# 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.

# 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.

This is a report on the focused inspection we undertook on 10, 11 and 22 May 2017. The purpose of this inspection was to follow up on a Section 29A Warning Notice, which we issued in August 2016, following a comprehensive inspection of the trust in June 2016.

We checked whether the trust was meeting the requirements of the Warning Notice. As a result, there is no rating of this inspection. The Warning Notice required the trust to make significant improvements in certain areas because:

- There were unsafe and unfit premises where healthcare was provided and accommodated staff.
- There was 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.
- The design and operation of the governance arrangements were not effective in identifying and mitigating significant risks to patients.
- Risks to the delivery of high quality care were not being systematically identified, analysed and mitigated.
- Staff were not being held to account for the management of specific risks.
- There was a lack of processes in place to provide systematic assurance that high quality care was being delivered; priorities for assurance had not been agreed and were not kept under review. Effective action had not been taken when risks were not mitigated.
- The data used in reporting, performance management and delivering high quality care was not robust and valid.
- There were not suitable arrangements in place for ensuring directors were fit and proper.

We found that the trust had partially met the requirements of the Section 29A Warning Notice. The trust had made significant improvements regarding; mental capacity act assessments/best interest decisions /deprivation of liberty safeguards, some elements of premises and equipment, medicines management and managing incidents. However, the trust is still required to make further improvements with regards to the fit and proper persons' requirement, estates maintenance, accuracy of the referral to treatment data and governance.

**Over key findings were as follows:**

- Systems and processes that operate effectively in accordance with good governance remain weak.
- The head of internal audit only had limited assurance on the trust's annual report.
- Eleven Priority 1 recommendations remained outstanding beyond the agreed deadlines, and several deadlines had been put back.
- The trust had made significant progress with regards to addressing legionella/pseudomonas risks in the water system.
- There had been improvements in monitoring FP10 prescriptions and the risk of these going missing had been reduced.
- Authorised Patient Group Directions were in place in the radiography department and most radiographers had appropriately signed them, following our prompting during the visit.
- Renal services had been relocated, so patients were no longer in an unsafe environment. Operating theatres 5 and 6 had been refurbished since the previous inspection.
- The water leaks to the maternity staff room had been resolved.
- The Wandle Unit had been demolished and building work had commenced on the construction of a new building.
- Fixed wire testing had been carried out by the trust in accordance with BS7671.
- Planned preventative maintenance and work programs had been developed and introduced to help reduce the thermo-regulation problems of Lanesborough theatre 1 occurring in the future.
- Governance around estates management had improved and there were annual reports for all services.

# Summary of findings

- Replacement box filters that prevent contamination of the theatre air handling units, were stacked in the plant room by the side of theatres 5 and 6 vent plant, allowing for possible contamination of the “new filters” Theatre plant rooms we visited were untidy and cluttered with numerous water leaks.
- There were still gaps in assurance with regards to estates maintenance, but the trust had plans within a reasonable timetable to mitigate these.
- New transformer units, which are used to increase or decrease the alternating voltages in electric power applications, were needed to meet power demands. This was because there was a risk of power failure at St George's Hospital.
- Serious incidents were now being reported within internal and external KPI deadlines.
- Mental Capacity Act and Deprivation of Liberty Safeguards training, understanding and application had improved on the areas where we had concerns.
- Referral to treatment data was still inaccurate and still not being reported to NHS England. A recovery programme and Clinical Harm Review Group was making progress, but it could take up to two years to be fixed. So far, two cases of serious harm to patients had been identified, as a result of delays in making their follow up appointments.
- On some risk registers, there were no ‘action due date’ and there should be. Also, the concerns identified as part of the Workforce Race Equality Standard (WRES) was not on the Human Resources corporate risk register.
- There was a WRES reporting template and action plan on the trust’s website dated July 2016, which was in the process of being updated. We saw the new action plan, but this was a work in progress and still had to go through a number of checks before it could be uploaded on the website.
- There were mechanisms in place to ensure that staff delivering end of life care services in the acute hospitals and community services worked closely together.
- The trust was continuing to fail meet the Fit and Proper Person Requirement Regulation (Regulation 5, HSCA, 2014).

Importantly, the trust must:

- Ensure that it has systems and processes that operate effectively in accordance with good governance.
- Strengthen governance and reporting arrangements, so as to provide the board with increased oversight of Elective Care Recovery Programme delivery.
- Continue to address the gaps in assurance with regards to estates maintenance.
- Continue with the recovery programme and Clinical Harm Review Group with regards to RTT data.
- Ensure it meets the Fit and Proper Person Requirement Regulation.

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.

## Our inspection team

Our inspection team was led by:

**Inspection Manager:** Roger James, Care Quality Commission

The team included four CQC inspectors, an assistant inspector and two specialist advisors with backgrounds in governance and estates.

## How we carried out this inspection

Before our inspection, we reviewed a range of information we held including the trust's action plan, its written confirmation to us about meeting the requirements of the Warning Notice, performance data, board minutes and minutes from a variety of governance meetings.

