St George's Healthcare NHS Trust

Quality Report

St George's Hospital
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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	Good
Are services at this trust safe?	Requires Improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Good
Are services at this trust well-led?	Good

Summary of findings

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Overall summary

St George's Healthcare NHS Trust is one of the largest hospital and community health service providers in the UK. With nearly 8,000 staff and around 1,000 beds, the trust serves a population of 1.3 million across South West London. The trust provides healthcare services, including specialist and community services, at two hospitals – St George's Hospital in Tooting and Queen Mary's Hospital in Roehampton –therapy services at St John's Therapy Centre, healthcare at Wandsworth Prison and various health centres. During this inspection, we visited both hospitals, St John's Therapy centre and a selection of health centres, looking in detail at both acute and community services.

Key findings from this inspection include:

Staffing

This trust (like many others) experiences difficulty in recruiting enough nurses to cope with the increasing demands on the service and the complexity of patients admitted to the ward areas. We held a number of staff focus groups where staff stated that they had actively chosen to work at St George's hospital as they enjoyed the culture of the organisation and felt that they were able to deliver a good service to their patients. However, we noted on some wards and areas that there were significant issues with shortages of staff which impacted on patients and the care they received.

Cleanliness and infection control

Overall, the hospital was found to be clean and good infection prevention and control systems were in place. We noted that there were some issues of cleanliness within the mortuary and the day assessment unit. However, most ward areas and departments were clean and clutter-free. The chief nurse and director of operations was the lead for infection prevention and control and this ensured that this issue has board-level commitment.

Mental Capacity Act

We found that the trust staff were unsure of the processes to follow when they identified someone who may have limited or no capacity to make decisions about their care. We have asked that the trust take action to address this and will follow up to ensure action has been taken.

Summary of findings

The five questions we ask about trusts and what we found

We always ask the following five questions of services.

Are services safe?

Requires Improvement

The services provided by the trust were safe, however staff were unclear of the procedure to be taken when using the the Mental Capacity Act. Staff knowledge of this Act was limited which meant that staff were not always able to identify and take the correct steps to protect patients with limited capacity. The trust had and used mechanisms for monitoring performance. Incidents were reported via the trust's IT system and these were collated and actions taken to address identified deficits.

The trust had good systems in place to disseminate the lessons learnt from incidents that occurred in the hospital. These included patient safety forums held each month for all staff, safety bulletins and newsletters. Most staff were aware of these systems and received feedback from the trust on the lessons learnt.

The trust had risk registers in place which, while not addressing all the risks identified by staff in some areas, did have actions to be taken to minimise these risks. Risks identified by staff were to be added to the register following our visit by the local management teams.

Are services effective?

Good

Throughout the trust we found that national clinical audit information was used to improve the effectiveness of service. In most areas National Institute for Health and Care Excellence (NICE) guidance was implemented and, as a result, the effectiveness of the services offered was improved.

There were good systems in place throughout the acute and community trusts to identify where a patient's condition was deteriorating and action was seen to be taken. The critical care services, while not offering a dedicated outreach team, used medical staff to provide timely assessments of the care needed to manage the deteriorating patient.

Staff were trained to have the appropriate skills, knowledge and experience for the role they undertook. However, further embedding of the Mental Capacity Act 2005 legislation would further enhance outcomes for patients who were suffering from dementia or who had mental health issues.

We saw excellent examples of multidisciplinary working across the community and acute teams, including discharge of patients and management of complex disorders.

Are services caring?

Good

Prior to the inspection, we held focus groups and a listening event to obtain the views of patients and service users. We also reviewed the data obtained

Summary of findings

from the NHS Friends and Family Test, the NHS Choices website and the CQC's Adult Inpatient Survey (2012). This told us that patients were generally satisfied with the care that they received at the trust. This was also borne out by discussions we had with patients and relatives while on site.

There were a few patients who told us of areas of poor quality care but we found that the trust used complaints in a proactive way. This included the use of DVDs which recorded the patient experience and were used to highlight where practice could be improved for a better patient experience.

Women and their partners in the maternity and critical care settings were particularly pleased with the care they received. As were patients who used the community services that the trust provides.

Are services responsive to people's needs?

Good

We saw some excellent examples of the way the trust had responded to meet the needs of the population it serves. These included the service provided at the minor injuries unit at Queen Mary's Hospital, which provided general health advice as well as injury treatment. We also noted that parents on the children's wards were taught how to care for their child once at home.

