

St George's University Hospitals NHS Foundation Trust

Quality Report

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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust

Inadequate 

Are services at this trust safe?

Inadequate 

Are services at this trust effective?

Requires improvement 

Are services at this trust caring?

Good 

Are services at this trust responsive?

Requires improvement 

Are services at this trust well-led?

Inadequate 

Summary of findings

Letter from the Chief Inspector of Hospitals

St George's University Hospitals NHS Foundation Trust is a combined health care service. The trust provides secondary and tertiary acute hospital services and community services to the local population. The trust employs around 8,500 WTE staff and serves a population of 1.3 million across Southwest London.

Change in rating

- This trust had been rated good overall in a 2014 CQC comprehensive inspection. This most recent inadequate rating reflects a marked deterioration in the safety and quality of some of the trust services as well as to its overall governance and leadership.
- It is important to note that at the time of the inspection, the trust had introduced a range of supportive and recovery mechanisms as a means of stabilising the organisation. An interim chair and chief executive had been appointed to offer the organisation direction and to develop a robust and deliverable recovery plan. A number of interim appointments had been made to ensure there was a leadership which was able of delivering on the organisations' recovery plan. The executive team were clear about the challenges they and the trust faced and acknowledged the need for significant improvement across the board. Key substantive appointments had been made to the non-executive board which included the appointment of individuals with significant experience in regards to improving patient safety.
- Whilst we have rated the trust as inadequate overall, we noted good care in several areas and some outstanding practice in maternity for which clinical and support teams should be commended.
- We issued a letter of intent proposing to take urgent enforcement action under Section 31 of the Health and Social Care Act, 2008 due to the state of disrepair of some buildings at St George's Hospital. In response, the trust took appropriate action and therefore no enforcement action was pursued in that instance. We did however issue a Section 29A Warning Notice to the trust for breaches in regulations related to safe and fit premises at St George's Hospital, obtaining consent under the Mental Capacity Act, 2005, good governance and the fit and proper person requirement.
- Contributing factors for the deterioration in the trust's overall rating include, neglect of maintenance of its buildings; failure to ensure the requirements of the fit and proper persons regulation had been implemented; and a leadership culture which was weighted towards trying to achieve financial stability which inadvertently impacted on the quality of services being provided.
- Members of the executive and non-executive recognised that an attitude of 'learnt helplessness' existed across the organisation. Both the Chairman and Chief Executive recognised the need to improve staff engagement, to develop a long term sustainable vision and strategy for the organisation and to re-introduce accountability and strong leadership across all divisions within the trust.

Safe

- Several areas of the hospital's estate were in a state of disrepair. There was water ingress during heavy rain to several areas we visited. Work had commenced to repair some of the affected areas, but the huge backlog, meant that this would take a significant level of investment and time to resolve.
- Heating and power failures which had previously affected one medical ward remained on the risk register and had not been fully resolved however some mitigating action was in place.
- A number of operating theatres were not fit for purpose. Staff implemented contingency plans which included the elective closure of operating theatres when electrical faults or unsafe temperatures posed risks. Sixteen of the 31 theatres needed to be completely refurbished. Since the inspection, we have been told by the trust that the refurbishment of theatres 5 and 6 has been completed.
- There were poor fire detection systems and poor fire separation provision in Lanesborough Wing, St George's Hospital. Following the inspection, St George's Hospital was inspected by the Fire Safety Regulation Department and issued with a compliance level 1 with 'verbal action'.
- Due to ageing infrastructure, there was a risk of water contamination, specifically legionellosis. The risk of contamination was increased because of insufficient

Summary of findings

flushing of low-use water outlets. Ward staff were not routinely submitting evidence to demonstrate they had flushed water outlets as was required by trust policy. There was limited evidence to suggest that individuals or divisions were being held to account for this omission. The trust took action following the inspection to ensure that routine flushing of water outlets took place.

- The ED was not large enough for the current throughput of patients and modern standards, which meant that in some areas, privacy and dignity of patients was compromised. The environment was old and this meant that some areas looked dirty, despite regular cleaning. Many parts of the department were extremely hot and uncomfortable.
- Children and young people with mental health conditions were cared for on Frederick Hewitt Ward, but an environmental risk assessment had not been carried out to identify ligature points and other risks to their safety.
- The storage of equipment and fluids in the ED within the major incident cupboard was unclear and created confusion about what was training equipment and what was 'live' equipment.
- Mandatory training completion by staff was low in many areas.
- Many staff were trained in safeguarding adults and children and there were policies and processes in place for them to follow. However, 53% of medical staff working with children and young people had not completed level three safeguarding training, which is a requirement for all staff working with children. Safeguarding training was identified as a risk on the services risk register. Access to training was a problem; there was no dedicated trainer and no safeguarding supervision for staff.
- There was variable adherence to infection control procedures and some medical and surgical staff ignored challenges from colleagues.
- There were several examinations where radiographers gave contrast to patients despite PGDs not being in place. Also, the serial numbers of prescriptions (FP10's) for prescribers were not always monitored for use in some outpatient clinics. Apart from these, medicines were largely stored and managed appropriately.

- There were instances where care records were not stored securely, increasing the risk of unauthorised access. Otherwise, records were well documented with fully completed care plans and legible entries that had been signed by the relevant staff member.
- Medical and nursing cover across the hospital was generally good, apart from in the paediatric wards.
- Most staff knew how to report incidents and there was evidence of learning from incidents being shared as well as changes to improve practice being made.

Effective

- There was a lack of formal mental capacity assessments and best interest decision making as required under the Mental Capacity Act, 2005 and some patients had decisions made for them that they were capable making themselves. This existed both at St George's (acute) and Queen Mary's (community) Hospitals. For example, on some medical wards, bed rails to prevent falling out of bed and mittens to prevent pulling out of nasogastric tubes, were used on patients, who had not given their consent, nor had mental capacity assessments.
- There were no individualised plans of care specifically for community end of life care patients in the last phase of life that were based on national guidance or evidence based care and treatment. Moreover, there were no audits or quality monitoring of patient outcomes in the community end of life care services.
- There was no replacement of the Liverpool Care Pathway (LCP) following its removal from use in June 2013 and the community end of life care team was not consistently delivering effective care in accordance with national guidelines or evidence based care. There was however, treatment based on evidence-based guidance in several other areas.
- The Nursing Daily Evaluation Last Hour and Days of life document was a prompt sheet that was not backed up by either assessment or evaluation tools.
- Pain was assessed and patients told us their pain was managed well. However, pain relief was not always documented in records and there could be a delay to administration of analgesia when patients arrived within the department.
- Information technology issues impacted on staff's timely access to information and as a result records were fragmented in some areas.

Summary of findings

- There had been improvements in the appraisal process for nursing staff, but there were limited opportunities for training and development.
- Most areas participated in national clinical audits and patient outcomes were measured. Many clinical areas showed positive results, particularly maternity and surgery.
- Outcomes for renal patients in relation to survival rates and transplantation were excellent and were amongst some of the best in the country.
- A strong obstetric team focused on effective intrapartum care and staff used innovative and pioneering approaches to care with excellent outcomes. The maternity service was achieving year on year reductions in emergency caesarean sections.
- The maternity unit was strong in fetal medicine and had done pioneering work in non-invasive testing.

Caring

- Staff delivered care in a kind and professional manner.
- Although we observed and received some very positive reports of staff's kindness and caring attitude to patients, we also received some reports from patients about a lack of empathy from staff and poor communication.
- Patients were largely treated with dignity and respect.
- Most patients were positive about the care that they had received from staff and the way they had their treatment explained to them.
- Feedback from survey results showed high levels of satisfaction by patients and relatives with most of the services provided.
- There was sensitive support in place for bereaved parents of children.

Responsive

- The service had consistently failed to meet the ED four hour target for the last year and had only recently made changes involving all departments to reduce the time in the department and improve adherence with the target. There had begun to be some improvement in performance against the four hour target.
- The trust had to temporarily cease national reporting of the RTT data. This was because, they could not guarantee the data they were reporting was robust and accurate.
- People were not able to access services for assessment, diagnosis or treatment when they needed

to. The trust was not meeting national waiting times for diagnostic imaging within six weeks and outpatient appointments within 18 weeks for the incomplete pathways.

