

Croydon Health Services NHS Trust

Croydon University Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. 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

Summary of findings

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Summary of findings

Overall summary

Croydon University Hospital is the main acute hospital managed by Croydon Health Services NHS Trust. It has 565 inpatient beds, a 24-hour A&E, maternity and children's departments, and a range of other services. It serves a large and diverse local population with one of the highest black and minority ethnic populations in South London. The trust employs around 3,500 staff and has a budget of £244 million. The UK Border Agency has its main reporting centre in Croydon and a high number of immigrants live locally and need healthcare support.

We chose to inspect Croydon as one of the Chief Inspector of Hospitals' first new inspections due to risks identified by our 'Intelligent Monitoring' and resulting concerns about the quality of care. We were particularly worried about poor patient experience. The trust's scores in the national inpatient survey for 2012/13 were among the worst in the country. This information, along with feedback from people who used the service and information from Croydon Healthwatch, and local Clinical Commissioning Groups, helped us decide where to look during our inspection.

Our inspection team of 25 included CQC inspectors and analysts, doctors, nurses, patient 'experts by experience' and senior NHS managers. The team spent several days on site observing care, talking to patients and staff, and looking at records and patient feedback. We held a public listening event in Croydon, which was attended by around 90 people who had used the hospital's services. We also carried out unannounced inspections of areas where we thought there was a risk of poor care.

We consider that A&E must be improved. While staff employed by Croydon University Hospital were well-motivated and tried hard to make the arrangement work, the department has high staff vacancies and the environment in A&E made it hard for staff to deliver good care. The building was badly laid out and lines of sight were poor. The trust has applied for funding to rebuild its A&E and we believe this would make a big difference to patient experience.

In addition we had serious concerns about A&E and the way in which patients move between the Urgent Care Centre (UCC), which sees people when they first arrive,

and the hospital. The UCC is run by another provider against whom we are taking action. The commissioners of this service must ensure that what they commission meets the needs of local people.

Staffing has been a problem for this trust for many years. This is being tackled by a major recruitment drive and staff in many parts of the hospital said that the situation was improving. We did, however, have concerns about staffing in older people's wards. These wards were busy, and both staff and patients recognised that care was poor because of a lack of enough staff with the right mix of skills.

The quality of medical care (across wards for older people, people who have had a stroke, people with diabetes and similar) was mixed. Some wards were well-led and were delivering safe, effective care but others were under pressure and more needed to be done to ensure the basics were done well – for example, helping people who have dementia to choose their meals, and ensuring good infection control.

Maternity and children's services were caring, safe and well-led. Mothers, parents and other relatives were largely positive about the care they had received, felt supported to make choices, and were kept informed about what was going on. Care was largely responsive to people's needs. However, we saw that the inpatients ward for children was cramped.

We saw evidence that surgery was generally safe and effective, with recent improvements in staffing numbers reflected in positive staff and patient feedback. We did, however, see good practice around the use of a safe surgery checklist. On one ward staff said more support was needed to ensure they could manage the range of specialities effectively. End of life care was also well-run, with appropriate links made with the local hospice, and multi-disciplinary teams working to make sure people's needs were met.

More can be done to ensure the Critical Care Unit is delivering consistently safe and effective care. There was too much reliance on non-permanent staff outside of core hours and the unit was cramped.

Summary of findings

The trust can do more to become a learning organisation and learn from audits, its own performance data, and best practice guidelines. Some service areas were let down by a lack of attention to basics such as ensuring patients were appropriately dressed before going home, care planning and record keeping.

The hospital's senior team has been through a lot of change. All of the executive team – with the exception of the Director of Nursing – have been in post less than a year. Many of the welcome changes at Croydon have been driven by the Chief Executive and the new team. Staff went out of their way to tell us about this.

We saw evidence that many staff from all professional backgrounds were committed to working with the new team to drive up quality. Patients had noticed this and it was reflected in feedback we got, although it is clear the trust has a history and reputation that is making it hard for it to move forward. We also heard about recent incidents at our public listening event that confirm the trust has many challenges ahead.

In summary:

- This is a new management team that is working to change culture (through the 'listening into action' programme,' which is working well). It is early days but the new team is having an impact.
- The A&E unit is not consistently providing safe care, mainly because of relationships with the UCC run by another provider (against which we are taking action).
- Poor patient experience is still a theme across the trust, and the hospital needs to continue its work to improve this.

Staffing has been a problem for this trust for many years and this is being addressed through a major recruitment drive. There are still significant staffing problems in A&E and on the older people's wards.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

While most services were delivered safely, the A&E must be improved. It is crowded, badly designed, and staff vacancies are high. The 'Urgent Care Centre' (which is not run by the hospital) is not safe and we are taking action against it. We are concerned about staffing levels in some parts of the hospital and whether they always have enough skilled, experienced staff to deliver safe care. There were not enough staff in wards for older people and this must improve.

Are services effective?

Services are largely delivered effectively and outcomes for patients are within expected ranges. We found no evidence of concerns about mortality rates or infection rates. Quality assurance (including audit findings and lessons learned meetings) is not always well understood at ward level.

Are services caring?

Most people we spoke to were positive about their care. Much of the care we observed during the inspection was good. However, we have concerns about outpatients and about there being too many discharges – particularly of older people – in the evening. There have been serious problems with patients' experience of care in the past (including some recent cases that were not acceptable, including some raised at our listening event) and there needs to be evidence of improvement here. But other patients were full of praise for staff, and the staff themselves wanted to make clear that there had been real improvements in recent months.