We noted that a significant number of patients had their operations cancelled by the trust in the weeks preceding our visit. We reviewed this as this was not responsive to the needs of patients. However, due to pressures of capacity within the hospital, the trust had taken this decision so that patients' safety was maintained.

Most services were accessible to patients. However, the specialist services sometimes had difficulty repatriating patients to their local hospital or home which impacted on the availability of services for others. This could mean that patients who were waiting for specialist operations had to wait longer for a bed to become available. The services at Queen Mary's Hospital enabled patients to move from acute care back into the community in a more timely manner.

The Mary Seacole Ward at Queen Mary's Hospital operated an assessment service so that patients who required a higher level of treatment or support could be assessed and, if possible, this care was then able to be provided within their own home with support from community services.

Are services well-led?

Good

The chief executive was visible in all parts of the trust, spending time at both hospitals and talking to staff and patients. While visible within the main acute site, other members of the senior team were not so visible at the community locations. However, all staff displayed the values of the trust and most were able to verbalise that these were 'excellent, kind, responsible, respectful'.

We found good governance arrangements centrally which were, in the main, implemented locally as well. Local leaders were visible, not least because of the Senior Sister's/Ward Charge Nurses's bright red uniforms. Most staff found

Summary of findings

that their leaders were supportive and listened to them. However, we did find a few areas where staff felt bullied and harassed by local managers. Once reported to the senior management, action was undertaken to address this issue.

Staff felt proud to work in the trust and sickness rates were low. Staff felt engaged and most felt enabled to raise concerns. Areas where this was not so are highlighted in the St George's Hospital report. Most staff had appraisals and supervision sessions with the appropriate personnel.

Summary of findings

What people who use the trust's services say

We reviewed a number of sources of data to inform us about what people who used the hospital said and we spoke with people at the listening event and focus groups. This information told us that, overall, the hospital was responsive to the concerns of people using the service however experiences of care provided by the trust varied.

The trust can be seen to be performing lower than the England average score for both the inpatient and A&E services in the NHS Friends and Family Test. This is a government initiative to test whether people would recommend the service to their friends and family. The response rate in A&E is lower than average while the inpatients is higher. There were four wards identified by patients as 'extremely unlikely' to be recommended to family and friends, including the Caesar Hawkins (medical short stay), Cheselden (cardiovascular and vascular), Gray ward and Richmond acute medicine unit. People at the focus groups and listening events who made negative comments also mentioned some of these wards.

Out of 69 questions, the trust was in the bottom 20% nationally in the Cancer Patient Experience Survey 2012-2013 for 39 of these questions. The areas which rated low were mainly around poor communication, lack of privacy, not being treated with respect and dignity, not having confidence in staff, patients not feeling listened to and staff not telling them all the relevant information.

The trust has an overall score of four stars out of five stars on the NHS Choices website. Staff were praised for being caring, dignity and respect were respected, patients felt involved in decisions and the hospital was praised for cleanliness. Negative themes include lack of prompt attention, attitude of staff, A&E waiting times, unhelpful staff and lack of consistency in care. This is reflective of the CQC's Adult Inpatient Survey 2012, where the trust performed about the same as other trusts in all 10 areas of the survey (A&E, waiting lists and planned admissions, waiting for a bed, hospital and wards, doctors, nurses, care and treatment, operations and procedures, leaving hospital, overall views and experiences).

Areas for improvement

Action the trust MUST take to improve

- There was a poor general understanding and implementation of the principles of the Mental Capacity Act 2005. (St George's Hospital and Queen Mary's Hospital – regulatory action taken)
- Medical records must be made available to staff working in the outpatients clinics. (St George's Hospital – regulatory action taken)

Action the trust SHOULD take to improve

St George's Hospital

- Ensure risk registers reflect the risks in each department and ensure appropriate action is taken to address recommendations from national guidance.
- Action is taken to address issues of bullying and harassment and support staff in raising concerns.
- Alleviate staff concerns about permanent staffing levels on the children and young people wards.
- Ensure appropriate cascade of information regarding staffing and lessons learnt from incidents across the hospital.
- Ensure that staff are aware of the strategic direction for end of life care. Clarify the management structures and the responsibilities of other team members to staff in the outpatient services.
- Address issues of privacy, dignity and confidentiality as detailed in the report for this hospital.
- Avoid the unnecessary overbooking of outpatient clinics.
- Ensure that all staff receive appraisals and supervision and that this is documented.
- Review the combining of cardiology and cardiothoracic patients on Caroline Ward.
- Ensure that there are adequate numbers of porters to cover the A&E department, particularly at peak times (Friday and Saturday nights).
- Prevent the breaching of single-sex bays.