- The trust was not meeting the urgent two week referral target for patients with suspected cancer and cancer waiting times on the whole were variable across the targets.
- Follow up appointments were not always made in a timely manner and 'Did Not Attend' rates were higher than the England average.
- Theatres were unable to meet demand. Cancellation of operations were frequent and some of these were not rebooked within 28 days.
- Bed occupancy levels in surgical wards were higher than the England average, with a steady increase over 2015.
- Patients sometimes had to wait for tests because of demand on ultrasound and MRI scanners.
- There were a significant number of patient moves at night, between the hours of 10pm and 6am, which caused disruption and anxiety to some patients.
- Although a hospital passport had been completed for patients with a learning disability, their care plans were not adapted to take account of their individual needs.
- Care of people living with dementia was variable. The butterfly scheme existed but the Dalby Ward environment had not adapted to meet the needs of people living with dementia.
- There was not always a systematic approach to the management of actions and learning from complaints.
- Interpreters were sometimes used when patients were consenting to treatment and did not understand English, but at other times staff relied on relatives to interpret.
- Not all women currently received continuity of midwife care.
- There had been delays in access to some gynaecology clinics and procedures, although reductions had been achieved over the previous three months by running extra clinics.
- The curtains used to screen the beds on at least four of the medical wards did not always preserve people's privacy.
- Some patients were unhappy with having to use of disposable utensils and plastic beakers.

Summary of findings

- Parents were informed via text, when their child came out of theatre following surgery.

Well-led

- Leadership across several departments was weak, with many longstanding problems failing to be addressed within a timely manner. There was a lack of strategic direction for some of the services from the top of the organisation.
- We found a reactive rather than proactive approach to risk and environmental safety.
- The lack of multidisciplinary team meetings (MDT) with colleagues from medical and surgical departments and other allied health professionals was an area of concern.
- An external review of Referral To Treatment (RTT) data quality at St George's University Hospitals NHS Trust (June 2016) found that due to a high number of unknown start times of a patient's referral journey, patients were prevented from being treated in chronological order. The trust was also inconsistent in achieving their two week targets for patients with suspected cancer.
- Following the inspection, the trust wrote to NHS Improvement and NHS England, to confirm their intention to temporarily cease national reporting of our RTT data. This was because, they could not guarantee the data they were reporting was robust and accurate. The trust was taking action to proactively resolve the issue and was seen to be working with commissioners and external agencies in a collaborative way to ensure timely and robust resolution.
- The risk register in several divisions, did not fully document all risks identified across the departments and mitigating actions were not always sufficient to address risks. Actions taken to mitigate the risks were insufficient and timescales to fully address the risks were unclear.
- Some staff felt able to approach their senior management team and felt well supported by their senior clinical staff. However, staff working with children and young people did not receive feedback from their appraisals and felt support was inconsistent.
- There was low morale among theatre staff and consultant surgeons. Some consultant surgeons were not working with a multidisciplinary approach and were not engaged in the divisional objectives.
- Black and minority ethnic staff felt that they were not given the opportunities that less experienced white staff had in some areas.
- There was ineffective senior leadership and high levels of staff stress on Gwynne Holford Ward, Queen Mary's Hospital (community).
- There was no overall vision and a lack of strategic direction for community end of life care services from the top of the organisation.
- Systems and processes were not sufficiently established or operated effectively to ensure the trust was able to assess, monitor and improve the quality and safety of community end of life care services.
- Fit and proper persons, which is a legal requirement for trusts to undertake, was not fully embedded in the trust.
- Junior doctors reported that there was no formal channel through which concerns and suggestions could be raised.
- The trust performed worse than other trusts in 24 questions, in the NHS staff survey in 2015.
- Trust compliance with the workforce race equality standards was poor. Staff from black and minority ethnic backgrounds reported poor opportunities for career progression or promotion. Governance and board oversight of the workforce race equality standards was poor.
- Both the interim chair and chief executive had acknowledged the significant challenges faced by the trust and spoke candidly of them. Interim appointments were being made to address deficits in the leadership.
- Engagement of patients and the public in the improvement of services was evident.
- There were examples of the development of services and the introduction of new practices to take the service forward.
- We saw innovation across some areas, including participation in research, journal publication and use of social media to disseminate key information to staff.

We saw several areas of outstanding practice including:

Summary of findings

- Outcomes for renal patients in relation to survival rates and transplantation were excellent and were amongst the best in the country.
- The outcomes achieved by the specialist medical and surgical services provided by the hospital.
- The effectiveness of maternity care delivered by the hospital.
- The responsiveness of the neonatal unit to parents whilst their baby was on the unit and the support provided by the outreach nurse.
- The involvement of children of varying ages on the interview panel as part of the recruitment process for ED paediatric nurses.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Develop a long term strategy and vision
- Move towards having a stable, substantive leadership team.
- Ensure all premises and facilities are safe, well-maintained and fit for purpose.
- Ensure all care is delivered in accordance with the Mental Capacity Act, 2005, when appropriate.
- Review and implement robust governance processes, so that patients receive safe and effective care.
- Ensure RTT data is robust and accurate so that patients are given appointments and treatment based on their needs and within national targets.
- Ensure serial numbers of prescriptions (FP10s) for prescribers are always monitored for use.
- Ensure radiographers only administer medication (contrast media) where appropriately authorised Patient Group Directions (PGDs) are in place.
- Ensure the fit and proper persons' requirement regulations for directors are always complied with.
- Ensure the paediatric ward environment, staffing and training requirements are suitable for treating and caring for children and young people with mental health conditions.
- Ensure medicines are stored in an appropriate manner, by keeping cupboards locked when not in use.
- Ensure the process for decontamination of nasoendoscopes is compliant with guidance.

In addition, the trust should:

- Maintain patient privacy, dignity and confidentiality at all times.
- Review the fluid storage within the ED major incident cupboard to ensure that training equipment is not stored with 'live' equipment.
- Ensure staff consistently follow guidance related to the prevention of healthcare associated infections with specific regard to hand hygiene.
- Ensure medical equipment across the trust stored on is cleaned and that there are systems in place for monitoring the cleanliness of equipment returned to the ward.
- Ensure all staff caring for children receive level 3 safeguarding training.
- Ensure the process for investigating serious incidents is timely and undertaken by people trained in investigation so they understand the root causes of an incident and identify measurable action.
- Minimise the cancellation of operations and when this cannot be avoided, they are rescheduled within 28 days.
- Reduce the moves of patients to wards that are not appropriate.
- Ensure staff use the early warning scoring system effectively, including the timely escalation of deteriorating patients to relevant personnel.
- Ensure divisional and trust priorities are shared by personnel of all grades and professions who work together to promote the quality and safety of patient care.
- Address the low morale among theatre staff and consultant surgeons.
- Replace damaged chairs and furniture within patient areas so that they can be thoroughly cleaned.
- Ensure that all patients within the ED 'streaming' area are assessed within a private area.
- Ensure staff can observe the patients whilst they are waiting in their outpatient departments.
- Ensure patient electronic records are not easily visible or their paper records are not easily accessible by the public.
- Improve the percentage of telephone calls answered by staff in the outpatient department are within the service level agreement targets.
- Communicate effectively with patients when outpatient clinics overrun.

Summary of findings

- Ensure there are sufficient cystoscopes (to examine the inside of the bladder) to supply day surgery, main theatres and endoscopy.
- Ensure all relevant staff are appropriately inducted to the trust and within clinical environments to which they are allocated to work.

On the basis of this inspection, I have recommended that the trust be placed into special measures.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to St George's University Hospitals NHS Foundation Trust

St George's University Hospitals NHS Foundation Trust, is a teaching trust with two hospital locations; St George's Hospital, Tooting, and Queen Mary's Hospital, Roehampton. The main acute site is St George's Hospital, which provides general and specialist services and has an emergency department. Queen Mary's Hospital does not have an emergency department. We visited both locations during this inspection.

St George's University Hospitals NHS Foundation Trust has 1,083 beds; 995 at St George's and 88 at Queen Mary's. The beds at St George's Hospital comprise of 871 general and acute, 67 maternity, 57 critical care. The beds at Queen Mary's Hospital comprise of 46 for people with limb amputations who require neurorehabilitation and 42 for sub-acute care, treatment and rehabilitation of older people.

The hospitals are both in the London Borough of Wandsworth. The lead clinical commissioning group is Wandsworth, who co-ordinates the commissioning activities on behalf of the other local clinical commissioning groups such as Merton and Lambeth.