Are services responsive to people's needs?

The hospital needs to do more to be responsive to people's needs, particularly in A&E (while four-hour targets are currently being met, a high number of people are being discharged just before four hours is up) and for appointments for orthopaedics and eye conditions (both areas the trust has already taken steps to improve). Some parts of the hospital are in poor condition and this means care is not delivered as effectively as it could be.

Are services well-led?

The trust's new senior management team has made impressive strides in the past six months in particular. Staff wanted to tell us about the impact they have made. More evidence of sustained improvement is needed, but we saw and heard many positives. Complaints are not always responded to within an appropriate timescale, and some patients told us staff were defensive when responding to their concerns.

Summary of findings

What we found about each of the main services in the hospital

Accident and emergency

The provision of care in A&E needs improvement. Another provider runs the Urgent Care Centre that assesses patients and, despite efforts by Croydon University Hospital, continued to use an approach that was not safe. We are taking action against this other provider. The A&E environment was not well designed or maintained. It was cramped and lacked lines of sight between staff and patients. The observation ward was very crowded. Vacancy levels were high. Staff were, however, positive about changes to care pathways and about the training and support they were receiving. The dementia zone was singled out as an example of good practice.

Medical care (including older people's care)

We saw a mixed picture of quality across these wards. While we saw clear evidence of good care and leadership in some wards, quality elsewhere was let down by a lack of attention to good practice or detail (for example, in record-keeping and infection control). The older people's wards were the biggest area for concern, with patients saying there were not enough staff and staff confirming they were always under pressure. The trust is in the process of changing the skill mix and number of staff in these wards to ensure care is delivered safely. We saw many examples of good care, although some patients complained (for example, staff speaking over them in a foreign language) and older people did not always feel involved in their care. Patient records frequently did not include care plans that reflected all the needs of the patient. This meant there was a risk that they would not get the help and care they required.

Surgery

We had few concerns with surgery and overall this service was safe, effective and well-led. Patients told us that the surgical wards had enough staff to meet their needs and thought staff were caring. Staff said that the number of permanent nursing staff had recently improved. The wards were visibly clean and good infection control practice was largely followed. Theatre teams were using the World Health Organisation's 'safe surgery checklist' which is designed to prevent avoidable mistakes, and this was a well-managed process. We saw some examples of excellent care and staff were largely positive and aware of good practice (for example, the 'butterfly scheme' for dementia care). One ward, Queens 1, covered a broad range of specialities and staff need more support to cover them all.

Intensive/critical care

More can be done to improve quality in this area, particularly on the Critical Care Unit. The unit was using high numbers of agency and bank staff (non-permanent staff) at weekends and nights. We had concerns about the lack of

Summary of findings

space in the unit. The admission areas for the theatres were breaching single-sex guidelines. The trust was not, however, using the Intensive Care National Audit and Research Centre audits programme and we believe it should do this to make sure services are being delivered in line with best practice.

Maternity and family planning

Most women and family members were happy with the maternity services and we saw evidence that they were both safe and caring. The unit was well-led and positive changes were being made and sustained. Women were offered choices and most found doctors and midwives caring, with some exceptions at night. Systems were in place to recognise and respond to emergencies quickly. The hospital cares for a relatively high number of high-risk pregnancies and the midwives we spoke to were passionate about ensuring women got the right care and support. The staff team included a range of specialists to meet the diverse needs of local women. Staffing levels were improving and staff were positive about the service they offered. Some women mentioned delays in the antenatal clinic.

Services for children & young people

Overall this was a safe, caring and well-led service, with some issues around premises. We found contrasts in this area between a well-equipped modern day surgery unit with good facilities, and a cramped and inadequate inpatient ward that staff told us was always “very busy”. Recruitment was under way to help with this. Parents and children were happy with the care they received and we saw good examples of care, compassion and communication. Doctors were visible on the wards and staff told us communication between nurses and doctors was very good.

Discharge arrangements were good and parents said they were well-informed about what was going on. We saw clear evidence that the service was responsive to patient's needs, including clinical governance meetings that included learning from patient feedback and building on lessons learned. We reviewed a number of policies and procedures that reflected best practice guidelines.

End of life care

We found that this service was generally safe, effective and well-led, with multi-disciplinary teams meeting daily to discuss people's needs. The palliative care team had links with the local hospice and we heard examples about where the hospice had worked with hospital staff to help people understand choices about end of life care and treatment. The trust was using the Liverpool Care Pathway and had taken steps to make sure it was correctly implemented. The trust has an end of life care steering group that oversees good practice. We saw evidence of learning from audits of recent deaths to ensure that care and treatment had been appropriately delivered.

Summary of findings

There were some areas for improvement. We saw that not all 'do not attempt cardiopulmonary resuscitation' orders were properly completed. The trust must address this. We also saw an example of a family, whose relative had just died, who were not given enough privacy.

Outpatients

The premises and facilities in some outpatients departments were inadequate. In busy periods people were left without seats and, in some clinics (notably orthopaedics), this meant people were uncomfortable and waiting too long. Some waiting lists were poorly managed and many patients were arriving expecting to wait for many hours beyond their appointment time. Although staff knew there was a regular problem with overbooking, they did not seem to understand why or how this could be better managed. This was not responsive to people's needs.

We saw examples of good care throughout the inspection once people were actually seen. For example, the Chronic Obstructive Pulmonary Disease clinic was run by caring, passionate staff who were having a marked impact on preventing readmissions. Staff across outpatients were caring and friendly, and patients were positive about the care they had received. Comment cards were largely positive and staff liked working there. Services are being transferred from Croydon to Purley Memorial Hospital and this move should result in improvements.