Summary of findings

- Ensure that patients are always transferred to the most appropriate ward.
- Ensure that all staff always adhere to fire safety regulations.
- Review the recording system for pain relief of patients in the children's emergency department so that it includes a space for staff to detail hourly checks.
- Review communication systems in the event of admission and discharge with community health providers.

Queen Mary's Hospital

- Improvements to outpatient services for children.
- Ensure that patient documentation is complete.
- Ensure that staff receive appropriate training in using, moving and handling equipment.
- Review the signposting in the orthotics department.
- Review confidentiality within the sexual health clinic waiting area.
- Ensure that all staff are aware of the location of emergency equipment.

St John's Therapy Centre

- Defibrillators and resuscitation equipment should be reviewed in all premises where coil fittings and implants are performed.
- Information should be reviewed to address the needs of the local population.
- All clinical staff should receive safeguarding supervision from a named professional, in line with best practice guidance.
- The trust should review the integration of the IT system and ensure a prompt response to community IT issues.
- Senior managers should be more visible in the community settings to enhance leadership.
- The relevance of communication that is cascaded to community staff should be strengthened where appropriate.
- Patients' allergy status should be recorded on the medication administration charts as well as on care records.

Good practice

Areas of good practice noted through the inspection include:

- The provision of a sympathetic environment within the mortuary suite.
- Outstanding maternity care, underpinned by information provided to women and partners and robust midwifery staffing levels with excellent access to specialist midwives.
- The responsive and caring environment of the Neonatal Special Care Baby Unit
- Timeliness of specialists to review patients awaiting a critical care assessment.
- Outstanding leadership of intensive care unit and high dependency unit services with open and effective team working and a priority given to dissemination of information, research and training.
- Multi-professional team working in neurology theatres.
- The functioning of the hyper-acute stroke unit on William Drummond Ward.
- The local leadership of Richmond acute medical unit.
- The well-led, integrated and calm environment of the A&E department.
- The provision of health advice at Queen Mary's Hospital minor injuries unit.
- Excellent multidisciplinary working across the community services.
- Community staff promoted excellent communication across teams.
- Community staff focused on the individual patient and worked hard to build trusting and open relationships with patients.
- The safety of children, young people and families was promoted through specific systems developed by the trust.
- The evident local culture of reporting and learning from medical incidents.
- The development of DVDs to engage clinical and managerial staff in reflecting on and improving practice and therefore patients' experiences.

St George's Healthcare NHS Trust

Detailed Findings

Hospitals we looked at:
St George's Hospital, Queen Mary's Hospital and St Johns Therapy Centre.

Our inspection team

Our inspection team was led by:

Chair: Gillian Hooper, Director of Quality & Commissioning (Medical & Dental), Health Education England

Head of Hospital Inspections: Fiona Allinson, Care Quality Commission (CQC)

The team included CQC inspectors and a variety of specialists: doctors, nurses, health visitors, dieticians, Experts by Experience and patient representatives.

Background to St George's Healthcare NHS Trust

St George's Healthcare NHS Trust is one of the largest hospital and community health service providers in the UK. With nearly 8,000 staff and around 1,000 beds, the trust serves a population of 1.3 million across South West London. The trust provides healthcare services, including specialist and community services, at two hospitals – St George's Hospital in Tooting and Queen Mary's Hospital in Roehampton – therapy services at St John's Therapy Centre, and healthcare at Wandsworth Prison and various health centres.

The trust's main site, St George's Hospital, one of the country's principal teaching hospitals, is shared with St George's, University of London, which trains medical students and carries out advanced medical research. St George's Hospital also hosts the St George's, University of London and Kingston University Faculty of Health, Social Care and Education, which is responsible for training a wide range of healthcare professionals from across the region.

The trust offers very specialist care for the most complex of injuries and illnesses, including trauma, neurology, cardiac care, renal transplantation, cancer care and stroke. A large number of these services cover significant populations from Surrey and Sussex, totalling about 3.5 million people. In the community aspect of the trust, the services include a limb design and fitting service and a special seating service which casts and makes wheelchairs for people who cannot use a standard wheelchair.

