developed to support coding long stay episodes and is now being trialled.

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
- a patient being treated for severe mental illness
- a patient not expected to die (including an elective procedure 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 the death occurred, services may review previous episodes of care 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 and children and young people from 22 weeks gestation up to their 18th birthday, regardless of location of care. The Perinatal Mortality Review Tool is used to review deaths from 22 weeks' gestation onwards, including late miscarriages, stillbirths, and neonatal deaths. Perinatal mortality trends show lower than average rates of mortality when compared to other similar trusts.

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, and 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 2025 to March 2026

	Q1	Q2	Q3	Q4	Total
Number of adult inpatients patients who died	300	264	308	317	1,189
Number of paediatric inpatients who died	22	19	23	15	79
Number of maternal deaths	2	0	0	0	2
Number of adult inpatient deaths subjected to Structured Judgement Review	49	39	40	25	153
Estimate of the number of deaths reviewed where problems in care more likely than not, contributed to the patient's death	2	1	2	1	6

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 table below:

Thematic learning

Thematic learning	Summary of completed action(s)	Summary of planned actions and/or sharing of thematic learning
Sepsis	• A new sepsis dashboard has been developed which will display how many eligible patients had sepsis screening / when antibiotics were administered and other useful metrics. Testing is in progress ahead of publication in 2026/27. • High and medium risk National Early Warning Score (NEWS2) pop up advisories for staff are being reviewed. The Low NEWS2 pop up advisory has been retired as it wasn't adding value. • Sepsis navigators for paediatrics, the emergency department and maternity have been designed and will be implemented during the next Epic update.	• Sepsis and NEWS2 education modules for colleagues are being updated and redesigned with scenario based learning and anonymised case studies. • Flag for patients with one NEWS2 parameter scoring 3+ to be added to the ward white board as a visual reminder to team.
Oxygen therapy management	• New local educational initiative in wards dealing with pulmonary hypertension patients regarding oxygen cylinder content and expected cylinder duration. • Developed standard operating procedures for self-administration of oxygen by patients with severe pulmonary hypertension.	• Ensure cylinder duration guidance for staff and patients is available on the ward. • Update standard operating procedure to include: - patient risk assessment - management of bedside oxygen supply in cases where an oxygen cylinder is being kept at the bedside - identification if ward cylinder supply needs to be temporarily increased.
Major haemorrhage response	• Developed quick reference handbook style checklists to support major haemorrhage and rapid blood responses. • Implemented dedicated telephone lines for theatres. • Reviewed the role of Epic to communicate patient details in major haemorrhage and rapid blood responses. • Reviewed lab processes and responsibilities of transfusion scientists. • Standardised documentation of TEP conversations. • Updated ward accreditation process, now includes a question for all patients who have DNACPR – do they also have TEP as expected?	• Provide visual reminders, for example posters, to standardise phraseology. • Use a dedicated Epic order to communicate crucial details such as the patient identifiers would reduce the burden on staff placing telephone calls. • Create dedicated phone lines in each theatre so that calls could be placed closer to the team leaders.

Freedom to Speak Up

We are committed to creating a culture where everyone feels able and confident to speak up. The Trust's Freedom to Speak Up service encourages all staff to speak up about concerns they may have about patient safety, the way the Trust is run or behaviours that do not meet the Trust values. The initiative is led by a team of three full-time and one part-time Freedom to Speak Up Guardians, supported by a team of volunteer Ambassadors for Speaking Up. They play an active 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 for staff feeling safe and confident in raising concerns about unsafe clinical practice or about anything that concerns them, which demonstrates a positive speaking up culture. During 2025/26, 388 contacts were made to the Guardians, and key themes are shared with the National Guardian's Office on a quarterly basis and are published on their website. We also collect additional data, such as ethnicity to help us understand who is using the service, so we can promote it more effectively.