The trust serves a population of 1.3 million across Southwest London. A large number of services, such as cardiothoracic medicine and surgery, neurosciences and renal transplantation, also cover significant populations from Surrey and Sussex, totalling around 3.5 million people.

As well as acute services, the trust also provides a full range of community services to patients of all ages following integration with Community Services Wandsworth in 2010.

Deprivation

The health of people in Wandsworth is varied compared to the England average. Deprivation is lower than average, however about 19.2% children live in poverty.

Activity

- The trust has approximately 995 beds including 57 critical care beds and 67 maternity beds located at St Georges Hospital, Tooting.
- The trust employs around 8,536 WTE staff.
- There were approximately 669,570 outpatient attendances at St George's Hospital between July 2014 and June 2015.
- There were approximately 146,908 attendances to the emergency department in 2015/16.
- There were 1,448 deaths at St George's Hospital between April 2015 and May 2016
- The trust had revenue of £711.1 million for 2014/2015. The trust reported a financial deficit of £16.8 million in 2014/2015.

Our inspection team

Our inspection team was led by:

Chair: Martin Cooper, Medical Director

Head of Hospital Inspections: Nick Mulholland, Care Quality Commission (CQC)

The trust was visited by a team of 62 people, including: CQC inspectors, analysts and a variety of specialists.

There were consultants in emergency medicine, anaesthesia and intensive care, obstetrics and gynaecology, radiology and neonatal care. The team also included nurses with backgrounds all the specialties we inspected, as well as a midwife, an infection nurse and a student nurse. There were also specialists with board-level experience and three experts by experience.

Summary of findings

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

The inspection team always inspects the following core services at each inspection:

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

We also inspected the community services provided by the trust including:

- Community in-patient services for adults
- Community adult services
- Community end of life care
- Community services for children, young people and families.

Before our inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the trust. These organisations included the clinical commissioning groups, NHS Improvement, Health Education England, General Medical Council, Nursing and Midwifery Council, Royal College of Nursing, NHS Litigation Authority and the local Healthwatch. We also received information from the trust's council of governors. We observed how patients were being cared for, spoke with patients, carers and/or family members and reviewed patients' personal care or treatment records. We held focus groups with a range of staff in the trust including nurses, allied health professionals, administration and other staff. We also interviewed senior members of staff at the hospital.

Facts and data about this trust

Context

- Both St George's and Queen Mary's Hospitals are based in the London Borough of Wandsworth and serves a population of 1.3 million people.
- St George's offers a range of local services, including: an emergency department, medicine, surgery, critical care, maternity, paediatric services and outpatient clinics. The hospital is also a major trauma centre and provides specialist services in neurology, cardiac care, renal transplantation, cancer care and stroke.
- Queen Mary's Hospital has two adult community rehabilitation wards, one for people with limb amputations and the other for older people.
- In the 2011 census, the proportion of residents in Wandsworth who classed themselves as white was 71.4 %.

- The health of people in Wandsworth is varied compared to the England average. Deprivation is lower than average, however about 19.2% children live in poverty.

Key intelligence indicators

Safety

- Between May 2015 and April 2016, there were 132 serious incidents including seven never events reported to STEIS.
- Trust wide, a large number of pressure ulcers were regularly identified each month using the safety thermometer, with 234 throughout the reporting period, March 2015 to March 2016. 20 of these cases meet the SI criteria.
- Trust wide, four cases of MRSA, 39 of MSSA and 33 C diff cases were reported at the trust between March 2015 and March 2016.

Summary of findings

- There were 44 falls and 92 CAUTIs reported to the patient safety thermometer.

Effective

- The SHMI for this trust for October 2014 to September 2015 was 0.91 and within expected limits.
 - The HSMR for this trust for January to December 2015 was 87.5 and better than expected. The HSMR for emergency admissions at weekends was 91.0 (as expected) and for emergency weekday admissions was 87.0 (better than expected).
 - There were two mortality outliers in this trust.
1. Cardiac pacemaker or defibrillator introduced through the vein
 2. Coronary atherosclerosis and other heart disease
- Both are being followed up by CQC.

Caring

- In the CQC inpatient survey 2014, this trust performed about the same as other trusts in all 12 questions.
- In the friends and family test results for May 2016, 95% of inpatients recommended the hospital with a 30.6% response rate.
- The number of written complaints has decreased since 2010/11, and remained fairly consistent, aside from a reduction in 2012/13, which saw the lowest number of written complaints in the five year period.

Responsive

- Between April 2013 and August 2015, 6,640 patients experienced delays in the transfer of their care.
- Bed occupancy at the trust, between April 2015 and March 2016 was 95.5%.
- The trust has temporarily ceased national reporting of its RTT data, because, at present, it cannot guarantee the data they are reporting is robust and accurate. This means that the data will not be included in the national data set.

Well-led


- Staff sickness absence rates in this trust for the period between January and December 2014 averaged 3.4%.
- Results from the NHS staff survey in 2015, showed that this trust had a similar performance to other trusts for eight questions and performed worse than other trusts in 24 questions. The overall engagement score for this trust was 3.7, which was slightly lower (worse) than the national average.

Inspection history

This is the second comprehensive inspection of St George's Hospital. The first being in February 2014. We previously rated the trust as good overall, however safe was rated as requires improvement. Critical care services had previously been rated as outstanding. End of life care services had previously been rated as requires improvement.

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>We rated safe at trust level as inadequate because:</p> <ul style="list-style-type: none">• Several areas of the hospital's estate were in a state of disrepair. Work had commenced to repair some of the affected areas, but the huge backlog, meant that this would take a significant level of investment and time to resolve.• There was water ingress during heavy rain to several areas we visited, which we found unacceptable.• Heating and power failures which had previously affected one medical ward remained on the risk register and had not been fully resolved at the time of the inspection.• Some operating theatres were not fit for purpose. Theatres were sometimes closed due to electrical faults or unsafe temperatures. Sixteen of the 51 theatres needed to be completely refurbished. Since the inspection, we have been told by the trust that the refurbishment of theatres 5 and 6 had been completed.• During the inspection we identified and raised concerns with the trust related to poor fire detection systems and poor fire separation provision in Lanesborough Wing, St George's Hospital.• We referred the fire safety issues to the local Fire Safety Regulation Department, who carried out a fire safety audit of the Lanesborough Wing, on 14 July, 2016. The Fire Safety Regulation Department issued a compliance level 1 with 'verbal action' to the trust.• We also found that there was a risk of water contamination, specifically legionellosis, due to insufficient flushing of low-use water outlets.• The trust responded to our concerns about the water safety issue by taking action which included enabling estates staff to regularly flush low use outlets and be responsible for recording this.• Children and young people with mental health conditions were cared for on Frederick Hewitt Ward, but an environmental risk assessment had not been carried out to identify ligature points and other risks to their safety.• Medicines were largely managed appropriately, save for a few exceptions. For example, there were several examinations where radiographers gave contrast to patients despite PGDs not being in place. Also, in some areas, medicines were not always	<p>Inadequate </p>

Summary of findings

stored in an appropriate manner, by keeping cupboards locked when not in use and there were not adequate systems in place to monitor the use of prescriptions in some outpatient departments at St George's Hospital.

- Mandatory training completion by staff was low in many areas.
- Records were well documented with fully completed care plans and legible entries that had been signed by the relevant staff member. However, there were instances where care records were not stored securely, increasing the risk of unauthorised access. There were still cases of patient records being unavailable for outpatient appointments, as there was during the 2014 inspection. However, this had improved. An audit of records being available in clinics from April 2015 to April 2016, showed results ranging between 95.42% to 97.2%, with a trust target of greater than 98%.

Duty of Candour

- The majority of frontline staff were aware of the “Duty of candour” which ensures patients and/or their relatives are informed when they are affected by something which went wrong and given an apology. Duty of candour awareness was included within the trust induction.
- Information provided by the trust and what we reviewed during the inspection, showed that where incidents had occurred which met the threshold for the requirements of the duty of candour to be applied, discussions had taken place with patients and/or their relatives. Patients had been kept informed of investigations resulting from the incident.
- Senior staff were aware of their responsibilities relating to the duty of candour and were able to give us examples of when the duty had been applied.