Detailed Findings

Wandsworth is a borough in South West London. It borders Lambeth (east), Merton and Kingston Upon Thames (south), Richmond upon Thames (west), Hammersmith and Fulham, Kensington and Chelsea and Westminster (north). The 2010 indices of deprivation showed that Wandsworth was the 121st most deprived local authority (out of 326 local authorities). Between 2007 and 2010, the deprivation score for Wandsworth increased, meaning that the level of deprivation worsened. Census data shows that Wandsworth has an increasing population and a higher than England average proportion of minority ethnic residents. Life expectancy is 8.9 years lower for men and 6.8 years lower for women in the most deprived areas of Wandsworth.

St George's Hospital has been inspected on five occasions since registration in April 2010. It was not fully compliant for all the outcomes inspected on two out of five occasions. The last inspection took place in August 2013 and the hospital was found to be non-compliant for Outcome 9 (management of medicines), Outcome 13 (staffing) and Outcome 21 (records). During this inspection we reviewed the actions the trust had taken to address these issues and found that the issues raised had been rectified, apart from the staffing levels on Trevor Howell ward. We found that staffing levels on this ward were maintained using bank (overtime) and agency staffing and this did not impact on the care experienced by patients.

Why we carried out this inspection

We inspected this trust as part of our new in-depth hospital inspection programme. We chose this trust because it was considered to be a low risk service.

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:

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients
- Community inpatient services
- Children and families who use services
- Adults with long-term conditions who use services.

Before visiting, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew about the trust. We carried out an announced visit between 10 and 13 February 2014. During the visit we held focus groups with a range of staff in the hospital, including nurses, doctors, physiotherapists, occupational therapists, porters, domestic staff and pharmacists. We talked with patients and staff from all areas of both hospitals and the community/therapy centre, including the wards, theatre, outpatient departments and the A&E departments. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients'. We held a well-attended listening event where around 80 patients' and members of the public shared their views and experiences of the trust. An unannounced visit was carried out on 22 February 2014 at St George's Hospital and Queen Mary's Hospital.

Requires Improvement

Are services safe?

Summary of findings

The services provided by the trust were safe, however staff were unclear of the processes to be followed when using the Mental Capacity Act. Staff knowledge of this Act was limited at this location which meant that staff were not always able to identify and take the correct steps to protect patients with limited capacity. The trust had and used mechanisms for monitoring performance. Incidents were reported via the trust's IT system and these were collated and actions taken to address identified deficits.

The trust had good systems in place to disseminate the lessons learnt from incidents that occurred in the hospital. These included patient safety forums held each month for all staff, safety bulletins and newsletters. Most staff were aware of these systems and received feedback from the trust on the lessons learnt.

The trust had risk registers in place which, while not addressing all the risks identified by staff in some areas, did have actions to be taken to minimise these risks. Risks identified by staff were to be added to the register following our visit by the local management teams.

Our findings

Safety and performance

The trust reported two 'never events' (incidents so serious that they should never happen), between 1 December 2012 and 31 November 2013. Both never events occurred in surgery but only one at the St George's Hospital site. The second never event occurred at a location which the trust do not own but from where services were being provided on behalf of the trust. Most theatre staff were aware of this incident and could describe the actions taken as a result of this. Staff were aware of how to report incidents and had done so in the past.

The trust reports serious incidents through the National Reporting and Learning Service. St George's Hospital accounted for 60% of all serious incidents while 25% of the serious incidents occurred in patients' homes. The remaining serious incidents were split between Queen Mary's Hospital, Wandsworth Prison, community and residential services and nursing homes. Grade 3 and 4 pressure ulcers were the most common serious incidents, with 189 and 34 of each respectively. In total, 61% of the 223 pressure ulcers were acquired in patients homes, in community settings or in nursing or residential homes. The trust monitored the reporting of pressure ulcers.

All ward areas we inspected had information displayed on the wall regarding the safety of patients' on their ward. This ensured that information was available to staff and patients'. The trust invited all staff to attend the monthly patient safety forum where incidents were explained, analysed and discussed and the audience were invited to ask questions of the investigation team. This ensured that the organisation maintained an open and transparent culture around incident management.

Learning and improvement

The trust set and monitored the number of pressure ulcers, falls, urinary tract infections, among a number of other safety areas. We saw evidence of good governance systems that ensured incidents were investigated and action taken. Most staff could give an example of where practice had changed as a result of an incident or complaint to improve outcomes for patients'. Information was disseminated in a variety of ways, including newsletters, team meetings, trust-wide meetings and safety bulletins.