The Freedom to Speak Up service works closely with the Trust mediation service to try and resolve concerns without the need for formal grievance or disciplinary processes. The Freedom to 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 NHS England. In 2025/26 the Trust averaged a 'fill rate' of approximately 92% of training grade posts, with 8% of posts vacant. This compares to a 5%-7% vacancy rate in 2024/25 and 2023/24.

Recruitment to these vacancies, and to all Trust appointed resident doctor posts remained robust with a total of 770 posts appointed to in the 2025/26 period.

Recruitment difficulties remain, in common with the rest of the NHS, for middle-grade posts and in specific specialties including anaesthetics, paediatrics and paediatric intensive care units. However, the Trust's Certificate of Eligibility of Specialist Registration (CESR) rotations with partnering Trusts, for Trust appointed resident doctor posts, remain popular in several specialties including anaesthetics and ICU and have helped to improve recruitment to these areas.

The Trust does not keep a central record of rota gaps, but any specific issues are reviewed at clinical group level. Paediatrics and anaesthetics remain a particular area of concern in London. Whilst 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.

On-going work between the medical workforce and clinical services has continued to ensure rota patterns increase service efficiency and coverage. In 2025/26 a pilot in critical care at St Thomas', using AI rostering solutions, helped to reduce locum spend in the service across several complex rotas. Resident doctor coverage was increased, while considering the need for work-life balance. Initial feedback from this pilot from the resident doctors has been positive. The pilot continues until August 2026.

National core set of quality indicators

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 below the national average
- the Trust's mortality rate has moved from SHMI Banding 3 (lower than expected) to SHMI Banding 2 (as expected)
- the Trust reported issues with missing data, data quality and data flow which occurred at the same time as the increasing SHMI. Whilst a number of these have been resolved, there are residual issues (uncoded activity; missing gender; removal of low-risk Same Day Emergency Care (SDEC) data from the model) that may be contributing to why the SHMI has remained higher than historical periods.

Summary hospital-level mortality indicator

	April 19 - March 20	Nov 20 - Oct 21	April 21 - March 22	April 22 - March 23	April 23 - March 24	April 24 - March 25
SHMI	76	75	71	78	88	96
Banding	3	3	3	3	3	2
% deaths with palliative care coding	56.1%	53.0%	54.0%	50.0%	50.0%	56.0%

Source: NHS Digital (data updated quarterly on a rolling basis) SHMI Banding 3 = mortality rate is lower than expected, SHMI Banding 2 = mortality rate is as expected.

Patient reported outcome measures

Patient reported outcome measures (PROMs) are used to assess the quality and impact of healthcare from the patient's perspective. They aim to measure the health gain experienced by patients following specific procedures, including hip and knee replacement surgery. In England, PROMs data for hip and knee replacements are collected nationally as part of the NHS PROMs programme. The most recent publication of these measures in England is April 2024 to March 2025.

Patients undergoing these procedures are asked to complete a short questionnaire, a validated measure of health-related quality of life. The questionnaire is completed before surgery and again approximately 6 months after surgery. Responses are converted into a single index score ranging from –0.594 to 1, where higher values indicate better health status. The difference between the pre-operative and post-operative scores is referred to as the health gain. This adjusted change reflects the improvement in a patient's overall health status following surgery, as reported by the patient themselves, and is used to assess the effectiveness of hip and knee replacement procedures at population level.

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 2024/25 there were 853 eligible hospital episodes and 639 pre-operative questionnaires returned – a participation rate of 74.9% (65.2% average across England). At 6 months, 462 post-operative questionnaires were returned – a response rate of 72.3%.

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 overleaf
- for hip replacements, reports show that the Trust is no longer outside the control limits. This suggests that outcomes are now within the expected range of variation across providers, with patient scores improved compared to 2023/24
- for knee replacements, patients report lower pre-operative scores than the national average, which suggests that our patient cohort starts from a poorer baseline before surgery. The average pre-operative score is 0.289 compared with 0.420 nationally. Knee replacement patients also report lower adjusted health gain than the national average, at 0.259 compared with 0.320 nationally, which may in part reflect the poorer baseline of the Trust's patient cohort before surgery.