Safeguarding

- The trust had an identified executive lead for safeguarding children. At the time of the inspection, the chief nurse assumed this role.
- Many staff were trained in safeguarding adults and children and there were policies and processes in place for them to follow. However, 53% of medical staff working with children and young people had not completed level three safeguarding training, which is a requirement for all staff working with children. Safeguarding training was identified as a risk on the services risk register. Access to training was a problem; there was no dedicated trainer and no safeguarding supervision for staff.

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Incidents

- The trust reported 132 serious incidents including seven never events to STEIS between May 2015 and April 2016. These never events were, three retained foreign objects post procedure, two wrong site surgery, a misplaced nasogastric tube and an overdose of insulin.
- Most staff knew how to report incidents and there was some evidence of learning from incidents being shared as well as changes to improve practice being made.

Medicines

- Staff understood how to recognise and report medicines related safety incidents. This was reflected in the higher than average reporting rate of incidents at the trust (14% vs 10% nationally). Medicines errors and safety incidents were reported via Datix and these were reviewed by the medicines safety committee and the pharmacy team on a quarterly basis. The feedback to staff was communicated in a variety of channels such as newsletters, emails and face-to-face monthly clinical governance meetings if required.
- Data showed that the most common types of incidents related to delayed or omitted doses of medicines. Although the level of incidents reported has increased, the level of harm has decreased from the previous year. There was a never event involving a 10-fold error in the dosage of insulin administered to a patient on the General Intensive Care Unit. As a result of this, we saw evidence that the pharmacy team had implemented actions to minimise the chance of this occurring again. For example, spot-check audits were carried out throughout the trust to ensure the dosage of insulin is written as 'units' instead of 'u'. There was a significant reduction in the writing of 'u', which showed that the trust had recognised the types of medicines incidents that occurred and had processes in place to monitor and improve them to promote patient safety.
- The serial numbers of prescriptions (FP10's) for prescribers were not always monitored for use. This applied to audiology, diabetic and rheumatology outpatient clinics.
- Medicines at the trust were not always stored securely and appropriately. We found that most keys to medicines cupboards, trolleys and patient bedside lockers were held by appropriate staff and medicines trolleys were immobilised (chained to the wall) when not in use. However, in a few areas (such as Richmond AMU and Cavell Surgical Ward) there was

Summary of findings

not restricted access to medicines cupboards, trolleys or fridges containing medicines. In the emergency department and neonatal unit, some emergency medicines were not stored in locked drawers/cupboards at all times.

- Medicines cupboards and fridges inspected were clean and tidy, and fridge temperatures were generally within the recommended range of 2-8°C, with daily checks carried out. Throughout the trust all the medicines inspected were in date and no delays in the top up of these medicines were reported by staff. Room temperature monitoring had recently been introduced throughout the trust, and we found evidence that this was carried out on a daily basis, which meant that medicines requiring storage below 25°C had been taken into account. The allergy statuses of patients were routinely recorded on the medicines chart and electronic prescribing system, along with VTE risk assessments in most cases. These were audited by pharmacy and showed good outcomes of being done.
- Medicines used for resuscitation and other medical emergencies (for example anaphylaxis) were readily available, accessible for immediate use and tamperproof. We saw evidence of daily and monthly checks to ensure the appropriate medicines were stocked and not expired. However, rectal diazepam was stored in the emergency drug cupboard within the emergency department (resus area). Staff informed us that a risk assessment had been carried out to ensure it could be accessed in a timely manner for patients being treated for seizures. We asked for, but did not see documented evidence for this during the inspection.
- Controlled Drugs (CDs) were securely stored in accordance with legal requirements. A separate key was held by authorised staff and entries double-signed in the register to provide evidence of an authorised witness. However, the recording of daily checks were not always done in a consistent manner within the CD register. For example, in the emergency department, daily checks were done at the back of the register, whilst in some surgical wards, the checks were done in separate books.
- The use of electronic prescribing had been implemented in some areas of the trust, whilst other areas such as Richmond AMU and some surgical wards still used paper medicines charts. Pharmacy staff were proactive in carrying out medicines reconciliation. The latest data showed that more than 90% of patients had a medicines reconciliation done within 24 hours across several areas in the trust.
- There was the right skill mix of pharmacy staff to ensure that the risks associated with the management of medicines were

Summary of findings

managed and reduced. Senior pharmacists were involved in multi-disciplinary teams in high risk areas such as critical care, paediatrics and medicines safety. However, a senior pharmacist did highlight a slight concern with regards to the recruitment of pharmacy technicians to provide ward top ups, and also of succession planning for prescribing pharmacists.

Staffing

- Medical and nursing cover across the hospital was generally good, apart from in the paediatric wards, Gwynne Holford Ward at Queen Mary's Hospital and the community end of life care team. There were high nursing vacancy rates in several areas (covered and bank and agency nurses), but this had been reducing over the past year, following a successful recruitment drive.
- There was high use of agency staff in paediatrics, Gwynne Holford Ward at Queen Mary's Hospital and the community end of life care team. This was a concern because agency staff were unable to undertake some procedures, for example administer intravenous medicines, which in turn increased the workload for permanent staff. As a result there were often delays in patients receiving care.
- Staff reported a bureaucratic recruitment system which led to long delays to getting staff employed. For example, some vacancies had to go through multiple senior managers before it went to a panel for approval. In response, the chief nurse implemented a policy to allow student nurses trained at the trust to "fast-track" into vacancies without having a formal interview.
- Nurse staffing requirements on the medical wards had been reviewed using a recognised tool (Shelford tool) and acuity and dependency data provided by the wards.
- For more detailed information, please refer to the reports for St George's Hospital and the trust reports for community services.

Are services at this trust effective?

We rated effective at trust level as requires improvement because:

- There was a lack of formal mental capacity assessments and best interest decision making as required under the Mental Capacity Act, 2005 and some patients had decisions made for them that they were capable making themselves. For example, on some medical wards, bed rails to prevent falling out of bed and mittens to prevent the pulling out of nasogastric tubes, were used on patients, who had not given their consent, nor had mental capacity assessments.

Requires improvement



Summary of findings

- The community end of life care did not consistently provide care in accordance with national guidelines. There were no individualised care plans specifically for community end of life care patients in the last phase of life, that were based on national guidance or evidence based care and treatment. There was no replacement of the Liverpool Care Pathway (LCP) following its removal from use in June 2013. Moreover, there were no audits or quality monitoring of patient outcomes in the community end of life care services.
- The Nursing Daily Evaluation Last Hour and Days of life document was a prompt sheet that was not backed up by either assessment or evaluation tools.
- Slow and chronic problems with information technology, impacted on staff's timely access to information and led to delays to patient care.

However, we also found that

- The maternity team were delivering year on year improvements in reducing their caesarean section rate. Other maternity indicators were also better than the national average.
- Despite the challenging environment from which renal services was provided, the team were delivering good outcomes which compared favourably with national performance.
- There was an embedded nurse preceptorship programme in place, which was designed to support newly qualified nursing staff.
- In the Sentinel Stroke National Audit (SSNAP) from January 2015 –December 2015, the trust had achieved a level A overall (the highest possible level, in a range of A to E) for the hyper-acute stroke unit and level B for the stroke unit.
- The fetal medicine centre carried out endoscopic in-utero fetal surgery with good outcomes resulting, for example in improved survival, gestational age at delivery and birthweight for women with pregnancies complicated by twin to twin syndrome.

Evidence based care and treatment

- There was a strong obstetric team focused on effective intrapartum care and staff used innovative and pioneering approaches to care with excellent outcomes.
- The maternity service benchmarked itself against London and national standards. It was achieving year on year reductions in emergency caesarean sections, a key measure of success. The caesarean section rate at the unit was already very low by comparison with other units nationally. The rate of breastfeeding on discharge was 89% and this level had been consistently maintained.

Summary of findings

- St George's University of London Medical School shared the site and some consultant staff with St George's Hospital. These links and participation in national and international research, gave access to the latest evidence in some areas of surgical practice. However, the use of evidence-based practice was variable across the trust.
- Pain scores for patients were not always documented in their records.