Summary of findings

What people who use the trust's services say

In the inpatient Friends and Family Test in June 2013, Croydon Health Services NHS Trust had a score of 52. This was significantly below the national average of 72. It was also 9 below the figure that the trust had achieved two months earlier.

Although this showed a declining trend in recent months, the trust did have a response rate in June that was higher than the national average. This suggests continuing engagement with the Friends and Family Test and efforts to better understand the views and experiences of patients.

Areas for improvement

Action the trust **MUST** take to improve

- Arrangements between A&E and the Urgent Care Centre, as far as it can.
- Staffing levels to provide care in older people's wards.
- Reduce discharges in the evening, especially for older people, and make sure people are properly dressed before they go home.
- Improve outpatients to reduce waits, ensure there is enough seating, and tell people why they are waiting and for how long.
- Improve care plans to make sure they involve people and reflect their needs.

Action the trust **COULD** take to improve

- Staffing, cover and skills mix (detailed in the report across a number of services).

- Improve continuity of care for patients who are not in the right ward for their condition.
- Develop a stronger attention to detail on key practices – for example infection control, checking fridge temperatures, and responding to equipment audits.
- Improve the accuracy and storage of patient records.
- Support staff to learn from audits, incidents and quality assurance processes.
- Monitor the availability of pain relief – especially for people moving between wards.
- Implement their new 'Do not attempt Cardio Pulmonary Resuscitation' policy.
- Support food choices for people with dementia.

Good practice

Our inspection team highlighted the following areas of good practice:

- The trust faces a significant challenge to improve the quality of care, and needs to change the culture of the organisation and engage staff in this process. They are using the 'Listening into Action' approach which is succeeding in involving staff and allowing them to contribute to finding solutions. We saw widespread evidence that this was bringing about positive changes for patients and staff. CQC inspection team members were consistently impressed by awareness of this initiative and the ability of staff to point to

improvements it was making in the quality of care. The open and transparent leadership demonstrated by leaders in the trust was recognised by staff and is to be applauded, although the proof will be in the delivery.

- Sustained improvements in maternity services.
- The care of people with dementia in A&E.
- The new Acute Medical Unit.
- The way the trust works with social services to support people to go home.
- The Chronic Obstructive Pulmonary Disease clinic, which was working well to prevent avoidable respiratory admissions.
- The palliative care team, who carried out good joint working with a local hospice.

Summary of findings

- The enthusiasm of staff for working at Croydon.
- The caring and passionate attitudes of many staff.

Croydon University Hospital

Detailed findings

Services we looked at:

Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Maternity and family planning; Children's care; End of life care; Outpatients

Our inspection team

Our inspection team was led by:

Chair: Professor Edward Baker, Medical Director, Oxford University Hospitals NHS Trust

Team Leader: Jane Ray, Care Quality Commission

The team of 25 included CQC inspectors and analysts, doctors, nurses, patient 'experts by experience' and senior NHS managers.

We also identified elevated risks around referral to treatment times (18 week waits) and emergency readmissions following elective surgery for respiratory medicine.

This information, along with feedback from people who used the service and information from Croydon Healthwatch, and local Clinical Commissioning Groups, helped us decide where to look during our inspection.

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)

Why we carried out this inspection

We chose to inspect Croydon as one of the Chief Inspector of Hospitals' first new inspections, due to risks identified by our 'Intelligent Monitoring' and resulting concerns about the quality of care.

We were particularly worried about poor patient experience. The trust's scores in the national inpatient survey for 2012/13 were among the worst in the country.

Detailed findings

- Surgery
- Intensive/critical care
- Maternity
- Children's care
- End of life care
- Outpatients.

Before visiting the inspection team looked at lots of information held by CQC about the trust and asked other organisations to share what they knew about it. This information was used to guide the work of the inspection team during the announced visit on 17 and 18 September 2013.

During the announced visit the team:

- Held focus groups with different staff members from all areas of the trust.

- Looked at the personal care or treatment records of a sample of patients.
- Observed how staff were caring for people.
- Talked with patients, carers, family members and staff.
- Interviewed staff members.
- Reviewed information that we asked the trust to provide.
- Held a public listening event in Croydon, where patients and members of the public shared their views and experiences of the trust.

The team would like to thank all those who attended the focus groups and listening events and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Are services safe?

Summary of findings

While most services were delivered safely, the Accident & Emergency department must be improved. It is crowded, badly designed, and staff vacancies are high. The 'Urgent Care Centre' (which is not run by the trust) is not safe and we are taking action against it.

We are concerned about staffing levels in some parts of the hospital and whether they always have enough skilled, experienced staff to deliver safe care. There were not enough staff in wards for older people and this must improve.

Our findings

Accident and Emergency

In its current state the A&E environment is not suitably designed or adequately maintained. It was generally cramped and lacked some lines of sight between staff and patients. The general decoration was in need of attention. Much of the paintwork was chipped and plaster was crumbling in places.

There is a 16 bed ward for observing patients who are expected to stay less than 24 hours. This observation ward was not suitable for patients. It was very cramped and the layout made it difficult to observe patients. There were no separate male and female bathrooms. Two patients said they found the bathroom area difficult to use. The floor was damaged in places and taped down – making cleaning more difficult and creating a risk of infection.