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 spoke with a range of staff in the trust including nurses, allied health professionals, administration and other staff. We observed the environment in which care was being delivered, reviewed policies and other documents and also interviewed senior members of staff at the trust.

## Facts and data about this trust

Both St George's and Queen Mary's Hospitals are based in the London Borough of Wandsworth and serve 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.

The trust also provides community health services for the people Wandsworth.

In the 2011 census, the proportion of residents in Wandsworth who classed themselves as white was 71.4 %.

# Summary of findings

## Our judgements about each of our five key questions

| | Rating |
|---|---|

### Are services at this trust safe?

**Cleanliness and Infection Control**

- During the inspection in June 2016, we found that legionella and pseudomonas aeruginosa had been detected within the water supply system. There was poor control of water temperature, exposure of patients to low usage water outlets and poor compliance by ward staff completing records to demonstrate water outlets were flushed.
- Significant steps had been taken by the trust to address legionella/pseudomonas control. An external review by an independent consultant in January/February 2017, found a considerable amount of work had been undertaken by the trust to put in place arrangements to help ensure the delivery of safe water for the trust's patients, visitors and staff. The report published in April 2017, stated that water temperature monitoring arrangements represented good practice and exceeded standards witnessed at other trusts.
- However, it was noted that the estates department recognised the additional resourcing that ongoing effective water risk management was likely to require and as a result, a water safety manager, a team of engineers and plumbers, were to be appointed to assist.
- We saw minutes of the monthly operational water meeting and water safety committee. These showed good oversight of water safety and completion of the actions log as required.
- Despite the improvements being relatively recent, the trust stated that they were now fully compliant. Samples of water temperature/flushing documentation were presented. We noted that regular flushing of low usage water systems by staff was now happening and there was chlorination of water, where problems had been found through water testing.

**Medicines management**

- At the last inspection, we found that the serial numbers of prescriptions (FP10s) for prescribers were not always monitored. This meant that there was a risk of controlled stationery going missing and liable for abuse by staff obtaining medicines illegally.
- A new system had been in place since July 2016, where specialty outpatient clinic staff collected the FP10s from the pharmacy, with a form that listed all of the serial numbers. This

form was then completed by the clinic staff with the name of the doctor using the prescription and the patient it was prescribed for. We visited the rheumatology clinic and saw the completed forms for the previous month. One prescription had been listed as missing on these forms, but there was evidence to show that this had been followed up with the doctor responsible.

- A monthly audit was carried out by the pharmacy team on the provision of FP10s and we saw these audits completed from November 2016 to April 2017. Where clinics had not been compliant with the policy requirements, there had been actions documented about how this was followed up. We were able to see from the audits, that there had been improvement in monitoring prescriptions since our last inspection and that the risk of these going missing had been reduced.
- At the last inspection we found that radiographers were administering medicines without appropriately authorised Patient Group Directions (PGDs) in place. PGDs are documents permitting the supply of prescription-only medicines to groups of patients, without individual prescriptions.
- We visited both the scanning departments and found that there was now a folder located in each department containing ten PGDs for the medicines that radiographers could administer. However, the individual PGDs had not been signed by each health professional working under the direction. Instead, a cover sheet with all signatures for all ten PGDs had been used. This was not in accordance with the Human Medicines Regulations 2012. We raised this with the provider and when we returned on a visit ten days later, found that eight radiographers had signed the individual PGDs appropriately.
- A 'back to floor' audit had been started at the beginning of May 2017 by the pharmacist team that audited PGDs throughout the hospital. We saw a record of one audit undertaken for the vascular team that demonstrated that their PGDs had been checked and were compliant with the regulations.

**Environment and equipment**

- At the previous inspection, during heavy rainfall, we noted rain water running down walls and over electrical sockets on the renal unit in Buckland Ward. Action was taken to close the area off when this was highlighted to the trust and some remedial work to the roof had been made. The trust had relocated the whole ward in December 2016. Twenty three in-patient beds were now being provided in Champneys Ward and outpatients were receiving dialysis at two mobile units located within the hospital grounds.