Throughout the hospital sites of the trust we noted that staff had limited knowledge of the Mental Capacity Act. This meant that staff could not assess patients with limited capacity and therefore could not gain appropriate consent to treatment. When patients' were identified as having limited capacity staff were unclear as to what actions should be taken.

Systems, processes and practices

Medicines management

Following a previous inspection where issues over the management of medicines had been identified, we ensured that a pharmacist was part of the CQC inspection team. The CQC pharmacist found that medicines management had good systems in place in most areas for the management, storage and administration of medicines.

Infection control

We found that all areas of the trust were clean and had infection prevention and control systems in place. Hand gels and hand washing was evident in both the acute and community settings. The chief nurse and director of operations was also the trust's director of infection

Are services safe?

prevention and control. This ensured that there was someone with the executive authority and responsibility for ensuring that strategies were implemented to prevent avoidable healthcare associated infections at all levels in the organisation. There were arrangements in place for nursing patients' in isolation to reduce the spread of infection should they acquire infectious illnesses such as MRSA.

Equipment and environment

The hospital environment largely facilitated the effective delivery of care. However, there were some issues in the older parts of the trust's buildings, in particular, in medicine at St George's Hospital, (see the specific location report for details). We saw that, in most areas, equipment was available to provide care and, where an issue had been highlighted, plans were in place to address this. An example of this was the trust's plan to standardise the type of ventilator equipment used to ensure patient safety. A further example was the move throughout the hospital to use smart pumps, programmed with a set drug dosage to support patient safety.

Monitoring safety and responding to risk

While a number of wards reported they had vacancies, we saw that an appropriate number of staff were available on the wards to ensure the safety of patients. The trust had a reporting system in place to alert senior management when staffing was not safe so that staff could be moved around the unit to accommodate needs.

The trust, like many others during the winter months, had issues with capacity. Discharging patients appropriately ensured that those with pre-planned admissions had a bed available. However, unlike many trusts, St George's Healthcare NHS Trust had problems repatriating people to their local hospitals following specialised surgery. The week prior to our inspection, the trust had taken the decision to cancel 150 planned operations as they recognised that, potentially, there would not be the capacity to undertake these procedures safely.

We saw risk registers in many departments and spoke to staff who knew what was on their local register. This ensured that the risks were identified and that all staff were working to minimise the impact of perceived or actual risks. However, we noted that, in some departments, not all risks identified by staff were on the risk register. These were to be added to the local risk registers by the ward manager.

Anticipation and planning

The trust had a cost improvement programme and the board actively challenged planned improvements so they did not impact on the safety of patients. The chief executive and the senior team were able to explain how the trust would develop in the future and maintain the services it currently offers while expanding its specialist services.

Good

Are services effective?

(for example, treatment is effective)

Summary of findings

Throughout the trust we found that national clinical audit information was used to improve the effectiveness of service. The only exception to this was the results of the audits relating to end of life care where the trust had been slow to implement the recommendations. In most areas, National Institute for Health and Care Excellence (NICE) guidance was implemented and, as a result, the effectiveness of the services offered was improved.

There were good systems in place throughout the acute and community trusts to identify where a patient's condition was deteriorating and action was seen to be taken. The critical care services, while not offering an outreach team, used medical staff to provide timely assessments of the care required to manage the deteriorating patient.

Staff were trained to have the appropriate skills, knowledge and experience for the role they undertook. However, further embedding of the Mental Capacity Act 2005 legislation would further enhance the experience for patients who were suffering from dementia and mental health issues.

We saw excellent examples of multidisciplinary working across the community and acute teams, including discharge of patients and management of complex disorders.

Our findings

Using evidence-based guidance

Throughout the trust, we saw examples of where NICE guidance was implemented. Examples included: rotoblation in the cardiac unit (a procedure where a catheter is inserted into a narrowed artery), use of smoking cessation guidance across the trust, and supportive and palliative care guidance. The trust had a number of services for which it is nationally and internationally renowned, including specialist seating, limb manufacture, cardiac, stroke, major trauma and neurology services. These services work closely with the universities to ensure that patient outcomes are improved through research and development.