Patient outcomes

- Performance against a range of national audits was variable. In some specialties, there were examples of where audits had driven improvements, but not in other areas.
- Outcomes for renal patients in relation to survival rates and transplantation were excellent and some of the best in the country.
- The outcomes achieved by the specialist medical and surgical services provided by the hospital were very good. In the Sentinel Stroke National Audit (SSNAP) from January 2015 –December 2015, the trust had achieved a level A overall (the highest possible level, in a range of A to E) for the hyper-acute stroke unit and level B for the stroke unit.
- The fetal medicine centre carried out endoscopic in-utero fetal surgery with good outcomes resulting, for example in improved survival, gestational age at delivery and birthweight for women with pregnancies complicated by twin to twin syndrome.
- The clinic organisation and outpatient care for the termination of pregnancy was effective in supporting women with serious medical conditions because there was access to other specialists, if necessary.
- The majority of staff told us they received appraisals on their performance as required. However, records were inaccurate and didn't always reflect this.
- Access to some mandatory training was difficult at times due to demand being greater than places available.

Multidisciplinary working

- Effective multidisciplinary working was variable. There were examples where this worked well, for example medical wards and maternity. However, improvements were required to achieve effective multidisciplinary working in surgery and community end of life care.
- A multidisciplinary approach ensured women with pre-existing medical conditions had an integrated approach to antenatal care.

Summary of findings

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- There was evidence that staff explained treatment to most patients and sought their consent before proceeding. Patients were given information about the benefits and risks of surgery before they signed the consent form. Interpreters were booked to assist with obtaining consent if patients needed this.
- Most nursing staff did not have a good understanding of the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Although some staff had a theoretical knowledge of the implications of the Act and Deprivation of Liberty Safeguards, they told us the medical staff usually took the lead when assessments of capacity were required. This is not a requirement of the Act.
- For more detailed information, please refer to the reports for St George's Hospital and the trust reports for community services.

Are services at this trust caring?

We rated caring at trust level as good because:

- Staff delivered care in a kind and professional manner. They were passionate and dedicated about making sure the people they cared for were provided with the best care possible.
- Community nursing staff cared for end of life care patients in their own homes with dignity, respect and compassion.
- Most patients were positive about the care that they had received from staff and the way they had their treatment explained to them.
- In critical care, we saw some specific examples where staff anticipated and met specific patient needs, such as nursing a patient in accordance to their religious beliefs on GICU and supporting a patient through a marriage ceremony on CTICU.
- Feedback from survey results showed high levels of satisfaction by patients and relatives with most of the services provided.
- Performance against the national friends and family test showed that the trust was consistently better than the national average. In the friends and family test results for May 2016, 95% of inpatients recommended St George's Hospital with a 30.6% response rate.

Compassionate care

- Although we observed and received some very positive reports of staff's kindness and caring attitude to patients, we also received some reports from patients about a lack of empathy from staff and poor communication.
- Patients were largely treated with dignity and respect.

Good



Summary of findings

- Performance against the privacy, dignity and well-being criteria within the patient led assessments for care environment audit (PLACE) for 2013, 2014 and 2015 was slightly worse than the England average for all three years (trust performance for 2013, 2014 and 2015: 86%; 87% and 83% respectively versus 89%, 88% and 86% nationally).
- In the CQC inpatient survey 2014, this trust performed about the same as other trusts in all 12 questions.

Understanding and involvement of patients and those close to them

- Most patients we spoke with felt well informed about their care including any investigations that were planned.
- Patients told us that staff explained treatments and results to them in manner that they could understand.

Emotional support

- There was a chaplaincy service available to provide emotional support to patients and relatives if required.
- Bereavement officers supported bereaved families and friends after a patient's death by explaining all the legal processes and what to expect when someone had died.
- There was a weekly bereavement clinic which bereaved family and friends could attend if required.
- Staff were aware of the need to support children and other members of their family, during admission.
- A specialist bereavement midwife helped couples with emotional and practical support and also supported midwives involved in the death of a baby.
- For more detailed information, please refer to the reports for St George's Hospital and the trust reports for community services.

Are services at this trust responsive?

We rated responsive at trust level as requires improvement because:

- Inaccuracy in the Referral To Treatment (RTT) data meant patients were experiencing delays in receiving their first appointment.
- An external review of RTT data quality at the trust published in June 2016, found that patients were not being treated in chronological order. The prioritisation process for ensuring patients in need of an appointment quickly was in its initial stages.
- The trust had to temporarily cease national reporting of the RTT data. This was because, they could not guarantee the data they were reporting was robust and accurate.

Requires improvement



Summary of findings

- People were not able to access services for assessment, diagnosis or treatment when they needed to. The trust was not meeting national waiting times for diagnostic imaging within six weeks and outpatient appointments within 18 weeks for the incomplete pathways.
- Follow up appointments were not always made in a timely manner and 'Did Not Attend' rates were higher than the England average.
- Theatres were unable to meet demand and were used to full capacity. Cancellations of operations were frequent and some of these were not rebooked within 28 days. The trust acknowledged that this was an area for improvement and was working to improve the overall theatre infrastructure in a planned way.
- Bed occupancy levels in surgical wards were higher than the England average, with a steady increase over 2015.
- Patients sometimes had to wait for tests because of demand on ultrasound and MRI scanners.
- There were a significant number of patient moves at night at St George's Hospital, between the hours of 10pm and 6am, which caused disruption and anxiety to some patients.

Service planning and delivery to meet the needs of local people

- The trust worked local clinical commissioning groups, NHS England and the local authority to provide general and specialist services.
- St George's Hospital is a designated major trauma centre for the South West London and Surrey trauma network and it also has a hyper acute stroke unit (HASU). The hospital had a helipad which opened in 2014, so that patients with major trauma could be brought to the hospital by air ambulance.
- Despite providing both acute and community services, communication and joint working between these services, were under-developed. This was particularly true for the acute and community end of life care teams.
- Outpatients were able to use the 'choose and book' system to enable them to choose an appointment in a location closer to their home.
- A text reminder service had just been re-introduced to help lower the outpatient DNA rate. The service had been removed previously to save costs.

Meeting people's individual needs

- There was a learning disability nurse specialist who supported staff appropriate patients.

Summary of findings

- There was no method of clearly identifying patients attending the emergency department with a learning disability and there was a strong reliance on carers to assist staff and care for patients. Staff reported that they had no specific training for patients with a learning disability, however they said they could access specialist nurses 9am to 5pm Monday to Friday, if there were specific issues.
- Although a hospital passport had been completed for patients with a learning disability, their care plans were not adapted to take account of their individual needs.
- Interpreters were sometimes used when patients were consenting to treatment and did not understand English, but at other times staff relied on relatives to interpret. This was not always appropriate.
- Curtains used to screen the beds on at least four medical wards at St George's Hospital did not always preserve people's privacy. Some did not completely surround the bed spaces and others had too few curtain hooks to enable the curtains to hang properly.
- Some patients were unhappy with having to use of disposable utensils and plastic beakers on some medical wards at St George's Hospital.

Dementia

- The trust had a dementia team in place to improve the care of people living with dementia. Dementia and delirium pathways had been developed, along with a proforma for the assessment of delirium and dementia and a care plan. Training for staff had begun and the initiative was being rolled out in a staged process. Nurse specialists for dementia supported staff and patients and were available Monday to Friday, 9am and 5pm.
- Patients identified to be living with dementia in the emergency department were given a dementia passport and documented in their notes, if it was not already. However, there was a reliance on carers accompanying the patient to assist them.
- Care of people living with dementia was variable. The butterfly scheme existed but the Dalby Ward environment had not adapted to meet the needs of people living with dementia.

Access and flow

- St George's Hospital had consistently failed to meet the emergency department four hour waiting time target for the last year and had only recently made changes involving all departments to reduce the time in the department and improve adherence with the target. There had begun to be some improvement in performance against the four hour

Summary of findings

target. The most recent data available for April to June 2016 showed the hospital had improved to 92.5%, which was above the England average, with three weeks in that quarter where the target was achieved.

- Bed occupancy across St George's Hospital during the inspection was 92%. This had been steadily increasing since Q3 2014/15 and had got as high as 98.2% in Q3 2015/16. Bed capacity at Queen Mary's Hospital was utilised to relieve pressure at St George's. The paediatric assessment unit at St George's Hospital was regularly used to care for children and young people when there was no bed at the hospital. This was not good practice.
- Patient flow management had improved in the past year, but there were still some issues with delayed discharges. To help speed up the discharge process, social services at a local authority had agreed to make 'out of panel' funding decisions.
- There were many reported problems with the private provider of non-emergency hospital transport. This caused delays and cancellations to patient journeys and impacted on patients (including end of life patients) being discharged and trauma patients requiring repatriation to their local hospital.
- There had been delays in access to some gynaecology clinics and procedures, although reductions had been achieved over the previous three months by running extra clinics.
- On the paediatric wards, children often shared bays with other children of a different gender or age group. Parents were asked to sign a disclaimer confirming their acceptance that their child could share an area with children of a different age or gender.