# Summary of findings

- Staff we spoke with explained that the relocation had been challenging. There had been a reduction in bed numbers. Some staff had been required to be flexible and some moved to other locations to work. There were challenges finding sufficient storage space on the ward and in the mobile units; and renal services were no longer located together. However, senior nurses spoke highly of their staff's professionalism during the period of change and stated that they were proud of the way that they had coped with the challenges.
- Safety of patients had been considered as part of the re-location and this was demonstrated by a specific protocol that was followed in the event of a patient deteriorating in the mobile unit. The protocol took into account the unusual environment of the unit and had been adjusted following rehearsals to make it work better.
- Staff recognised that patients using renal services had a great deal of disruption over the period of change. They engaged with patients through a variety of sources, such as meeting with the renal patients association and pro-actively providing information about the forthcoming annual general meeting. Staff also heard patients' views through consulting with the local Healthwatch, an organisation that gathers and represents the views of the public on matters of health and social care.
- During our visit in June 2016, we found 18 out of 31 theatres were not being properly maintained and needed rebuilding or extensive refurbishment. There had been a lack of capital investment in theatre complexes in Lanesborough Wing, St James' Wing and Paul Calvert. This caused many disruptions to the theatre schedule. We also found that the theatre air handling units in St James' Wing were failing intraoperatively.
- During this inspection, the trust's engineer told us and we saw that two new theatre vent plants had been installed for theatres 5 and 6 in October / November 2016.
- The vent plants were connected to a laminar flow ventilation system giving flexibility of use for the theatres. We noted that the vent plants were due for box filter replacements with the filters being a little "dirty" but still within their operating parameters (replacement filters were available). Replacement box filters prevent contamination of the theatre air handling units. The vent plant appeared to be in good order and HTM 04:01 compliant.
- The replacement box filters were stacked in the plant room by the side of theatres 5 and 6 vent plant, allowing for possible

contamination of the “new filters”. These filters should be stored in a clean, dry environment, away from the plant room to prevent contamination and damage, according to the manufacturer’s instructions.

- Theatres 5 and 6 had been refurbished since the previous inspection and formed part of a multi-million pound capital program to refurbish all the trusts operating theatres. The capital program was scheduled to last 3.5 years and was currently in progress.
- During the inspection in June 2016, we found that the maternity staff room was unfit for purpose. There was water ingress caused by condensation leaks. Half of the room was cordoned off as dangerous, because ceiling tiles had fallen as a result of the water ingress.
- During this inspection, we found that issues with the maternity staff room had been resolved. Midwives reported this was done quickly after the last inspection and there were no further water leaks. Staff told us that the estates department were responsive to addressing the matter.
- We visited the maternity staff room and new replacement tiles had been installed and were satisfactory. The damage to the ceiling tiles was caused by water leakage from the plantroom above. We observed that the plantroom floor had been re-sealed to prevent any future leak penetration of the concrete slab to the floor below, and that previously leaking water pumps had been replaced. There was however, evidence of new leaks on various steam valves, giving the potential for future leak penetration. This did appear to be in the process of being repaired and was confirmed by the trust’s engineer.
- In the previous inspection, two-thirds of the Wandle Unit was condemned by the Trust Fire Safety Advisor/Officer as a serious fire hazard, but one-third of the building was being occupied by 20 to 25 staff at any one time.
- During this inspection, we found that the Wandle Unit had been demolished and building work had commenced on the construction of a new building.
- In the previous inspection, St George’s Hospital fixed wire testing was non-compliant in 131 of the 169 areas monitored by the trust.
- We found on this inspection, that fixed wire testing had been carried out by the trust in accordance with BS7671 (a small sample was seen). This identified the areas of concern and there was now a five year rolling programme of fixed wire installation compliance by an external contractor. The first year was scheduled to be completed by the end of 2017, and then move onto a 20% cycle of testing to ensure continuous testing.

# Summary of findings

- All back-up generators were life expired and there were two rental generators in the garden to support Lanesborough Wing.
- The thermo-regulation of Lanesborough theatre 1 was a day to day operational problem which was dealt with shortly after it was identified to the trust's estates department. Planned preventative maintenance and work programs had been developed and introduced to help reduce this type of problem occurring in the future.
- The trust now had an Estates Strategy to 2021. This included: demolition programme for worst buildings; stabilise the urgent safety infrastructure; move higher acuity activity to new accommodation where buildings were demolished; migrate lower acuity off site or towards Lanesborough Wing.
- At the previous inspection, there were no annual reports on some safety areas such as electrical wiring since 2010. During this inspection, governance around estates management had improved. There were now annual reports for all services : heating, water, ventilation, electrics, water and power supply. The local CCGs and chief executive were aware of the issues and their severity.
- Authorising engineers were now in post. These appointed authorised persons and competent persons were in line with good practice. All statutory duties were assigned to a Responsible Person.
- There was an appointed compliance person in the estates department, in order to provide internal assurance.
- There were continuing extreme risks on the corporate risk register. These included: theatre ventilation breakdowns/ failures; poor performance of mechanical and electrical services to theatres; potential interruption to electrical supply; minimal five yearly electrical testing not done.
- The air circuit breakers which were being used were no longer supported by manufacturers and meant there was a risk of power failure. The trust was aware of this and knew that new transformer units were needed to meet power demands.
- We found at St George's Hospital, that there was a battery power contingency for dips in power (which occurred every time the local train operator turned off the power as a result of a rail incident at Clapham Junction).
- During this inspection, only one fixed boiler of five at St George's Hospital was working, so there were two truck-based boilers onsite, until the fixed boilers can be repaired.
- The lifts in Lanesborough Wing had been fixed and there was a new maintenance contract. There were no longer daily failures of the lifts.