The trust had a governance system which reviewed the data from local audits and communicated the results at ward or department level through to board room level. We saw evidence that the trust subscribed to a number of external bodies who undertook national audits. Actions were taken as a result of these audits to improve the care provided to patients. However, we saw that actions were not taken in a timely manner within the end of life service. This is described in further detail in the relevant section of the St George's Hospital location report.

Patients were assessed and cared for in line with national guidance around pain relief, nutrition and hydration and basic care needs were attended to. However, we found that the recording of this was not always sufficient to inform other staff of the risks. We also found that the recording of pain relief for children was not in line with national guidance. For further information, please refer to the St George's Hospital report.

Performance, monitoring and improvement of outcomes

The outcomes of this trust were generally in line or above the national average for a number of national clinical audits. This included the Intensive Care National Audit & Research Centre (ICNARC) report. The intensive care units performed well, with low rates of re-admissions and low length of stays. The ICNARC data showed that fewer people died than might have been expected given the area, age and health of the population.

The trust reported numbers of pressure sores, urinary tract infections, venous thromboembolisms (blood clots) and falls with harm. This range of issues is often reported via a monitoring tool called the Safety Thermometer. These measures are good indicators of the effectiveness of nursing interventions. In December 2012, all indicators were above the national average (a positive sign). However, the rate of venous thromboembolisms dropped dramatically and stayed below the national average (a very positive sign). The rate of falls with harm similarly reduced to around the national average. However, the rate of pressure ulcers and urinary tract infections continued to be above the national average for most of the year. The trust had action plans in place to address this and improve outcomes for patients. We saw that most staff were aware

Good

Are services effective?

(for example, treatment is effective)

of these but, in some areas, the actions were taking time to become embedded into practice. The tissue viability nurses were relatively new in post and were working with ward staff at St George's Hospital to improve care in this area.

Staff, equipment and facilities

We saw that, throughout the trust, there were appropriately qualified, and competent staff available to provide good care for patients. Most staff stated that they had access to training that enabled them to undertake their role. While most staff stated that they received one-to-one appraisals and supervision, this was not consistent across the trust. Please refer to the Queen Mary's Hospital report for examples where this did not occur. Where we were able to identify an episode of poor practice, the trust had already identified this and was managing the performance of the personnel involved.

Multi-disciplinary working and support

At a local level, there was good multi-disciplinary working within teams. However , we noted that sometimes in the children's and young person's service, the communication between the acute and community teams was not always effective. Please see this area of the St George's Hospital report for further information. We saw good handovers between teams of nurses and between doctors when they changed shifts. The social therapy and rehabilitation (STAR) team was available on most wards and included occupational therapists, physiotherapists and local social workers. In conjunction with discharge coordinators and other members of the multi-disciplinary team, the STAR team was involved in facilitating the safe and effective discharge of patients. There was good communication and engagement between all members of the multi-disciplinary team.

Good

Are services caring?

Summary of findings

Prior to the inspection, we held focus groups and a listening event to obtain the views of patients' and service users. We also reviewed the data obtained from the NHS Friends and Family Test, the NHS Choices website and the CQC Adult Inpatient Survey (2012). This told us that patients were generally satisfied with the care they received at the trust. This was also borne out by discussions we had with patients and relatives while on site.

There were a few patients who told us of areas of poor quality care, but we found that the trust used complaints in a proactive way. This included the use of DVDs which recorded the patient experience and were used to highlight where practice could be improved for a better patient experience.

Women and their partners in the maternity and critical care settings were particularly pleased with the care they received, as were patients who used the community services that the trust provides.

Our findings

Compassion, dignity and empathy

We observed that staff interacted positively with, not just their own patients, but also with relatives and with patients in corridors and other public areas. We saw that patients were attended to in a timely manner and patients informed us that staff "could not do more for them". Despite a number of issues being raised at focus groups prior to our inspection (regarding the lack of care, dignity and respect), we observed staff, and patients reported that they received respectful and appropriate care.

We saw that intentional rounding (or around-the-clock care) occurred where necessary to ensure that patients' basic needs were met while they were waiting for a bed. Patients' on ward areas were assisted with their basic needs where necessary and this was done discreetly and in a caring manner. Patients in the children's service reported that their privacy was not always respected and issues were raised in the chemotherapy wards and sexual health clinics regarding the potential for other patients to overhear conversations. Please see the St George's Hospital and Queen Mary's Hospital reports for further information. The bereavement service at St George's Hospital mortuary was excellent in providing compassionate and respectful care.