Adjusted Average Health Gain (EQ-5D) Primary hip replacement	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Guy's and St Thomas'	0.45	0.43	0.37	0.38	0.36	0.41
National Average	0.45	0.47	0.46	0.46	0.46	0.45
Highest Performing Trust	0.53	0.57	0.53	0.55	0.58	0.54
Lowest Performing Trust	0.37	0.39	0.37	0.36	0.35	0.27

Adjusted Average Health Gain (EQ-5D) Primary knee replacement	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Guy's and St Thomas'	0.31	Data unavailable	0.26	0.27	0.23	0.26
National Average	0.33	0.32	0.32	0.33	0.32	0.32
Highest Performing Trust	0.45	0.40	0.42	0.41	0.41	0.51
Lowest Performing Trust	0.21	0.18	0.25	0.24	0.23	0.24

Readmission within 28 days of discharge

Using data from the Healthcare Evaluation Data (HED) system, we are able to access full year information for 2024/25 and part-year (M1-M9) for 2025-26. The HED system provides national average performance rates, and the capacity to benchmark our performance against peers.

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
- data is collated internally and then submitted monthly to NHS Digital via the Secondary Uses Service (SUS). This data is then used by the Healthcare Evaluation Data system to calculate readmission rates
- for the rolling 12 month period January 2025 – December 2025, the Trust had an emergency readmissions rate of 4.0%, which is less than the average for trusts within the Shelford group (7.6%) and less than national acute and specialist trusts which averaged 8.2%
- since the introduction of Epic, in October 2023, we have moved our Same Day Emergency Care (SDEC) reporting from emergency inpatient spells submitted via SUS, to A&E Type 5. This is submitted via the Emergency Care Dataset (ECDS). This accounts for the large reduction in emergency spells at the Trust and has led to a decrease in the calculated emergency readmission rate. It should be noted that work is still on going with operational teams to improve data recording across the whole of Epic.

Emergency readmissions within 28 days

Readmissions	2023/24			2024/25			2025/26 (April to December 2025)		
	Under 16	16 & Over	Total	Under 16	16 & Over	Total	Under 16	16 & Over	Total
Discharges	32,549	275,028	307,577	33,458	277,598	311,056	26,249	213,228	239,477
28 day readmissions	1,743	12,626	14,369	1,573	10,734	12,307	1,258	8,359	9,617
28 day readmission rate	5.4%	4.6%	4.7%	4.7%	3.9%	4.0%	4.8%	3.9%	4.0%

Source: Healthcare Evaluation Data (HED)

We continue to reduce the number of patients requiring readmission, for example:

- the Trusts performance management framework monitors readmissions and identifies any areas where there is a trend or change which may be a cause for concern
- our elderly care team reviews all cases at multidisciplinary team meetings and is actively seeking to improve clinical practice
- working with GPs and community teams to review patients who have been readmitted so that we can agree specific actions for these patients.

Patient experience

The NHS Outcomes Framework Indicator 'Responsiveness to personal needs' is a composite of several questions from the Adult Inpatient Survey. The Care Quality Commission (CQC) publish results from each question individually, but the composite cannot be calculated from this data.

A summary of results from individual questions from the Adult Inpatient Survey 2024 is included below. The Trust scores for the answers to the questions on involvement in care, medicines information and knowing who to contact if patients were concerned about their condition after leaving hospital were all banded as 'Better' other trusts of a similar size and type. For the 2 other questions the Trust was banded as 'about the same' as other Trusts.

Adult Inpatient Survey 2024	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'	**7.8**	**8.1**	**9.6**	**5.3**	**8.6**
Highest	8.5	9.3	9.9	6.0	9.4
Lowest	6.3	6.6	9.0	3.5	6.9

Source: Care Quality Commission

Patient recommendation to friends and family

We believe that patient recommendations to their friends and family are a key indicator of the quality of care we provide. For 2025/26 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 monthly 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 and maternity birth 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. Maternity Postnatal Community scores slightly below the national average. Inconsistent capture of responses has affected scores for the antenatal and community postnatal question scores. As a result, increasing the volume of feedback captured from women, and making improvements based on their feedback, is a continued focus of the 'Good to Outstanding' programme being delivered by our maternity services in 2026/27.