- There was a trained fire marshal on each roster (senior nurse) and there were plans to audit and replace fire doors where necessary.
- There were still gaps in assurance with regards to estates maintenance, but the trust had plans within a reasonable timetable to mitigate these.

**Incidents**

- During our visit in June 2016, we found there were delays in investigations into serious incidents (SIs). Staff did not always log SIs within 24 hours on Strategic Executive Information System (STEIS) and did always set up panels promptly and therefore exceeded the deadline for investigation reports to be sent to the commissioners within 60 days.
- During this inspection, we reviewed the Patient Safety Quality Board, notification of SI reports between August 2016 and February 2017. These reports listed the number of SIs by type and division. Since October 2016, all SIs were now being reported within internal and external KPI deadlines. The trust was required to notify the local CCG of all SIs within 48 hours and send investigation reports within 60 days.
- A senior nurse told us that staff reported incidents on datix immediately on the day that they occurred. This was in keeping with the trust's Serious Incident Policy (2017), which required staff to report all incidents that had the potential to be an SI, as soon as possible and ideally within 24 hours.
- A senior member of staff told us the trust met the 48 hour reporting standard to the CCG in most cases. They stated that if it was not clear that an incident was an SI, it would be taken to the Serious Incident Divisional Meeting, which took place on Mondays. In such circumstances, there could be a delay in notifying the CCG within 48 hours.
- A senior member of staff told us that every incident was quality assured by divisional governance teams. This was a new process, which was implemented following our previous inspection. This process had led to an improvement in the timeliness of staff reporting incidents.

## Are services at this trust effective?

**Consent, Mental Capacity Act & Deprivation of Liberty safeguards**

- At the previous inspection we found that most nursing staff did not have a good understanding of the legal requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards. On some wards, there had not been mental

capacity assessments and best interest decisions recorded for patients who may have lacked capacity to make specific decisions for themselves. This was not in accordance with the Mental Capacity Act 2005. There was also a lack of recognition that the use of bed rails to prevent patients' falling from bed and the use of mittens to prevent patients removing their nasogastric tubes, should have been done with patient's consent or an assessment of their capacity. These concerns related to Allingham, Dalby and Rodney Smith medical wards at St George's Hospital and Gwynne Holford Ward at Queen Mary's Hospital.

- Since the inspection, there had been a programme of work across the trust to train and educate staff on understanding of the MCA. This had included face to face training and 'e-learning'. Risk assessments had been introduced for bed rails and the use of mittens. Training had focussed on the four wards identified by the previous inspection and also other areas that were considered high risk. There had been eight drop-in 'face to face' sessions for staff and it was estimated that 100 staff had attended these. Bespoke training had also been provided for site managers and pharmacists. Staff on wards named in the CQC report confirmed that they had face to face training and completed e-learning. A new role of designated lead for mental capacity had been introduced in June 2016 and was being covered on a temporary basis.
- Most staff on wards we visited were able to discuss the MCA and show us where they could locate the policy and a flow chart for assessment if they needed to refer to it. One member of staff was unsure about the policy, but stated that they would request support from their manager.
- A database was kept of the number of referrals for support with safeguarding and mental capacity. This had been a combined data base, but was now split so it was clearer to monitor. The lead had noticed an increase in the amount of MCA referrals to around 30 a month. Referrals were followed up by a lead calling the ward to discuss the referral and support staff. If a Deprivation of Liberty application was required, this would be completed by the safeguarding and MCA leads, so that they had complete oversight of the numbers within the hospital and were able to monitor them.
- In October 2016, the trust carried out a baseline audit of compliance with MCA, Deprivation of Liberty Safeguards and recording of best interest decisions on Allingham, Dalby, Gwynne Holford and Rodney Smith Wards.

- The results were consistent with our current findings and were informing the programme of training that was underway. An e-learning module for MCA and best interest decision-making had been developed and went live in November 2016. At the time of this report, there was:
  - 82% completion by staff on Allingham Ward
  - 90% completion by staff on Dalby Ward
  - 77% completion by staff on Rodney Smith Ward
  - 97% completion by staff on Gwynne Holford Ward
  - 100% completion by matrons and heads of nursing serving the wards above
  - 52% completion by medical staff serving the wards above
- An audit completed in January 2017, showed that MCA related practice across the wards remained variable, however it identified clear evidence of good practice on Gwynne Holford Ward. The recommendations from the audit included using best practice identified to drive improvement, regular training and an audit cycle.
- We visited Gwynne Holford Ward during the inspection and saw evidence of changes that had been made in the ward to increase awareness of the MCA. A large notice board was dedicated to MCA, for staff to refer to. This included an MCA flow chart, a display of the five principles of the MCA, and the Deprivation of Liberty Safeguards assessment guide. There was a statement which was as a reminder to staff in relation to the MCA, which was “No decision about me, without me”.
- Training provided to staff on Gwynne Holford Ward was led by a clinical psychologist and had included one day full day of initial training, including scenarios and role play. Plans were being made for a refresher training package.
- On Gwynne Holford Ward, we saw there were four patients with Deprivation of Liberty authorisations and all records were in date. We checked six records of patients with bed rails in place and all had completed bedrail assessment sheets. On the bed rails assessment, there was no area to document the patient’s consent to rails where appropriate. Four records had free text added to the form to state the patient had consented. We spoke to one of the patients where their consent for bed rail use was not documented and they stated that they were happy for the bed rails to be in place. We saw two records where there had been best interest decisions made for patients and there was clear documentation that this had happened. We also saw that bed rail monthly audits were completed and action plans stated if improvements were required.
- Staff on Gwynne Holford Ward were able to provide a recent example of a patient that had a Deprivation of Liberty