Staff vacancies are high within A&E. At the time of our inspection, there were six consultants but funding was available for up to 10 consultants. This would bring the department up to the level recommended by the Royal College of Emergency Medicine. The trust was actively recruiting but had not yet been able to fill these roles.

There were 44 nursing vacancies out of a total whole time equivalent (WTE) staffing of 100. Six band 6 nurses were starting work the week following the inspection. The trust also said it had other staff starting shortly, was having an open day, and was confident of filling its Band 5 vacancies.

Urgent Care Centre

Adults who walk into A&E (rather than arrive in an ambulance) have to report to a reception desk that is operated by staff who work for Assura Wandle LLP, a separate provider running the trust's Urgent Care Centre. People with certain conditions (for example, chest pain) should be sent straight through to A&E staff. The agreement is that other people must be assessed (that is, have their condition reviewed in order of urgency) within 20 minutes by a care professional from Assura Wandle.

We saw a summary of two serious incidents where patients waiting more than 20 minutes may have contributed to their deterioration. We were so concerned about the potential impact of this on patient safety that we are taking action and ordered an urgent inspection of the Urgent Care Centre. Although the Croydon University Hospital staff are trying to work in collaboration with Assura Wandle, the provision of care was not safe.

It should be noted that children are always triaged by the trust's A&E staff, not by Assura Wandle.

Staffing

The trust has acknowledged that its highest priority and biggest challenge is making sure there are enough permanent staff with the right skills and experience to deliver consistently safe and high quality care. Our team of inspectors could see that recruiting permanent staff is an enormous challenge for the trust, but one that they are actively working to address.

The Director of Nursing told us that each day a report is sent to senior management showing if there are enough nursing staff in each ward and department. This works well in ensuring that agreed staffing numbers are maintained, highlighting any gaps, and arranging extra staff if any patients need one-to-one care. The Chief Executive told us that they have reviewed the staffing levels in the Acute Medical Unit and were now reviewing A&E and intensive care.

The one area where there were not enough staff was the wards caring for older people. The qualified nurses in the focus group agreed. On these wards, we could see patients waiting to be seen. The patients told us they needed to wait a long time when they rang their buzzer. Healthcare assistants were providing most of the personal care and they said they were finding it difficult to do things on time,

Are services safe?

such as turning patients at risk of developing a pressure ulcer. From the staff rotas, we found that some shifts in the previous two weeks had had no permanent qualified nursing staff on duty.

We asked for the numbers of bank and agency staff used by the trust in nursing, midwifery and healthcare assistant roles. There had been 267 WTE (whole time equivalent) bank staff in April 2013. This gradually reduced to 229 in June 2013 but rose again over the summer. There had been 122 WTE agency staff in April 2013. This went down below 100 in June, but again rose over the summer. While many of the bank and agency staff had worked in the trust before, staff and some patients said that they do not provide the same consistency and quality of care.

We also asked for the number of vacant posts. We were told that previously a fifth of posts had been deliberately been left unfilled. However all of them were now in the process of being filled. There were 315 WTE vacant nursing and midwifery posts when we inspected, a quarter of the total establishment. There were also 34 WTE vacant medical and dental posts, which was 7% of the establishment.

Senior staff told us they were working closely with schools of nursing to attract new graduates, looking to recruit from abroad, and making the recruitment process as smooth as possible. They were keen not to compromise on the quality of recruits. They were also focusing on some key areas such as A&E where the vacancies were higher. It was positive to hear the student nurses say that they would be happy to work at the trust once they had qualified.

The Chief Executive explained that they are working towards having one extra qualified nurse on every shift across the trust. Fifty qualified nurses started in September 2013. We were told that the quality of the staff was generally good and the recruitment process had been thorough.

We also looked at the staff skill mix. The trust is working towards a ratio of 70% qualified nurses to 30% healthcare assistants on the wards. The ratio of qualified staff is higher in some departments such as intensive care. They are also reviewing the mix of roles needed to care for people with more complex needs. Some staff said that, while they welcomed the extra qualified staff, it was also important to look at the overall staffing numbers. This was also the view of the specialists in our inspection team.

In a recent staff survey, some staff had complained about working excessive hours. However, the staff we talked to did not raise this as a concern and there was nothing to suggest they were put under pressure to work too many hours.

Medical cover at night and weekends

We knew that obtaining support from an appropriately qualified doctor out of hours was an area of concern for the trust. Since mid-August 2013 the trust has been operating the 'Hospital at Night' programme. This is a national programme to ensure patient safety and the effective use of staff at night. At Croydon University Hospital it operates from 8.30pm till 8am. It includes a fixed handover to ensure acutely ill patients are passed to the appropriate clinician.

The consultant cover in the evening and weekend has also been reviewed and extended. We talked to junior doctors during the day and in the late evening. They said that with the Hospital at Night programme and current consultant cover, they feel adequately supported. Senior staff in the trust would like to see this cover extended further, but the new arrangements represent positive progress.

Patients on the 'wrong' ward

Patients and staff raised this issue with us during the first day of our inspection. A number of patients were not on the correct ward for their treatment, because a bed was not available. In particular medical patients were being put on surgical wards. In the previous six months, there had been between 3.5 and 4.4 beds occupied in this way each night on three surgical wards. Patients told us how they felt they had been "lost". Medical staff described the difficulties of locating their patients and the time this takes.

The trust explained that each morning they hold a "white board" meeting on the wards. This covers all patients, including those who are on another ward, and so they should not get "lost". The Director of Nursing also said that ward managers now have more non-clinical time, so they can make sure ward rounds are carried out effectively – especially if several different teams are coming onto the ward. The Chief Executive said that numbers of patients affected in this way are monitored on a daily basis.