Friends and Family Test 2025/26

Guy's and St Thomas'	A&E	In-patient	Out-patient	Maternity Antenatal	Maternity Birth	Maternity Postnatal Ward	Maternity Postnatal Community
% Positive response	87.2%	96%	93.5%	88.5%	92.6%	85.3%	91.8%
National average*	79.0%	95.0%	94.1%	92.4%	92.3%	92.0%	92.7%
% Negative response	8.1%	1.6%	3.3%	5.4%	3.8%	5.5%	5.3%
National average*	16.2%	2.6%	3.5%	5.5%	5.4%	5.0%	4.0%

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 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

Staff recommendation to friends and family

Staff advocacy remains a key strength for the Trust and a powerful indicator of both staff experience and quality of care.

Feedback from the NHS Staff Survey and Quarterly Pulse Survey continues to show high levels of engagement, with colleagues expressing strong confidence in the organisation as both a place to work and to receive care.

In 2025, the Trust improved on both advocacy questions compared to 2024, outperforming the national trend, which has seen a year-on-year decline. We ranked 4th nationally and 2nd in London for recommending the Trust for care or treatment, and 2nd nationally for recommending the Trust as a place to work.

These results reinforce the strong link between staff experience and patient care, and reflect a workforce that is committed, engaged and proud of the organisation.

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 tables below.

Staff recommending the organisation as a place to work	2022	2023	2024	2025
Trust Average	**70.8%**	**69.9%**	**72.5%**	**75.0%**
Average for Acute, Acute and Community Trusts	56.5%	60.5%	60.9%	57.8%
Best result for Acute, Acute and Community Trusts	75.3%	77.1%	79.4%	79.4%
Lowest result for Acute, Acute and Community Trusts	40.9%	44.0%	35.4%	34.2%

Staff recommending the organisation to a friend or relative if they needed care/treatment	2022	2023	2024	2025
Trust Average	**82.4%**	**80.5%**	**82.1%**	**83.4%**
Average for Acute, Acute and Community Trusts	61.8%	63.3%	61.6%	60.8%
Best result for Acute, Acute and Community Trusts	86.3%	88.8%	89.6%	88.4%
Lowest result for Acute, Acute and Community Trusts	39.2%	44.3%	39.7%	34.7%

Source: NHS Staff Survey Coordination Centre

National core set of quality indicators

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. Following implementation of the Epic electronic health record system, the Trust is continuing to develop solutions to ensure 95% of patients are assessed on admission for thrombosis and bleeding risk within 14 hours.

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. This 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 in November 2024. This resulted in significantly improved performance including a drastic reduction in the time to completion for inpatient admissions). This can be seen in the table below. 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 assessments within 14 hours
- the VTE prevention team are working to improve performance and utilising the Epic infrastructure to meet our targets.

VTE assessments	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26*
Guy's and St Thomas'	**97.9%**	**97.7%**	**97.4%**	**89.1%**[1]	**88.0%**	**94.6%**
National Average	96.0%	96.0%	Data not available – national reporting suspended			
Best Performing Trust	99.0%	99.7%				
Worst Performing Trust	89.0%	87.5%				

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

* Data is from 01/04/2025 to 28/02/2026

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 the UK Health Security Agency.

The Trust is below the threshold for all Gram-negative BSIs, but above the threshold for *C.difficile*. The threshold for healthcare-associated cases of *C.difficile* for 2025/26 was no more than 59 cases (set by NHS England based on Trust data from the preceding 12 months). The Trust has exceeded this threshold, reporting a total of 67 healthcare-associated cases for 2025/26. 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 2025/26.