Involvement in care and decision making

Patients told us they felt they were involved in their treatment and knew what was happening at each stage of the treatment. We saw that the staff in the community services used a checklist system to ensure that they had given patients comprehensive information and this acted as a failsafe mechanism to ensure that all information was passed on to appropriate personnel. Patients on the surgical ward felt that their operations had been explained to them in full and they were aware of what to do on discharge. Similarly, staff on the children's ward showed parents how to manage treatment for their children on discharge.

We found that, throughout the trust, information was predominantly available only in English, despite the trust having a diverse population. We spoke to numerous staff and patients about this issue and found that most patients did not find this to be a problem. However, some did and, where necessary, translation facilities were used. Staff were aware that the use of family and friends to translate was not good practice and only resorted to this in an emergency.

Trust and communication

Staff took time to talk to patients and their relatives and to involve them in important decisions. There were information leaflets available that staff could print off which helped explain medical conditions and treatments. Patients' throughout the trust told us that their treatment and support had been explained to them in a way that they could understand. However, in surgery, staff felt that sometimes they did not have sufficient knowledge to explain treatment or the reasons for delays.

Emotional support

Chaplaincy staff were available throughout the hospital and we saw some excellent examples of how staff had supported people when they had received bad news. This included a midwife supporting a patient following the death of a baby, in liaison with the bereavement officer in post. The bereavement officer identified people for follow-up counselling and psychology as appropriate. Families

Good

Are services caring?

told us they had experienced good end of life care from the St George's community services team, specifically highlighting very good bereavement counselling when children had died.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

We saw some excellent examples of the way the trust had responded to meet the needs of the population it serves. These included the service provided at the minor injuries unit at Queen Mary's Hospital, which provided injury treatment and general health advice. We also noted that parents on the children's wards were taught how to care for their child once at home.

We noted that a significant number of patients' had their operations cancelled by the trust in the weeks preceding our visit. We reviewed this, understanding that, due to pressures of capacity within the hospital, the trust had taken this decision in order to maintain patients' safety.

Most services were accessible to patients. However , the specialist services sometimes had difficulty repatriating patients to their local hospital or home which impacted on the availability of services for others. The services at Queen Mary's Hospital enabled patients to move from acute care back into the community in a more timely manner.

The Mary Seacole Ward at Queen Mary's Hospital operated an assessment service so that patients, who required a higher level of treatment or support, could be assessed and, if possible, this care was then able to be provided in their own home with support from community services.

Our findings

Meeting people's needs

The trust served the people of Wandsworth and surrounding areas, but also a wider population requiring specialist services. This caused significant demands for beds within the trust. The designation as a major trauma centre added to this demand and meant that, at times, patients' were not cared for on the ward designated for their medical condition. Sometimes this meant that patients had to move within the hospital which could cause distress and delays in treatment. Having staff in community teams under the management of the acute trusts facilitated swifter discharge of local people back to their homes. The assessment of patients at Mary Seacole Ward also ensured that inappropriate admissions from the community were prevented and alleviated some pressure within the system. However, the main problem for the hospital was the repatriation of patients from outside the local community back to their own areas following specialist surgery.

Vulnerable patients and capacity

The community services were well-resourced and experienced in meeting the needs of people who were vulnerable or lacked the capacity to communicate their needs. The staff from the acute service could access support from the community teams as necessary. However, staff were not always up to date with the requirements of the Mental Capacity Act 2005 and were unsure of how to seek assistance. Understanding of the Act's deprivation of liberty safeguards was similarly patchy. This meant that patients may receive care to which they do not consent.

Staff, however, had a good understanding of the importance and procedures for safeguarding adults and children. They knew what to do and how to report issues. The community services and children's areas in particular were able to give examples of when they had had to implement these procedures.

Access to services

The hospital was meeting national targets for waiting times for appointments and treatment. However, within the outpatient clinics, patients felt that they waited some considerable times in some clinics. This was caused by the overbooking of some clinics to compensate for the higher than national average of patients who did not attend, thereby reducing access for others. However, the trust was in the process of implementing clinics at different times to improve access for patients.

As discussed earlier, the trust cancelled a significant number of operations prior to our visit in order to ensure patient safety in light of bed capacity issues. However, while this may have ensured that patients were safe, this issue was highlighted by patients at listening events and focus groups as one of the most frustrating features of their interaction with the hospital.