While we did not find any evidence of patients not receiving treatment as a result of being on the 'wrong' ward, there is clearly a risk that their treatment might be delayed. This needs to be monitored.

Are services safe?

Ward moves

Patients during the inspection and at the listening event told us about the numbers of ward moves they had experienced. These sometimes took place late in the evening. For the six months to September 2013, 14% of patients were cared for on two wards and 3% on three wards. A small number were cared for on four to seven wards. (These numbers excludes the Acute Medical Unit, which is a short-stay ward.) These are not excessive numbers, but they need to be monitored as they can affect patients' experiences.

Use of escalation wards and planning for the winter

The trust has two wards that can be opened at short notice. These are called escalation wards. Several staff and patients raised concerns with us about them. When we inspected, one of the escalation wards was open, but for patients from another ward that was being refurbished. We were told that one of the wards had been opened for 24 hours the previous week. A junior doctor said that this had been staffed by agency and bank nurses and had been "very disorganised". The Chief Executive said that they were aiming to reduce the use of inpatient beds and to ensure when escalation wards are used that is done in a planned manner.

Staff told us that managing last winter, when the numbers of admissions rose, was very difficult. The Chief Operating Officer described the plans to manage this year's winter pressures. This includes recruiting a permanent team of staff to open an escalation ward. We felt that this planning process was sufficiently robust, and if implemented fully should enable patients to get inpatient care if they need it during the winter.

Equipment

Equipment had been an area of concern in previous inspection reports. We found that there was enough equipment throughout the trust and that it was in a good state of repair. There was a programme of ongoing maintenance checks, and ward managers had a budget to order replacements as needed. Any national alerts about a piece of equipment are implemented and monitored through the patient safety committee. A few staff said that they would like to see some additional equipment, but we did not hear of anything that would directly affect patient safety.

We found that the resuscitation trolleys in most parts of the trust were being checked each day and out of date equipment replaced. In a couple of places, such as Fairfield 1 ward, the checks had shown that some equipment was missing, but this had not been replaced. The trust needs to make sure that, where the daily checks identify the need for some action, it happens.

Medicines

Medicines had been another area of concern in previous inspections of the trust.

We found that there were appropriate arrangements in place for obtaining medicines. The pharmacy department was open seven days a week and there was a satellite pharmacy on the Acute Medical Unit. There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. On average in the previous six weeks, 95% of prescriptions were dispensed within the target time of three hours. There was a pharmacist on call out of hours, and senior staff on site had access to an emergency drug cupboard. An independent retail pharmacy in the main reception dispensed prescriptions for outpatients. This meant that both inpatients and outpatients had access to medicines when they needed them.

Medicines were prescribed and given to people appropriately. The prescriptions and records of administration that we looked at were clear and complete. This showed that people were receiving their medicines as prescribed.

Medicines were managed safely, and the quality of prescribing was monitored. Pharmacists visited most wards and there was evidence that medicines were reconciled on admission. Pharmacy staff checked if patients' own drugs could be reused and clinical interventions were recorded. We saw that regular antibiotic audits were undertaken to promote prudent antimicrobial prescribing. The latest audit, in July 2013, showed that 93% of antibiotic prescribing met the relevant guidelines, which helps reduce resistance and the incidence of healthcare associated infections.

We saw that nurses had written guidance to help make sure people were given the correct advice about their

Are services safe?

medicines. Each person was given a business card with a contact number for the pharmacy's medicines information line. This meant that patients had clear information on how to take medicines after leaving trust.

Medicines were stored securely in locked cupboards in all the areas we visited. However, the trust should note that, although the actual temperatures of the medicines refrigerators were being recorded daily, staff were not recording the maximum and minimum temperature on five out of six refrigerators checked. Therefore the trust could not assure itself that medicines had been stored at the correct temperatures and were safe to use.

We checked the emergency drugs on each of the areas we visited. Records showed that they were checked daily and we saw there were no expired medicines. However, the trust should note that the opening dates of liquid medicines were sometimes not being noted, and therefore it was not possible to determine if these medicines were fit for use.

Infection control

It had been suggested in a staff survey that there were not enough facilities for hand washing. However, we did not find this. There were wash basins available and enough supplies of hand gel for staff and visitors. All areas of the trust that we visited were clean. Staff in all areas had access to protective equipment such as disposable gloves. Where equipment such as commodes had been cleaned, they were tagged so that staff knew they were ready to use again.

We observed almost all staff following the procedures to maintain standards of infection control. However, we did see a couple of cases where this did not happen. In one instance, a member of staff took blood without wearing protective gloves.

We could see there were clear infection control procedures, an infection control lead, and regular in-depth infection control audits with the results fed back to the wards. The trust's infection rates for *Clostridium difficile*, MRSA and MSSA were all statistically within range. Any cases are discussed fully at the Infection Control Committee and confirmation of the measures taken are noted.

Staff were clear on the procedures they would follow if there was an outbreak of an infectious disease. Where there was a trust-acquired infection, we saw that there was an in-depth analysis to establish if there are any areas for

improvement. We saw a few of these reports and they were completed very thoroughly. From May to July 2013, 13 patients in intensive care were found to be infected bacteria called Glycopeptide Resistant Enterococci. This had been reviewed and a number of measures put in place to manage the outbreak. This had been appropriately discussed at the For Learning and Action Group (FLAG) and reported at Board level.