authorisation in place and who wished to return home from hospital. They explained how the patient had been supported to attend the court of protection with staff from the ward in order for a judge to determine appropriate care. The patient had been able to speak with the judge directly during this hearing and this demonstrated the ward staff's adherence to their statement 'No decision about me, without me.'

- We also visited Allingham, Dalby, and Rodney Smith Wards at St George's Hospital. We saw evidence of MCA and Deprivation of Liberty Safeguards understanding among staff, awareness of consent to treatment and what constituted restraint. Staff were aware that some patients needed support and time to make decisions.
- Staff assessed a person's mental capacity to consent to care or treatment either when admitted through A&E or when admitted to the ward. The assessment was recorded in the patient notes. Patients with dementia or delirium had an identifier on their notes and on the patient board, so as to inform staff.
- We saw that when people lacked the mental capacity to make a decision, multidisciplinary groups of staff, usually involving a social worker and where possible the family, made 'best interests' decisions. All staff were aware that best interest decisions were made by the multidisciplinary team.
- Staff we spoke with understood how to seek authorisation for Deprivation of Liberty Safeguards.
- Staff told us the use of restraint (bed rails, mittens) when people lacked mental capacity was monitored at least weekly. For example, a person with delirium would not necessarily need any restraint once the confusion had passed.
- We noted that in the trust's action plan update to us in November 2016, it stated that the MCA Policy had been developed and approved by the chief nurse. The policy was accessible to staff via the Policy Hub on the Intranet.
- MCA and Deprivation of Liberty Safeguards had been incorporated within training programmes which had commenced in October 2016.

## Are services at this trust caring?

This key question was not inspected.

## Are services at this trust responsive?

### Access and flow

- During the inspection in June 2016, we noted that data quality systems were not fit for purpose and impacting on reliability of data for referral to treatment (RTT), specifically the incomplete

pathway. As a result, the trust wrote to NHS Improvement and NHS England, to inform them of their intention to temporarily cease national reporting of the RTT data. This was because the trust could not guarantee the data being reported was robust and accurate.

- During this inspection, we noted that a recovery programme was established. This programme had a board which was chaired by the chief executive officer and supported by NHS Improvement. A large number of patients (around two million) had been identified, dating back to 2014, where the trust was not able to say with certainty that these patients had been treated or were at the correct stage of their care pathway. These patients were being validated by an external company with the highest risk patients being validated first.
- Given that many more patients attend the St George's site, initial work to rectify issues focused mainly on that hospital. However, it was always the trust's intention to do a more fundamental review of the operational processes at Queen Mary's Hospital.
- In April 2017, out of the 7118 validations completed, 3068 patients had been found to have been treated but had no discharge letter, 216 patients had been re-booked onto a pathway and 576 patients needed follow-up appointments. Executive managers stated that there was some spare capacity within the outpatient plan to incorporate these extra follow up appointments.
- A separate clinical harm review group, chaired by a deputy medical director from NHS England, reviewed patients that may have been harmed as a result of the data issues with referral to treatment. The clinical harm review group looked for patients that may have been harmed by reviewing incidents, GP alerts, those who had waited over a year for treatment and those that had not seen a clinician for more than six months.
- By April 2017, over 3300 validations had been completed. Between August 2016 and April 2017, the group had reviewed 126 cases and found that no harm had occurred in 110 and low harm in 14. In two cases, serious harm had occurred and in both cases there had been a delay in making a follow up appointment for the patient.
- In December 2016, three patients were treated over 100 days in the lung, breast and urology pathways. Complex diagnostic pathways and patient choice continued to be themes in these breaches.