Learning from complaints and concerns

- There was an executive lead for complaints at the time of the inspection.
- Complaints were reported to the board monthly as part of the quality and performance report. This report was also reviewed at the quality and risk committee bi-monthly.
- The trust aimed to respond to 85% of complaints within 25 days; however this target was often not achieved.
- There was not always a systematic approach to the management of actions and learning from complaints. The information we were provided with in relation to complaints listed all the complaints received, but the action taken or response to the complaint was often not documented.
- For more detailed information, please refer to the reports for St George's Hospital and the trust reports for community services.

Summary of findings

Are services at this trust well-led?

We rated well-led at trust level as inadequate because:

- There existed no credible vision or strategy for the organisation.
- Staff were not fully committed to "Living the values" of the trust.
- Fit and proper persons, which is a legal requirement for trusts to undertake, was not fully embedded in the trust.
- Governance and risk management processes were weak and offered little in the way of assurance.
- There existed little in the way of accountability of risks.
- Staff engagement and the culture of the organisation required significant improvement.
- Trust compliance with the workforce race equality standards was poor. Staff from black and minority ethnic backgrounds reported poor opportunities for career progression or promotion. Governance and board oversight of the workforce race equality standards was poor.

However,

- The interim chair and chief executive had acknowledged the significant challenges faced by the trust and spoke candidly of them.
- Interim appointments were being made to address deficits in the leadership.
- The interim chair had been recognised as offering a level of stability and challenge to the organisation with quality seen as the driving motivation for service improvement.

Vision and strategy

- In 2012 the trust launched a ten year strategy. The mission of the trust was to "Provide excellent clinical care, education and research to improve the health of the population".
- The vision of the organisation was to "Become an excellent integrated care provider and a comprehensive specialist centre for south west London, Surrey and beyond, with thriving programmes of education and research".
- The trust had set seven key goals to achieve as part of the ten year strategy:
 - Redesign care pathways to keep more people out of hospital.
 - Redesign and reconfigure the local hospital services to provide higher quality care.
 - Consolidate and expand key specialist services
 - Provide excellent and innovative education to improve patient safety, experience and outcomes.
 - Drive research and innovation through clinical services.

Inadequate



Summary of findings

- Improve productivity, the environment and systems to enable excellent care.
- Develop a highly skilled and motivated workforce championing the values of the organisation.
- The vision for the trust was poorly articulated by the majority of staff we spoke with during the inspection. The executive team reported the need to revisit both the vision and strategy of the organisation as a matter of urgency. Both the Interim Chair and Interim Chief Executive referred to the need for there to be a period of stability and of "getting back to basics". The chair recognised the trust had become derailed during the delivery of the clinical strategy and that there existed significant deviation from the work-streams and goals set out within the document.
- The trust had produced a Quality Improvement Strategy for 2012-2017. The annual plan for 2016/2017, titled "Getting the Fundamentals Right" was based on a board driven strengths, weakness, opportunities and threats analysis carried out in December 2015. There was recognition of the need to improve the estates infrastructure, staff turnover, staff engagement, culture and conduct, ward to board performance, performance management and capacity/high occupancy.
- In 2010, the trust launched a set of values which were aligned to the vision of the organisation of improving the health of patients. The values were launched following discussion with staff and patients and included:
 - Excellent
 - Look after our patients as we would like to be looked after ourselves
 - Set ourselves high standards and be open to new ideas
 - Be professional in our approach and in our appearance
 - Promote and share best practice
 - Kind
 - Anticipate and respond to patients' and carers' concerns and worries
 - Support each other under pressure and consider the impact of our actions on others
 - Help people find their way if they look unsure or lost
 - Smile, listen and be friendly
 - Responsible
 - Have patient safety as our prime consideration
 - Be responsible for ensuring good patient experience
 - Use resources wisely
 - Challenge poor behaviour in others
 - Learn from experience including our mistakes
 - Say sorry when things go wrong
 - Respectful

Summary of findings

- Keep patients, families and carers involved and informed
- Protect patients' dignity and confidentiality
- Wear our name badges, introduce ourselves and address people in a professional manner
- Respect colleagues' roles in patient care and experience
- Value and understand the diversity of those around us
- Whilst in the majority of cases, staff were observed to be "Living the values" of the trust, there were instances where this was not the case. Patients' privacy and dignity was not always being maintained; some staff were not always respectful of colleagues; staff were not always challenging the poor behaviour of others and the organisation was failing to fully learn from its mistakes.
- Our assessment of the organisation at the time of the inspection was that St George's University Hospitals NHS Foundation Trust lacked an aligned identity or purpose. There was a level of "silo" working amongst divisions with a high level of "fire-fighting" to address issues which many described as "urgent". Divisional managers were setting ambitious and unrealistic strategies which were neither cost-effective or achievable when considering the financial and operational position of the trust. The Interim chief executive recognised the need to first stabilise the organisation and to then devise a realistic and deliverable strategy.
- The trust lacked a cohesive and joined-up vision. There was ambiguity amongst staff from all divisions and at executive level as to the true identity of the trust. People referred to the trust as being a tertiary service; a university hospital; a district general hospital. Whilst in part, these descriptions of the trust are reflective of the services provided, there existed a risk whereby individual divisions were considering service expansion without considering the impact on other services. The executive team clearly acknowledged the need for the trust to consolidate services and to set a clear trajectory which outlined a defined future for the trust.
- The trust performed in the bottom 20% of all trusts in relation to the NHS Staff survey 2015 key questions:
 - Staff satisfaction with the quality of work and care they are able to deliver
 - Percentage of staff agreeing that their role makes a difference to patients /service users
 - Staff motivation at work
 - Recognition and value of staff by managers and the organisation

Summary of findings

Governance, risk management and quality measurement

- From November 2015, the chief nurse had assumed board level responsibility for risk management. Prior to this, the responsibility sat with the director of corporate affairs. A range of committees existed as a means of providing assurance to the board including the quality and risk committee, audit committee and the finance and performance committee. Non-Executive Directors chaired these committees and formal reports were submitted to the trust board on a regular basis. Following the appointment of new Non-Executive Directors, the chair of the quality and risk committee had changed in May 2016. The quality and risk committee further considered reports and information from a range of sub-committees including the patient safety committee, patient experience committee, organisational risk committee and the policy ratification group.
- The Chair and Chief Executive reported that the existing Board Assurance Framework was not fit for purpose and did not encapsulate the strategic risks faced by the organisation. As such, the BAF was under review at the time of the inspection. Both the Chair and Chief Executive spoke candidly of the need for a significant overhaul of the governance and risk management strategies within the organisation. An interim appointment responsible for the overhaul of governance and risk had been made, however this person had not commenced at the time of the inspection.
- At the time of the inspection, the board made reference to the corporate risk register as the log of corporate, operational and qualitative risks associated with the delivery of services. A report to the board in April 2016 identified a total of 57 risks on the corporate risk register, of which 39 were recorded as extreme. 15 of those extreme risks were associated with quality concerns and seven were linked to finance and operations. In total, 41% of corporate risks were linked to quality concerns. It was apparent through a review of the corporate risk register, that mitigation measures in place to resolve or manage risks was ineffective. The majority of risks rated as extreme, whilst being monitored, lacked robust plans or assurance to deliver the necessary improvements. Of the 39 extreme risks, seven risks had existed for periods of three or more years with risk scores remaining stagnated.
- The Chair acknowledged that the existing functionality of the various assurance committees had been poor. There existed a lack of accountability or ownership of risks. Minutes of meetings consistently revealed a lack of assurance to the non-executive directors with repeated risks continuing to exist without effective mitigation. Examples included the poor compliance of

Summary of findings

water flushing returns. Over a twelve month period compliance was noted to be around 74%; this was despite there being a known risk of Legionella and Pseudomonas bacteria proliferation within the ageing water supply infrastructure.