Never events

Never events are mistakes that are so serious, they should never happen. The trust reported one never event between August 2012 and July 2013 which was an error in oral surgery in April 2013. We confirmed that the surgical team were using the World Health Organisation checklist as part of their regular procedures to reduce the risk of never events.

Safeguarding people from the risk of abuse

Between June 2012 and May 2013 there had been 49 notifications of abuse at the trust. We found that staff demonstrated a good understanding of abuse and safeguarding procedures. The Director of Human Resources and Organisational Development told us that 100% of staff that needed to complete level 4 safeguarding training had done so; 70% had completed the other levels. This is being monitored on a monthly basis. There was information available in all the wards and departments about how to escalate concerns. A safeguarding lead and safeguarding board meets four times a year. The feedback from the local social services department was that the trust works well with the council and makes appropriate safeguarding referrals.

Other safety indicators

We checked a range of other safety indicators and none raised concerns for this inspection. We did, however, note increases in the number of pressure ulcers and blood clots in April 2013. As part of our inspection we looked at what steps are taken to reduce the risk of these outcomes.

The records of the Patient Safety Committee at the end of July 2013 showed there had been 39 pressure ulcers within the trust since April 2013, although the numbers of grade 3 pressure ulcers was reducing. The trust recognises that is still too high and is making sure all nursing staff receive appropriate training by the end of the year.

We saw good practice in the prevention and care of patients with pressure ulcers, including appropriate risk

Are services safe?

assessments, care plans and use of equipment. We were told that patients with a pressure ulcer have access to specialist tissue viability advice if needed. We did, however, find that records about repositioning patients had not always been completed. It was not possible to know if this was a recording issue or if patients were not being repositioned. The care of people with pressure ulcers is audited, but this issue had not been identified. We also found that people at risk of pressure ulcers did not always have a record of being reassessed as often as was needed.

The numbers of patients with blood clots has fallen. We saw that all patients have to be medically assessed for the risk of blood clots when they are admitted and an electronic alert will be made if this does not happen. This means that patients at risk of developing blood clots should be identified and care plans put into place.

We were not able to decide the reasons for an increase in April 2013 of pressure ulcers and blood clots, but we noted that this coincided with a period of high use of bank and agency staff.

The Patient Safety Committee has noted that the number of falls has increased since April 2013, but the numbers of patients experiencing moderate injury is very low. A weekly “falls safety” multi-disciplinary team review the care provided to patients who have experienced more than one fall.

We could see that the trust monitors the numbers of patients with a catheter in situ and this is below the national average.

Are services effective?

(for example, treatment is effective)

Summary of findings

Services are largely delivered effectively and outcomes for patients are within expected ranges. We found no evidence of concerns about mortality rates or infection rates. Quality assurance (including audit findings and lessons learned meetings) is not always well understood at ward level.

Our findings

Performance indicators

Before we inspected Croydon University Hospital, we looked at a range of indicators about its performance. These raised two areas for us to explore in more detail:

- A higher risk of patients with respiratory illnesses being readmitted following elective treatment.
- A higher than expected rate of stillborn babies and deaths of new born babies.

When we checked both of these indicators across a range of disciplines in the trust, we concluded that neither of them was correct. Instead, they were related to coding issues.

In respiratory medicine we found good practice to reduce the admissions of patients with respiratory conditions. A clinic had been set up each day on Heathfield 2 Ward to help patients with chronic obstructive pulmonary disease

(COPD). Patients could be referred by their GP or could self-refer if they were already being treated by the respiratory team. Patients referred before 11.30am could usually be seen on the same day and assessment and treatment provided promptly. A consultant told us that the introduction of this clinic had led to a decrease in admissions to the respiratory ward by 11%.

The concerns about babies had led to a review of the 28 cases involved. Only two cases should have been coded as death of an unspecified cause and these were being reviewed further. Twenty-six out of the 28 cases reviewed had been incorrectly coded and the cause of death was related to maternal factors and complications of pregnancy, labour and delivery.

Storage and management of patient records

At the time of our inspection the trust was about to implement the Cerner system. This is a very significant development that will affect patient systems, including patient records. It will be introduced in a number of stages.

As we walked around the trust we looked at the storage of patient information. Most records were stored securely in lockable cabinets on wheels. We did notice a few records left very much in open view. We also found that some information kept at the end of the patient's bed might have been better in the records that are kept locked. This included photos of pressure ulcers. We also noted that some written records were held together with only a tag, and they were falling out of the folder. This means that there is a risk that important records might get mislaid.

Are services caring?

Summary of findings

Most people we spoke to were positive about their care. Much of the care we observed during the inspection was good. However, we have concerns about outpatients and about there being too many discharges – particularly of older people – in the evening. There have been serious problems with patients' experience of care in the past (including some recent cases that were not acceptable, including some raised at our listening event) and there needs to be evidence of improvement here. But other patients were full of praise for staff, and the staff themselves wanted to make clear that there had been real improvements in recent months.

Our findings

We focused heavily on this question throughout the inspection, as the trust had performed worse than any other trust on seven out of the 10 sections in the NHS inpatient survey for 2012. The trust was also in the bottom 20% of the recent Cancer Patient Experience Survey.

Since April 2013 the trust has started to use the Family and Friends test. This is a national initiative supporting trusts to get feedback from their patients. It asks patients if they would be likely to recommend the trust to their family and friends. Croydon Hospital is gradually using this test more frequently. In recent results, satisfaction with the trust is below the national average. However, the test is new and the results cannot yet be used with confidence.