Referencing *C.difficile* cases we believe our performance reflects that:

- 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*.

Infection prevention and control	2022/23[1]	2023/24[1]	2024/25[1]	2025/26[1]
Hospital Onset cases	**60[2]**	**62[2]**	**66[2]**	**67[2]**
Rate per 100,000 bed-days	**14.7**	**21.7**	**14.0**	Data not available yet
National average	26.7	46.7	23.0	Data not available yet
Best performing trust	0.0	0.0	2.0	Data not available yet
Worst performing trust	92.8	131.2	81.0	Data not available yet

[1] Data is not comparable with previous years due to changing national definitions over time.
[2] Data contains community onset-healthcare associated (COHA) and hospital-onset healthcare-associated (HOHA) cases.

Patient safety incidents

The Trust uses the national Learning from Patient Safety Events (LFPSE) system to report patient safety incidents, which 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 re-uploaded to the LFPSE system.

NHS Digital's official benchmarking data for 2024/25 was not available at the time of publishing last year's report. Our data, at that time, was provided from our internal local risk management incident reporting system, including harm levels for transparency but excluding reporting rates whilst we awaited the official benchmarking data. NHS England has also paused the production of official statistics and full financial year figures are not available at the time of drafting our quality account. NHS England resumed data publishing on patient safety events in April 2025 but statistical benchmarking data is still in development and awaiting validation using the LFPSE Recorded Data Dashboard (RDD). We are therefore unable to provide benchmarking data for the last two financial years. Once benchmarking is available, the Trust will update previous submissions in the next quality account.

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 submitted on a daily basis direct to the LFPSE System and our reporting numbers show a continued strong safety culture, and our harm rates remain comparable
- 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
- 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.

Patient Safety Incident Response Framework

A comprehensive review of our first Patient Safety Incident Response Plan (PSIRP) and its implementation over the past 2 years has now been completed, in line with what was agreed at both Trust and Integrated Care System level. This evaluation identified key strengths as well as opportunities for further improvement. The insights gained have directly informed the development of our updated PSIRP and supporting policy, ensuring they better reflect current needs and learning across the organisation.

An amended PSIRP and Trust Incident Policy are in use across the Trust. These updates reflect the areas of highest risk and priority action across the Trust and clinical groups. The changes are intended to strengthen our improvement work and further support proportionate, consistent responses to patient safety incidents. Key changes to note:

- move to a more focused set of Trust improvement priorities (no longer labelled as 'Trust-wide priority incidents or improvement plans') that outline key patient safety areas of focus:
    1) administrative / patient pathway related safety
    2) medication safety
    3) surgical safety
    4) patient falls
    5) maternity safety
- identification of additional of improvement priorities, specific to clinical group areas of risk or quality, that focus on areas for local improvement, as well as linking to key risk and quality objectives in the Trust
- move to a simplified incident type and management approach. We have amended our incident policy to include only 2 types of incidents: National/Regulatory incidents (i.e. Never Events); and all other patient safety incidents.

Reported patient safety incidents	April 2024 – March 2025	April 2025 – March 2026
Total reported incidents on the Trust's LRMS	33,194	29,518
Average incidents reported per 1000 bed days	78.58*	76.91**
Total incidents causing severe harm or death on LRMS	92	102
% incidents causing severe harm or death	0.003%	0.004%

Source: GSTT's Local Risk Management System (LRMS)

* NHSE only published figures for Q3 & Q4 in 2024/2025

** NHSE has not yet published Q4 2025/2026 data.

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 quality data 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 2025/26 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 2025 to March 2026
  - papers relating to quality reported to the Board and the Trust Executive over the period April 2025 to March 2026
  - national audit publications for the period April 2025 to March 2026–
  - feedback from the South East London Integrated Care Board in June 2026
  - feedback from Governors in March 2026
  - feedback from executive and non-executive committee members in May 2026
  - the 2025 national staff survey published March 2026
  - 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, and 3 June 2026 for urgent and emergency services at Guy's and St Thomas'
- 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.