- A board report reference TBR 30.10.14 14/12 titled “Annual Infection Control Report for the period 2013/2014 states “Legionella once again raised its head at St Georges with another hospital acquired case. A new trust estates team is in place and there is now a comprehensive, structured, proactive plan in place and action is underway to reduce and eventually eliminate water risks within the hospital”. A review of minutes from the Water Safety committee meetings provided as part of this inspection demonstrated consistent poor compliance with ward staff completing records to demonstrate water outlets were flushed as set out in trust policies. This was recognised within the estates and facilities divisional risk register which was presented to the organisational risk committee dated 4 May 2016, whereby it was noted that “Risk to patient safety as a result of legionella infection.
- The risk had been increased back to a score of 4x5=20 due to a confirmed case of legionnaire’s disease. The area concerned did not complete all the required flushing returns for the month prior to the patient’s infection. The increase in risk score reflects compliance with the flushing of low use outlets in high risk areas”. It was noted that “Work is continuing to ensure that all areas of the trust complete flushing and the relevant returns. Flushing regimes and completed returns not fully issued to estates. Continues monitoring in place”. Poor return compliance was noted to be an on-going concern, however it was only following the death of a patient was it considered that poor compliance posed a significant risk. The Legionella flushing report generated 2 May 2016, demonstrated that for a 12 month period, the non return’s equated to 26.5%. It was therefore difficult to determine how the board and executive was assured that water flushing was consistently being carried out on a routine basis.
- Concerns were raised by members of staff both on the front line and at board level that the existing serious incident process was flawed. Staff reported that learning from serious incidents was inconsistently applied across the organisation and that changes to practice had not been embedded. Concerns were further raised by local commissioners regarding the SI process. There was also anecdotal concerns raised regarding the wider oversight of the process; an example was given whereby a

Summary of findings

consultant had been appointed to chair an SI investigation. However, the individual had since left the trust and so the investigation was left for a period of three months before a replacement chair was appointed.

- Significant delays in serious Incidents being reported during a review of the process by commissioners were being addressed by a detailed action plan which also sought to improve SI reporting and investigation as a whole. There were delays identified in the timely investigation of SIs within the Surgery Division. Following the declaration of SIs, it was noted that there were occasions whereby investigation panels were not set up in a timely way and therefore investigations exceeded the deadline for investigation reports to the commissioners (60 days or more with extension agreed). For example, between April 2015 and January 2016, only 19/34 (56%) of reports relating to surgery (theatres or surgical wards) were finalised within the deadline.
- Mortality and morbidity meetings took place across all directorates. There were inconsistencies in the quality of meeting minutes, which meant that we were not assured that meetings covered the required areas of a mortality review.
- A Central Alert System (CAS) liaison officer was in place. Alerts were acknowledged, distributed and closed as appropriate. Training was provided for staff to carry out the role. There were different leads for patient safety, medical devices and estates and action was taken accordingly.

Leadership of the trust

- At the time of the inspection, the chief nurse and the director of workforce and organisation development were the only substantive appointments at executive level. The chair had recently been appointed on an interim basis as a means of stabilising the trust and for establishing a recovery plan for the organisation. The long-standing Chief Executive departed from the trust in April 2016; at that time, the interim Chief Operations Officer was moved to the role of interim Chief Executive, however they remained in post for only a short period of time before the substantive Medical Director assumed the role of interim Chief Executive. The clinical director for critical care assumed the role of interim medical director shortly thereafter.
- We were not assured that there were effective coaching and development opportunities for members of both the executive and non-executive team.
- Staff on the front-line reported that the appointment of the interim chair was a positive moment for the trust.

Summary of findings

- Members of the Council of Governors (CoG) acknowledged that much work was required to improve the quality of the organisation. The interim chair acknowledged that further work was required to ensure full engagement with the Council of Governors.
- Front line staff reported that frequent changes amongst the middle management tier had led to increased levels of instability and consistency. This led to new programmes of work and change regimes not being completed or altered with the arrival of new managers.
- Stakeholders and members of the executive acknowledged that the trust lacked sufficient numbers or experienced leaders who had the sufficient leadership skills to drive forward and sustain the required improvements at the trust. The chair and chief executive were liaising with support agencies and peers to source individuals with the necessary skill sets and experience.
- The trust was identified as a negative outlier in the NHS staff survey 2015 in regards to the key question of whether staff were recognised and valued by managers and the organisation and had support from managers.
- Despite the challenges faced by the staff, there was an overwhelming sense from staff that they were keen to improve services so long as they had appropriate support and leadership to do so.

Culture of the trust

- The Chair and CEO spoke candidly of the need to improve the culture within the organisation. They acknowledged that staff engagement was poor and required significant improvement.
- The hospital had recently relaunched their 'Inter Professional Standards' in March 2016 and these were laminated and on display within departments. We were told that the introduction of these standards had decreased the delay in doctors from hospital specialties assessing patients for admission. The standards were being reinforced from the medical director downwards and embedded in inductions and Standard Operation Procedures (SOPs). These standards were viewed as positive by all the staff we spoke with and said that it had improved the flow of patients.
- During our inspection of the trust in 2014, we identified underlying levels of concern regarding bullying and harassment amongst staff. In the NHS staff survey 2015, the trust was a significant negative outlier in regards to the key question of whether staff had experienced harassment, bullying or abuse from other staff in the preceding 12 months (33% trustwide versus 24% nationally). We observed occasions whereby junior

Summary of findings

staff did not always have the confidence to challenge more senior colleagues. Allegations had been made of poor working relationships between staff, impacting on the quality and safety of care provided to patients. Whilst the trust had taken action to address those concerns, our observations during the inspection suggested that underlying issues and poor working relationships continue to exist.

- The results of the NHS staff survey for 2015 would suggest that significant improvement was required across the trust in regards to the culture of the organisation; this was reflective of the Interim Chair's observations during his short time with the trust. The findings of the survey were suggestive of a culture which was not conducive to the delivery of high quality, harm free care. The findings were also suggestive of a culture of inadequate leadership due to the fact that there has been progressive, and significant deterioration of the staff survey results over recent years.
- In the NHS Staff survey 2015, the trust was identified as having negative findings against:
 - Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month.
 - Fairness and effectiveness of procedures for reporting errors, near misses and incidents.
 - Staff confidence and security in reporting unsafe clinical practice.
 - Effective use of patient / service user feedback.

Equality and diversity - including Workforce Race Equality Standards

- Of the 8,536 staff employed by the trust, 41% were of a black or minority ethnicity.
- 95.9% of staff self-reported their ethnicity during 2015.
- The trust had a named lead for Equality and Diversity and there was an identified director with executive accountability.
- The trust reported that white staff were 2.0 times more likely to be appointed from shortlisting than BME staff. This was an increase from the previous year where white staff were 1.9 times more likely to be appointed from shortlisting. The trust utilised unconscious bias training as a means of overcoming any unintended discrimination in relation to recruitment processes.
- BME staff were 2.41 times more likely to enter formal disciplinary processes than white staff. This was an improvement when compared to the previous year when BME staff were 3.31 times more likely to enter formal disciplinary processes.

Summary of findings

- The inspection in relation to the WRES took the format of two BME staff focus groups (one managers, one staff), at St George's University Hospital on Thursday 16th June 2016. We also interviewed the named executive lead who had responsibility for workforce, equality and diversity.
- The trust ranked in the bottom 20% of all trusts in relation to the NHS 2015 staff survey question: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months. Data provided by the trust as part of their WRES reporting template indicated that 30% of BME staff and 32% of white staff reported feeling harassed, bullied or abused by patients. There had been a marginal improvement in the overall number of BME staff reporting negatively against this measure (1% reduction when compared to 2014).
- The trust ranked in the bottom 20% of all trusts in relation to the NHS 2015 staff survey question: Percentage of staff experiencing bullying, harassment or abuse from staff in the last 12 months. 35% of BME staff and 32% of white staff reported negatively against this measure.
- 59% of BME staff and 83% of white staff reported that they believed the trust provided equal opportunities for career progression or promotion. The trust was ranked in the bottom 20% of all trusts for this key question within the NHS staff survey 2015.
- 23% of BME staff and 8% of white staff reported that they had personally experienced discrimination at work from colleagues including managers and/or team leaders. The trust performance against this metric for BME staff was noted to be deteriorating, with the 2014 performance, when 21% of BME staff reported negatively against this measure. Additionally, interpretation of WRES standard 8 had been interpreted incorrectly by the trust with commentary made that improvements had occurred amongst white staff reporting negatively against the metric; there had in fact been a 1% increase in the number of white staff reporting negatively against the metric.
- The trust reported as part of their WRES indicator report that 0% of the executive board was from a black or minority ethnic background. The non-executive board consisted of "66% white, 17% white other and 17% not known".
- Part six of the WRES indicator standard affords providers an opportunity to afford any factors or data which should be taken in to consideration when assessing progress against WRES. In the 2016 assessment, the trust reported "Over the last 12

Summary of findings

months the trust has been going through a programme of change. The period of change and financial restraint has impacted on the experience of staff and increased pressures on some staff to deliver services differently".