Discharge arrangements

The trust has a number of initiatives to prevent people being admitted and to help plan their discharge:

- Social workers who work in A&E to help patients receive the treatment they need at home.
- The Acute Care of the Elderly Pilot Project, a multi-disciplinary team that helps support patients and plan their discharge.
- The Hospital Avoidance Team which supports patients who need a lot of planning for their discharge.
- Short-term support by the Red Cross and Age UK to help people do not have a package of care to manage when they get home.

However, patients and relatives had a number of areas where they were not happy with the discharge process. A small number told us that patients had been sent home too soon. Some felt they had to wait too long on the ward after they had been told they could go, as they were waiting for their medication.

We were particularly concerned about older patients being discharged in the evening or at night. In August 2013, 244 non-elective patients over the age of 65 were discharged between 6pm and 9am. The Chief Executive told us that a small trial was looking at preparing prescriptions the day before for patients who were going to be discharged. This had shown a very significant improvement in patients being able to leave earlier on their actual day of discharge.

We visited the discharge lounge several times. This had just been relocated and decorated. It was positive to see that staff were available to oversee patients waiting for discharge and provide support if needed. They also maintained contact with the provider who arranged the transport. Hot drinks and a packed lunch were available. There was no disabled toilet, although there was one further down the corridor. Reclining chairs had been ordered but anyone who needed to lie down had to wait in their ward. We did see that some patients had to wait in the lounge for a few hours and some were only dressed in their nightclothes. This was not warm for them, or dignified.

The waiting times for discharge and the time of day that discharge takes place needs to be improved as it impacts on patient care.

Respect, dignity and privacy

Throughout our visits, we saw that people generally had their privacy respected. Do not disturb signs were being used well to hold curtains together and staff were conscious of the need to close curtains and doors when supporting people with their care and treatment.

Most of the patients, relatives and friends we talked to at the trust were positive about the staff. Many said they were “caring”, “compassionate”, “friendly”, “helpful” and “supportive”. Some people at the Listening Event also spoke very positively about the care they had received.

However, during our visits and at the Listening Event, a small number of people talked about their negative experiences. This included staff speaking over patients in a foreign language, staff carrying out an observation without speaking to the patient, and staff not responding to

Are services caring?

patients calling on their buzzer. The trust told us that they are working to make sure staff have the right attitude and approach when caring for patients. This includes training in customer care using actors, which staff told us was very good.

We concluded that most staff working at the trust are caring for patients very well, but there is still a small number who do not have the correct attitude or approach. The trust is working to address this unacceptable behaviour.

Pain relief

Most patients we talked to felt they had received the correct pain relief, especially after surgery. A very small number of patients mentioned not having enough pain relief. This was often associated with moving from A&E to a ward.

Meals

Patients were generally very positive about the meals that are provided. The menu has choices for people from different religious and cultural backgrounds. The wards operate protected mealtimes, so that patients can eat their meals without interruption. People who need help are given their meals on a red tray so that staff can spot this more easily. Patients with dementia were asked what they wanted to eat, but being shown a visual menu might be easier for them to make a choice.

Cancer Experience Survey

We were told that changes are being made as a result of the recent Cancer Experience. There has been positive feedback about inpatient and outpatient care, but patients with cancer are still not satisfied with the care provided in A&E. A new care pathway is being established for these patients, which it is hoped will address concerns.

Do not resuscitate decisions

Three families the Listening Event raised concerns with us about a lack of clarity about 'do not resuscitate' (DNR) decisions. We looked at the records across a number of wards. There were a few records which had not been correctly completed. For example on two wards one DNR

form had been signed but not dated by the doctor. On another the form did not include a record of a discussion with the patient or their relatives, and no date had been set for the decision to be reviewed. We were told that the policy about DNRs had been reviewed and was starting to be implemented.

Care planning

We looked at patients' care plans across the trust. On the medical and surgical wards we found a number of patients where assessments were completed but the care plans did not reflect the patient's needs.

At the Listening Event, relatives of patients with dementia told us about how they did not feel involved. Most patients said they were well informed about their care and had appropriately consented to treatment where needed. However, a few though said that they had not had their treatment fully explained. On the older people's ward we found that the section in care plans to record the patient's views or their relatives had been left blank.

Care in outpatients

Some of the outpatients clinics were very well organised. Patients only had to wait a short time and were very satisfied with their experience.

However, in the fracture clinic and an orthopaedic clinic, there were not enough seats and people had to stand. Patients and their relatives and friends were becoming anxious about car parking. Patients were not always told how long they were going to have to wait. In the ante-natal clinic people were sometimes waiting more than half an hour, which was difficult hard if they had children with them.

When we asked staff about the delays, they said that in some cases the clinicians were still in ward rounds or multi-disciplinary meetings and so were never available for the start of the clinic. Some clinics were deliberately overbooked. We were told that work is starting on the scheduling of outpatient clinics, beginning with the Ear Nose and Throat clinic.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The hospital needs to do more to be responsive to people's needs, particularly in A&E (while four-hour targets are currently being met, a high number of people are being discharged just before four hours is up) and for appointments for orthopaedics and eye conditions (both areas the trust has already taken steps to improve). Some parts of the hospital are in poor condition and this means care is not delivered as effectively as it could be.

Our findings

Before we carried out our inspection, we looked at a range of indicators for the trust. This raised two main issues to explore in more detail:

- Compared to other trusts, more patients in A&E being either discharged or admitted just before the four hour target.
- Trauma and orthopaedic patients not having their first appointment within the 18 week target after being referred.