Continues on next page

Statements

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

By order of the Board

Charles Alexander, Chairman
29 June 2026

Dame Amanda Pritchard, Chief Executive Officer
29 June 2026

South East London Integrated Care System

NHS South East London

SEL ICB's Guy's and St Thomas' NHS Foundation Trust 2025/2026 Quality Account Statement.

NHS South East London Integrated Care Board (SEL ICB) welcomes the opportunity to review Guy's and St Thomas' NHS Foundation Trust's Quality Account for 2025/26 and thanks the Trust for its continued openness and constructive engagement with commissioners. The ICB has considered the information presented and triangulated this, where possible, against quality, safety and performance intelligence received throughout the year.

The ICB recognises that the Trust continues to demonstrate a strong organisational commitment to delivering safe, effective and high-quality care. This is evidenced by a mature quality governance framework, a positive patient safety culture, and sustained focus on learning and improvement. The Trust's alignment with the Patient Safety Incident Response Framework (PSIRF), and its systematic approach to embedding learning from incidents, mortality reviews and audits, provides assurance that improvement activity is increasingly targeted and intelligence-led.

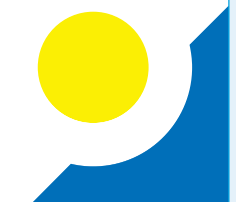
The ICB acknowledges the progress made against the Trust's quality priorities during 2025/26. In particular, the Trust's well-developed incident reporting culture and strengthened PSIRF and PSIRP arrangements reflect a more risk-based, proportionate approach to patient safety. Systems for learning from deaths are well established, with demonstrable impact in priority clinical areas such as sepsis, major haemorrhage, and treatment escalation planning. The Trust's continued performance on mortality outcomes, remaining comparatively low against national benchmarks, provides further assurance regarding the consistency of safe care delivery.

Notwithstanding this progress, the ICB notes that challenges remain in relation to operational performance and timely access to care. In particular, pressures across diagnostic pathways, cancer services and maternity services continue to impact waiting times and require sustained focus. The ICB will continue to support the Trust in implementing effective recovery trajectories and that improvements in access are delivered without compromise to quality and safety.

The ICB supports the Trust's proposed priorities for 2026/27, including a focus on reducing violence and aggression, improving staff safety, strengthening surgical governance, transforming outpatient services through data-driven approaches, and enhancing patient access and communication via digital innovation. These priorities appropriately reflect both local system risks and national expectations.

Overall, the ICB is assured that the Trust has made meaningful progress in strengthening its governance, embedding continuous improvement methodologies and advancing key safety initiatives. The Quality Account presents a clear and credible direction of travel, and the ICB looks forward to continuing to work in partnership with the Trust to ensure that improvements are sustained and deliver tangible benefit to patients across South East London.

Diane Jones
Interim Chief Nurse
Caldicott Guardian
NHS South East London Integrated Care System



GSTT proposed Quality Priorities 2026-27: Healthwatch Lambeth Response

Thank you for asking Healthwatch Lambeth to provide feedback on the Trust's priorities for 2026-7. 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. We support the Trust's decision to continue to with the same quality priorities into 2026-27 so that this they can be fully embedded into everyday practice. Our comments are below.

Quality priority 1 – Patient Safety

Reducing verbal and physical violence and abuse by patients

We appreciate progress made so far on reducing violence and abuse by patients and support the continued focus on this priority. Supporting staff to manage difficult situations safely is important for both staff wellbeing and patient care. We welcome plans to better understand the causes of aggression by listening to both staff and patients and the focus on communication, de-escalation and management, training, and support following incidents.

Quality priority 2 – Clinical effectiveness

Implementing Martha's Rule

We strongly support the continued roll out of Martha's Rule and the focus on listening to patients and families when they are worried about someone becoming unwell. This has the potential to improve patient safety and ensure that concerns are acted on earlier.

In relation to plans to expand the work through piloting in community wards we encourage the Trust to ensure information for patients around this is accessible and available in different formats and languages.