# Summary of findings

- We found that the trust achieved compliance against all of the cancer standards in December 2016. This is an improvement, because the trust was not meeting the two week wait and 62 day cancer standards in 2015/16 and in response a “Cancer Action Plan” was implemented.
- Cancer clinical harm Root Cause Analyses (RCAs) were completed for all patients and none were assessed as coming to harm against the agreed assessment criteria.
- Cancer services were participating in the Data Quality Kite mark initiative taking place in the trust. To date, no risks within their data had been identified.
- The number of patients waiting over 52 weeks for treatment at the trust had increased to an average of 40 per month.
- Themes arising from the analysis of breaches included delays in diagnostic pathways, compounded by the frequent cancellation of appointments, long stages of treatment waits particularly for dermatology and gastroenterology in the non-admitted phase and then long waits for treatment.
- In March 2017, 42, 52-week breaches were predicted. All 52 week breaches were automatically subject to a clinical harm review.
- There was oversight and monitoring of the recovery programme and clinical harm review group by stakeholders, including NHS England, NHS Improvement and commissioners.
- Training had started for staff in inputting data onto the system, in order that the problems with data quality did not occur again. In April 2017, 189 users had completed training and errors had reduced over the last 12 months. To further reduce errors and support training, standard operating procedures were being developed for five priority areas and there was a plan to roll these out within the next month. A training needs assessment was being completed and this was two thirds completed at the time of the inspection.
- The board were told in January 2017, that the RTT data issues could be fixed, but will require the whole organisation to engage. Independent external experts had approved this approach and estimated that the recovery programme would take up to two years.
- At the board meeting in February 2017, it was reported that the trust’s performance against the RTT standard had reduced, though proactive measures were being taken to improve data quality, and service managers were closely monitoring lists with patients who had waited in excess of 52 weeks.

# Summary of findings

- At Queen Mary's Hospital, work by an external company found significant data quality issues at each step in the patient pathway. The company made several recommendations in order to improve the RTT functionality.
- The report on Queen Mary's Hospital highlighted a number of systems and processes that presented a level of clinical risks which had the potential to cause clinical harm to patients. These included: an incomplete understanding of patient waiting times; difficulty in determining how many patients are waiting, for how long and for what; and clinicians not always having access to patient information. The trust had acknowledged that the issues raised throughout the report were of significant concern and had taken a number of immediate steps to ensure that patients referred to the hospital remained safe. These included: switching off the auto discharge function, strengthening the referral to triage process with daily reporting of key performance indicators (KPIs) to the hospital director and redistribution of staff and daily reporting of the letter backlog to the hospital director, to ensure that it remained below the agreed standard of 10 days.
- The Elective Care Recovery Programme (ECRP) Report which went to the board after the inspection in June 2017, highlighted a few issues including that there was a lack of clarity about demand and capacity and, as a result, the trust's ability to reduce at pace the backlog of patients currently waiting for treatment. The report also stated that the governance and reporting arrangements needed to be strengthened to provide the board with increased oversight of ECRP delivery.

## Are services at this trust well-led?

### Governance, risk management and quality measurement

- During the previous inspection, we found that the risk management process was inadequate.
- During this inspection, we reviewed the latest corporate and divisional risk registers. There were mostly robust arrangements for identifying, recording and managing risks and taking action as appropriate. The risks we had identified were reflected on the registers. However, whilst general bullying and harassment was on the Human Resources corporate risk register, the concerns identified as part of the Workforce Race Equality Standard (WRES) was not. Also, on some registers, there were no 'action due date' and there should be, in accordance with actions being SMART (Specific, Measurable, Achievable, Realistic and Time-specific).

- The internal audit committee report dated 25 May 2017, which went to the June 2017 board, stated that the committee was very concerned that Priority 1 recommendations remained outstanding beyond the agreed deadlines, and that several deadlines had been put back. It was agreed that deadlines for completing these recommendations can in future only be put back by agreement with the CEO. The trust told us following the inspection that there were four Priority 1 audit actions overdue, with a further three being due for completion by the end of June 2017. There was evidence that there was a plan in progress to complete the required internal audit Priority 1 actions.
- The report also stated that the head of internal audit (HOIA) confirmed that the trust's annual report could only be one of limited assurance, based on an aggregated assessment of the individual assurance rating to each of the 20 plus internal audits undertaken in 2016/17. The audit committee noted its understanding of the position, but reminded the executive that the trust must move to a position, through its recovery plan, to ensure that the HOIA opinion for 17/18 must be one of at least reasonable assurance. We were told by the trust following the inspection, that their internal audit programme for 2017/18 will be revisiting many areas previously audited and with the improvement work undertaken from the earlier internal audit reports, there was a reasonable level of assurance that the aggregated outturn for the 2017/18 Internal audit programme will show significant improvement.
- The audit committee reported that a considerable amount of detailed editing, re-wording, cross-checking and corrections were required to all the documents requiring audit committee approval, and that the narrative style and presentation and formatting of the documents was not yet of a satisfactory standard. If papers were not prepared and produced in a satisfactory manner, sub-committees of the board cannot fully function and therefore raises our concerns about organisational governance. We were told by the trust following the inspection that a robust process had recently implemented for the submission of papers that supported timely circulations of documents and papers to senior committee members. This process ensured that there was sufficient time for committee members to read papers and assimilate information, so that they could make better and more informed decisions.
- During our inspection in June 2016, we found no evidence that leadership, management or governance supported or enabled a high quality community end of life care (EOLC) service. There was no vision, strategy, board lead, specialist local lead, or set

of values for community end of life care. There was not a consistent approach to EOLC in the acute hospital service and the community services division and there was no trust oversight of EOLC services in the community.