- Compliance with the workforce race equality standard is a mandatory requirement of all NHS organisations. As such, WRES reports and associated action plans should be reviewed by, and approved by the board prior to submission and publication. With regards to the 2016 WRES report and action plan, the named executive lead confirmed with us that whilst the documents had been discussed at the equality and diversity committee, the board had not been sighted on, nor had they approved the WRES report or action plan prior to it being published.
- The BME staff focus group held at St Georges University Hospital on Thursday 16th June was attended by five members of staff; the attendance was of some concern given that the trust employed over 3,500 BME staff.
- The range of staff attending had between 2-15 years employment with the trust, with backgrounds in clinical services, support services and administrative roles. There was a general view that there was very little opportunity for BME staff to progress within the organisation. Staff provided personal accounts of their negative experiences of applying for new roles within the organisation.

Fit and Proper Persons

- There was a lack of an effective system overall in place to effectively manage the risks regarding fit and proper persons being employed.
- An audit of executive and non-executive director personnel files was conducted by the trust shortly prior to the inspection. The internal audit identified significant gaps in the documentary records for each of the ten records audited. In some instances, there had been no searches conducted of individuals to determine whether they had been declared bankrupt or insolvent. Further, five records of executive directors or non-executive directors did not have verification of disclosure and barring service checks (DBS).
- We reviewed the Executive and Non-Executive Directors' files to assess compliance against the Fit and Proper Person regulation. Overall, we found that this was not being managed effectively with qualifications, DBS clearance or references as missing from files.

Summary of findings

Public engagement

- The trust had a wealth of volunteers who supported the hospital by assisting patients and their relatives around the hospital. These volunteers who predominantly lived locally to the hospital, were committed to their hospital, in some cases for long periods of time.
- The trust had a range of patient panels who engaged with clinicians in designing services. Patients with chronic conditions such as those requiring renal dialysis were heavily involved in the development of dialysis services and provided a strong voice in wanting to see significant improvements to the environment in which they received care.

Staff engagement

- Junior doctors reported that there was no formal channel through which concerns and suggestions could be raised. For example, the trust did not have a formal junior doctor forum in place at the time of the inspection. Junior doctors that we spoke with reported that they would have welcomed such a forum. The junior doctor cohort further reported poor engagement with the senior leadership team with people reporting that they would "not know who to go to" should they have a concern. There was a general consensus that there was a significant detachment between the leadership of the organisation and "day-to-day doctor issues".
- The trust carried out a 'listening in action' programme, in order to hear the views of staff. However, we were told the outcome, recommendations and actions of this initiative was not made widely available to all staff.

Innovation, improvement and sustainability

- The executive team recognised the need to first stabilise the organisation and to then focus on establishing a sustainable and deliverable medium to long term strategy. At the time of the inspection the trust was working with local commissioners and external trust partners to devise a sustainability and transformation programme for South West London. The executive team accepted the notion that significant service re-configuration was inevitable and that this was necessary to enhance the quality and experiences of patients accessing health services.
- Staff and divisions were actively involved in initiatives to improve patient care, the environment and patient experience. These are detailed under each core service in the hospital location reports.

Overview of ratings

Our ratings for St George's Hospital - Tooting

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Medical care	Inadequate	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Outstanding	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Overview of ratings

Our ratings for Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	Good	Good	Requires improvement	Good
Community health services for children, young people and families	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Community health inpatient services	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Community End of Life Care services	Requires improvement	Inadequate	Good	Requires improvement	Inadequate	Inadequate
Overall Community	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement

Our ratings for St George's University Hospitals NHS Foundation Trust

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

Outstanding practice and areas for improvement

Outstanding practice

- Outcomes for renal patients in relation to survival rates and transplant outcomes were excellent and some of the best in the country.
- The outcomes achieved by the specialist medical and surgical services provided by St George's Hospital.
- The effectiveness of maternity care delivered by the St George's Hospital.
- The responsiveness of the neonatal unit to parents whilst their baby was on the unit and the support provided by the outreach nurse.
- The involvement of children of varying ages on the interview panel as part of the recruitment process for ED paediatric nurses.

Areas for improvement

Action the trust MUST take to improve

Importantly, the trust must:

- Develop a long term strategy and vision
- Move towards having a stable, substantive leadership team.
- Ensure all premises and facilities are safe, well-maintained and fit for purpose.
- Ensure all care is delivered in accordance with the Mental Capacity Act, 2005, when appropriate.
- Review and implement robust governance processes, so that patients receive safe and effective care.
- Ensure RTT data is robust and accurate so that patients are given appointments and treatment based on their needs and within national targets.
- Ensure serial numbers of prescriptions (FP10s) for prescribers are always monitored for use.
- Ensure radiographers only administer medication (contrast media) where appropriately authorised Patient Group Directions (PGDs) are in place.
- Ensure the fit and proper persons' requirement regulations for directors are always complied with.
- Ensure the paediatric ward environment, staffing and training requirements are suitable for treating and caring for children and young people with mental health conditions.
- Ensure medicines are stored in an appropriate manner, by keeping cupboards locked when not in use.
- Ensure the process for decontamination of nasoendoscopes is compliant with guidance.
- Maintain patient privacy, dignity and confidentiality at all times.
- Review the fluid storage within the ED major incident cupboard to ensure that training equipment is not stored with 'live' equipment.
- Ensure staff consistently follow guidance related to the prevention of healthcare associated infections with specific regard to hand hygiene.
- Ensure medical equipment across the trust stored on is cleaned and that there are systems in place for monitoring the cleanliness of equipment returned to the ward.
- Ensure all staff caring for children receive level 3 safeguarding training.
- Ensure the process for investigating serious incidents is timely and undertaken by people trained in investigation so they understand the root causes of an incident and identify measurable action.
- Minimise the cancellation of operations and when this cannot be avoided, they are rescheduled within 28 days.
- Reduce the moves of patients to wards that are not appropriate.
- Ensure staff use the early warning scoring system effectively, including the timely escalation of deteriorating patients to relevant personnel.
- Ensure divisional and trust priorities are shared by personnel of all grades and professions who work together to promote the quality and safety of patient care.
- Address the low morale among theatre staff and consultant surgeons.

In addition, the trust should:

Outstanding practice and areas for improvement

- Replace damaged chairs and furniture within patient areas so that they can be thoroughly cleaned.
- Ensure that all patients within the ED 'streaming' area are assessed within a private area.
- Ensure staff can observe the patients whilst they are waiting in their outpatient departments.
- Ensure patient electronic records are not easily visible or their paper records are not easily accessible by the public.
- Improve the percentage of telephone calls answered by staff in the outpatient department are within the service level agreement targets.
- Communicate effectively with patients when outpatient clinics overrun.
- Ensure there are sufficient cystoscopes (to examine the inside of the bladder) to supply day surgery, main theatres and endoscopy.
- Ensure all relevant staff are appropriately inducted to the trust and within clinical environments to which they are allocated to work.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements

Where these improvements need to happen

1. There are unsafe and unfit premises where healthcare is provided and accommodate staff.
2. There is a lack of formal mental capacity assessments and best interest decision making and some patients had decisions made for them that they were capable making themselves.
3. The design and operation of the governance arrangements are not effective in identifying and mitigating significant risks to patients.
4. Risks to the delivery of high quality care are not being systematically identified, analysed and mitigated.
5. Staff are not being held to account for the management of specific risks.
6. There are a lack of processes in place to provide systematic assurance that high quality care is being delivered; priorities for assurance have not been agreed and are not kept under review. Effective action has not been taken when risks are not mitigated.
7. The data used in reporting, performance management and delivering high quality care is not robust and valid.
8. There are not suitable arrangements in place for ensuring directors are fit and proper.

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