Leaving hospital

Discharge planning occurred within a multi-disciplinary team to ensure that discharges were appropriate and timely. Readmission rates at the hospital were low and this

Good

Are services responsive to people's needs?

(for example, to feedback?)

supports the appropriate discharge of patients. Patients' and relatives reported feeling involved in the discharge process and that systems were in place to support them in the community.

Learning from experiences, concerns and complaints

The trust used a number of systems to ensure that they received timely feedback from patients about their care. The NHS Friends and Family Test results were below the national average and staff were taking steps to ensure that patients and their relatives completed this. Complaints were dealt with in a timely manner and the trust used these in a positive way. The inspection team viewed a number of DVDs which the trust had produced to describe patients' experience of the care at the trust. These people described their experience and explained what was good and bad about the experience. Some of these patient stories were very moving. These DVDs were then used to engage staff in reflecting on practice to ensure that they took on board the lessons from the patients' experience.

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

The chief executive was visible in all parts of the trust, spending time at both hospitals and talking to staff and patients. Other members of the senior team, while visible within the acute site, were not so visible at the community locations. However, all staff displayed the values of the trust and most were able to verbalise that these were 'excellent, kind, responsible, respectful'.

We found good governance arrangements centrally which were, in the main, implemented locally as well. Local leaders were visible, not least because of the matron's bright red uniforms. Most staff found that their leaders were supportive and listened to them. However, we did find a few areas where staff felt bullied and harassed by local managers. Once reported to the senior management, action was taken to address this issue.

Staff felt proud to work in the trust and sickness rates were low. Staff felt engaged and most felt enabled to raise concerns. Areas where this was not so are highlighted in the St George's Hospital report. Most staff had appraisals and supervision sessions with the appropriate personnel.

Our findings

Vision, strategy and risks

A high number of staff could verbalise what the trust's values were ('excellent, kind, responsible, respectful') and we observed staff interacting with patients according to these values and generally displaying them in the way that they worked. All staff appeared committed to providing high quality of clinical care. Staff were aware of the risks within their own department and took action to minimise these.

Governance arrangements

Appropriate governance arrangements were in place throughout the trust. Information was collected on both the safety of the service and the quality of care and treatment provided. Plans were put in place to mitigate risks and improve quality. These were discussed at regular scheduled meetings with the appropriate senior staff. The outcomes of these meetings and any actions plans were fed back to other staff members at regular team briefings.

Senior members of staff, including board members, were able to identify the immediate and long-term risks to the organisation and were aware of the issues that the trust currently faced. This was because these issues were discussed at Trust Board meetings and members of the board were able to challenge the trust senior team. Financial pressures were also discussed and all members of the board challenged the chief executive to ensure that cost improvement was not at the expense of patient safety or experience. Complainants explaining their complaints on DVDs were shown to the Trust Board in order to engage them in challenging the trust to ensure that action was taken and that risks were reduced.

Audit reports were discussed at local and board level and actions taken as appropriate. There was a lack of an understanding by staff of the direction in the end of life care pathway, with not all patients being identified and therefore able to access services.

Leadership and culture

Staff told us they felt confident to directly approach the chief executive if they had concerns and spoke of good working relationships with general management. A number of staff told us that the chief executive was visible but less so were the other senior executive managers in the management structure. This was replicated not only at the acute site but in the community, where it was felt more acutely. The community teams felt distant from the "main" trust and felt that everything was centred at the St George's Hospital site.

In most areas, local leaders were described as "supportive and encouraging". However, in a number of areas, we found isolated cases of bullying and harassment by local managers. We reported these to the trust and action was taken. However, in at least one case, the trust was taking action to address the situation prior to our visit.

Patient experiences, staff involvement and engagement

Patient experience was captured through the NHS Friends and Family Test, touch screens in reception areas and through the Patient-Led Assessments of the Care Environment (PLACE) survey. We saw that this information

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

was used by the trust to improve care for patients. Staff reported feeling engaged in dialogue with the trust about plans and developments in their area of work. Medical staff felt that the chief executive was approachable and interested in their area of expertise. They felt that he had a good understanding of the issues they faced and could competently discuss future plans.

Learning, improvement, innovation and sustainability

Staff were aware of the objectives and targets they were required to meet to ensure that patients experienced good care. Targets and their progress were displayed in the ward and department areas. Local and departmental audits were undertaken and action plans developed and implemented. Most staff had their performance reviewed at least annually and poor performance was managed.