- During this inspection, we found the trust had taken steps to address these concerns. The End of Life Care Strategy (2016-2020) was approved by the board in December 2016 and launched to staff and public during the first week of our inspection, which was national 'Dying Matters' week. The strategy set out six ambitions for palliative and end of life care, which were based on key national policies and trust values. The implementation plan had 16 objectives linked to the strategy's identified actions, indicators, and desired outcomes. The trust had also nominated a non-executive director for EOLC.
- The EOLC steering group was set up to develop and oversee the implementation plan for the strategy, and had met monthly since November 2016. The governance structure for EOLC outlined the reporting lines of the steering group to the trust executive board and to other trust committees. Members of the group had questioned whether there was a quorum, because there had been no representation from one of the divisions.
- The EOLC steering group monthly meetings were regularly attended by a board member, a lay representative, members of the local commissioning group, community providers, and trust staff with a remit in EOLC. A community services division EOLC lead consistently attended the meetings, but the other three trust divisions did not always send a nominated EOLC lead. The minutes of the meetings indicated that attendees received updates and contributed to discussions about the implementation plan and made suggestions about adding to or amending the plan. The trust EOLC leadership group worked between the group meetings to prioritise actions and hold divisions to account for implementing the plan.
- The EOLC leadership was headed by the chair of community health services, who worked closely with the trust clinical lead for EOLC. The chief nurse appointed in January 2017, was the executive director responsible for end of life care. The three EOLC senior leaders demonstrated a knowledge of and commitment to a strategy that focused on service delivery for people at the end of life. They reported to us that they had regular meetings with divisional leads to discuss progress with divisional action plans and to monitor their delivery.
- We found that the trust EOLC strategy had addressed inconsistencies in approaches by expecting all four trust divisions to identify EOLC leads and link workers and to take action to meet the objectives of the implementation plan. A

divisional action plan identified milestones so that each division's progress towards achieving objectives were measured within a set timescale. An early milestone was to identify link staff in each team or area by March 2017. The community services division had a named link person and they met regularly with other staff to review EOLC development work across the division. Another milestone was having EOLC as a standing item at divisional governance boards and that action plans should be monitored at these meetings. The community services division had reached this milestone at the time of our inspection.

- There was also a senior leaders' action plan. This included developing a trust wide training plan for EOLC using funding obtained from Health Education England. The actions included a training needs analysis. The trust was piloting a trust wide care plan for the last hours and days of patients' lives. There were electronic and paper versions and a version for the community that took into account the differences to the frequency of checks by trust staff when patients were in their own home. Monthly meetings between acute and community staff had started in March 2017.
- During our inspection in June 2016, we found no evidence of activity data collection, outcome measures, audit or benchmarking for community end of life care services.
- The EOLC strategy implementation plan addressed the lack of data. It also listed a number of indicators to measure progress in meeting objectives, such as the number of staff trained. A performance scorecard of agreed key performance indicators had been developed.
- The EOLC strategy outlined expectations for improved data collection, but many of these were in the development stage at the time of our inspection. For example, there were plans to identify EOLC patients, with their consent, using 'coordinate my care', an electronic record for use by all relevant services. There would also be a record of the patient's preferred place of death. However, this had not yet been integrated into the trust's IT electronic patient record. The use of an electronic EOLC care plan at St George's Hospital was expected to provide data on whether staff were following standards of care. Because community services did not use electronic recording, the division was considering other methods of auditing, for example, through visits by senior staff to patients' homes.
- There were regular audits of Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) orders at the hospital to check that the trust was following expected practice. DNACPR forms in the

community were completed by GPs, but there were plans for the community services division to work with GPs to ensure good practice in documentation and communication with patients and relevant parties.
- The trust had implemented a review of all deaths at the hospital, which provided information about whether the patient had received appropriate EOLC. The community services division relied on reviews of patient notes in their homes to gather information.
- The trust was increasingly developing tools that would enable them to benchmark themselves against other NHS trusts. In November 2016, the local bereavement survey was discontinued and the trust adopted a survey used across London. Community services were also planning to enable more relatives of patients dying at home to complete a bereavement survey. However, because EOLC services in the community were provided by different services, including the local hospice, the results would not only reflect the trust's services. The trust also planned to benchmark their Chaplaincy/spiritual care workforce against national standards.

**Equalities and Diversity – including Workforce Race Equality Standard**

- During the inspection in June 2016, it was identified that the Workforce Race Equality Standard (WRES), for 2015 had been published without having been presented to the board and had not received board approval, despite this being required.
- During this inspection, we saw that an action plan had now been put in place for the WRES and this had been discussed with the board.
- Minutes from the board meeting in November 2016, showed that the director of workforce and organisational development (DWOD) at the time, drew the board's attention to the WRES. They reminded the board that the workforce department had prepared a WRES action plan with input from an internal WRES steering group and the staff network advisory group. The action plan was formally approved by the board in November 2016. The action plan was developed in order to address the deficits identified by the WRES reporting, annual staff survey and our previous inspection visit.
- There was a WRES reporting template and action plan on the trust's website dated July 2016, which was in the process of being updated. We saw the new action plan, but this was a work in progress and still had to go through a number of checks before it could be uploaded on the website.