Transforming outpatient care

We also welcome the focus on transforming outpatient care and improving the use of data to prioritise patients appropriately and reduce waiting times. Patients often tell us they experience frustration with delays, long waits, and difficulty navigating hospital systems. It will be important that new digital systems improve access rather than create further barriers for people who may struggle with technology or communication.

Maximising new electronic health record (Epic)

The continued focus on improving staff confidence and training in the use of Epic is also positive. In our recent survey on health and care apps, patient told us they were often frustrated by errors in their health records, including in MyChart. Better use of digital systems can improve patient safety, quality of care, communication, and the overall patient experience.

Quality priority 3 – Patient Experience

Improving communication with patients

We strongly welcome the continued focus on improving communication and making it easier for patients to contact services. Difficulties contacting departments, rearranging appointments, and getting updates about care remain common concerns raised by residents.

However, it is important that digital solutions are not the only way patients can access support. Many patients including those with disabilities, carers, and those without reliable internet access still rely on telephone contact. Inclusive communication and accessible non-digital options should also remain available.

healthwatch
Southwark

Healthwatch Southwark's Response to Guy's & St. Thomas' NHS Foundation Trust's 2026-27 Quality Priorities

As the independent champions of patient voice in Southwark, we welcome the opportunity to comment on Guy's & St. Thomas' NHS Foundation Trust's proposed Quality Priorities for 2026–27. Our response is informed by the experiences and views of our service users, alongside our organisation's experience of working in partnership with Guy's & St. Thomas NHS Foundation Trust.

We would like to thank the Patient and Public Engagement Team for continuing to share opportunities for us to contribute to key decision-making at the Trust.

We recognise that meaningful and sustained improvement requires ongoing effort and evaluation over time. We welcome the Trust's proposal to continue the current Quality Priorities into the 2026–27 year, in addition to three new priorities. Our response will focus on priorities relating to patient experience in alignment with our organisational remit. We are pleased to see a number of initiatives planned to empower patients and their families.

The Trust has already made notable progress in improving patient experience through better communications and ways to contact the Trust, as reflected in the achievements outlined. We are particularly pleased to see patient feedback included as a performance metric, alongside quantitative data, and would welcome opportunities to support the Trust to deliver feedback stalls or similar engagements.

In relation to self-scheduling, we would be keen to better understand how the Trust is educating patients of this service, which patient groups are currently using these services, and what actions are planned to increase accessibility and engagement. We would welcome opportunities to support awareness raising and promotion of self-scheduling appointments, particularly for patients who may face digital barriers.

Likewise, we are pleased that the Trust will be trialling several approaches to support the implementation of Martha's rule and look forward to the learnings and outcomes from this work. We support the promotion of Martha's Rule in patient areas, particularly in translated languages. We would encourage the Trust to also consider creating Easy Read versions of these posters, as well as holding targeted outreach, for example via Southwark's Community Health Ambassadors and VCS, to further raise awareness of Martha's Rule to underrepresented groups. We are happy to support promotion through our communications and engagements at the Trust's sites.

Finally, we consider the proposed measures to improve outpatient care to be appropriate. We are pleased to see efforts to ensure greater consistency in the standard of care experienced by patients, particularly through data informed approaches, as the concurrent priority will aim to optimise Epic.

We would additionally welcome opportunities to share outreach and training delivered in community health and voluntary sector settings about the 'Contact Us' programme to ensure patients and the public are supported to understand and use these digital tools. This approach would align with the wider NHS 10-Year Plan shifts from hospital to community care and from analogue to digital services, helping to reduce inequalities in access and experience.

We would like to acknowledge the hard work and dedication of colleagues at Guy's & St. Thomas' NHS Foundation Trust in delivering services for our borough. We look forward to sustaining and strengthening our close working relationship to improve service users' experiences of health and care.

Sincerely,

Healthwatch Southwark

Guy's and St Thomas' NHS Foundation Trust

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