- We reviewed the Workforce Information Report, which was discussed at the board in May 2017. This showed that a disproportionate number of black and ethnic minority (BME) staff, were subject to formal disciplinary procedures, (61%, when making up 42% of staff). Further analysis was being undertaken to understand the reason for this disparity. There was an internal WRES group, which was undertaking action to reduce the incidence of disciplinary cases against BME staff.
- The new director of human resources and organisational development took up his post in the first week of May 2017. We were told that the trust had pinpointed WRES as an area to focus on. They would start with data analysis and use the data to update the action plan.

**Fit and Proper Persons**

- During the previous inspection, we found that there was inadequate compliance by the trust with meeting the Fit and Proper Person Requirement (FPPR). We found on this inspection that there was still the lack of an effective system to manage the risks regarding fit and proper persons being employed.
- A review of executive and non-executive director personnel files was conducted by the trust and presented to the board in October 2016.The review identified that all records of executive and non-executive directors were compliant against the regulation, with the exception of one person, where it was stated a renewal of the disclosure and barring service checks (DBS) was required.
- Before the inspection, we were provided with an update from the then interim chief executive officer, in a letter dated 30 November 2016. This stated that all current board members had met the FPPR regulation and the board was assured of full compliance. The letter stated that the board received assurance of full compliance with FPPR at their meeting held on 26/09/16.
- We reviewed the executive and non-executive directors' files to assess compliance with the Fit and Proper Person Requirement Regulation. Overall, we found that this was not being managed effectively, because qualifications, DBS clearance, references, disqualified director's and insolvency checks missing from some files. The records we reviewed included five of the nine board members who were listed in the October 2016 review and were still employed by the trust at the time of our inspection.
- A new policy for fit and proper persons had been agreed by the board in October 2016. This policy met the requirements for the regulation. However, on our inspection, the newly appointed director of human resources and organisational development

presented us with an amended policy. This policy stated that in exceptional circumstances, a director may start work before all components of the FPPR regulation had been met. This policy had been amended in May 2017 (the month of our inspection) and had not yet been formally agreed by the executive directors and the board. It was due to be taken to the EMT on the last day of our inspection as 'any other business'.

- The new director of human resources and organisational development had made the amendment early in his appointment. This was following an inspection he made of the executive files and told us that the recent significant and fast change to the trust board meant that an exceptional process was required in the policy, as otherwise there would be 'no executive team in place'.
- Following the inspection, an internal CQC management review decided that the trust was continuing to fail meet the Fit and Proper Person Requirement (Regulation 5, HSCA, 2014). It was decided for senior CQC staff to raise the issue again with the trust chair, the improvement director for the trust and NHS Improvement, before consideration was given to further enforcement action.

# Outstanding practice and areas for improvement

## Areas for improvement

**Action the trust MUST take to improve**

- Ensure that it has systems and processes that operate effectively in accordance with good governance.
- Strengthen governance and reporting arrangements, so as to provide the board with increased oversight of Elective Care Recovery Programme delivery.
- Continue to address the gaps in assurance with regards to estates maintenance.
- Continue with the recovery programme and Clinical Harm Review Group with regards to RTT data.
- Ensure it meets the Fit and Proper Person Requirement Regulation.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors<br>**The provider was not meeting this regulation because:**<br>**1. Not all directors had all the required FPPR checks carried in accordance with this regulation.**<br>**Regulation 5** |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**Care and treatment were not always provided in a safe way because:**<br>**1. RTT data remained inaccurate and two patients had been seriously harmed as a result of delays to their follow up appointments.**<br>**Regulation 12 (2) (a) (b)** |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment<br>**Some premises and equipment were not properly maintained or suitable for the purpose for which they were being used because:**<br>1. Replacement box filters were stacked in the plant room by the side of theatres 5 and 6 vent plant, allowing for possible contamination of the “new filters”. |

This section is primarily information for the provider

# Requirement notices

2. New transformer units were needed to meet power demands.

Regulation 15 (1) (a), (c), (e)

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**Systems and processes were not established and operated effectively because:**<br>1. There were gaps in assurance with regards to estates maintenance.<br>2. The provider had to be prompted to ensure that individual PGDs had been signed by each health professional working under the direction in accordance with the Human Medicines Regulations 2012.<br>3. The governance and reporting arrangements needed to be strengthened to provide the board with increased oversight of ECRP delivery.<br>4. The head of internal audit had only limited assurance on the trust's annual report.<br>5. Priority 1 recommendations remained outstanding beyond the agreed deadlines, and several deadlines had been put back.<br>Regulation 17 |