A Department of Health national target says that 95% of patients who attend A&E should be treated within four hours and then either be discharged or admitted to hospital. Since May 2013 the trust had mainly been meeting the target. However, in the three weeks before our inspection, there were four days out of 21 when the target had not been achieved.

Staff told us that they felt the pathways out of A&E were now working well. We saw that patients who needed to be admitted were going to the Observation Ward and the Acute Medical Unit as well as other wards as needed.

We spoke to a number of staff about the orthopaedic delays. They said that a new consultant specialising in soft tissue knee surgery is now in post and extra outpatient clinics are taking place at the weekend. This is helping the trust move towards meeting the 18-week target.

Separately, patients told us that they were unhappy about how long it had taken to get an appointment for an eye

condition. We asked the trust about this and we were told that the need for this service to improve had already been recognised. The service is going through a transition to be provided by Moorfields at Croydon University Hospital.

Hospital premises

The trust is reviewing the trust's buildings and considering options for changes. Some of the facilities we visited were newly refurbished, such as the Acute Medical Unit. Others were in a poor state that affected patient care.

The Chief Executive explained that there are three key areas for redeveloping the estate:

- A&E, where a bid for funds is being submitted to the trust Development Authority. We fully support this bid, as the current layout does not allow a smooth flow of patients and presents significant challenges for staff delivering treatment. Also the Observation Ward next to A&E is too crowded and does not have separate male and female bathrooms.
- The Critical Care Unit, where we too were concerned about the lack of space.
- The Women's and Children's Wing.

We were also concerned about:

- Parts of outpatients that were very dark and had a shortage of seating. The Chief Executive said that the League of Friends had raised money to redecorate these areas.
- The poor condition of Rupert Bear Ward for children. A plan is being explored to relocate this ward next to the children's day surgery unit.

The Deputy Director of Estates told us about funding that has been made available to refurbish the Wandle wards. This is so they can meet the needs of people with dementia. Plans are also underway to upgrade the ground floor of the cardiac unit.

From speaking to senior staff and reading the strategy for the trust's estate, we recognise there are some very fundamental issues with the infrastructure that are being tackled to keep people safe. This includes resolving issues with temperature control and basic ongoing maintenance.

While there were major challenges with the infrastructure at the trust, the senior team were aware of this and were seeking solutions.

Are services well-led?

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

Summary of findings

The trust's new senior management team has made impressive strides in the past six months in particular. Staff wanted to tell us about the impact they have made. More evidence of sustained improvement is needed, but we saw and heard many positives. Complaints are not always responded to within an appropriate timescale, and some patients told us staff were defensive when responding to their concerns.

Our findings

Leadership

Patients, staff and stakeholders had many positive messages for us about the improvements that are happening and how this is leading to changes in the care and treatment given to patients. We were told how the Chief Executive and his senior managers are accessible and open. The Chief Executive, for example, providing a direct email address where patients can contact him.

Staff also said they see senior staff visiting parts of the trust as part of their work to assure themselves of the quality of care being provided, and welcomed this.

The main approach to improvement is called 'Listening into Action'. This is where groups of staff come together to identify how services can improve. This is proving to be very successful. This has already led to lots of "quick win" initiatives which are improving the delivery of services. Staff said how they can see the changes happening and welcome being part of this process.

We noticed a very positive atmosphere in the trust. Staff said how much they enjoyed working there. Junior doctors and student nurses told us that they had been made very welcome and would like to work at the trust in the future. A few staff were very unhappy about the changes taking place but they are a small minority. Senior staff said they were aware of these concerns and were working to address them.

Clinical leadership is being reviewed, and clinical directorates are being reconfigured. The trust is aiming to work more closely with other trusts, with for example more joint appointments of consultants where this will improve patient care.

Complaints

The trust is working on two main areas:

- Speeding up replies to complaints. In recent months only about half of complaints had been responded to quickly enough (within the target of 25 days).
- Improving how they address complex complaints.

At the Listening Event, patients and carers told us they did not feel there had been good communication or they had not received an apology. Some of these people had met with staff from the trust and in some cases had found them defensive. The trust acknowledged that there is further work to be done to make sure this process goes as well as possible.

Training and development

All new staff including bank staff need to complete a corporate induction before starting work. Staff told us this was very comprehensive. Agency nurses are inducted by their agency and then receive an introduction to the ward when they first work there. This ward-based introduction is not recorded or monitored.

There is then a programme of ongoing mandatory training. At the time of our inspection 91% of staff had completed the health and safety training. Around 70% of staff had completed the other mandatory training. Staff do however need to complete this training in order to be paid their annual incremental pay rise. Some staff did tell us they needed to complete their training in their own time.

We were told that at the time of our inspection 75% of staff had completed their annual appraisal (this figure was higher for clinical staff).

We were told about leadership training for ward managers and this was very well received.

We asked about the training on specific topics to help staff meet the needs of patients. This included training on pressure ulcers, dementia, caring for people with learning difficulties and palliative care. These all had nurse leads within the trust and they were rolling out training. The aim for the training on pressure ulcers is for this to be completed for all nursing staff and health care assistants by the end of March 2014. Other specific training has been focussed in a few areas, for example staff working in the dementia bay in A and E have received dementia training. We did however find staff caring for people with specific needs who had not received this training. We were told that

Are services well-led?

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

232 staff had received training on dementia and 286 staff had received training on supporting people with learning difficulties. Staff need to be supported to understand good practice in meeting people's specific needs so they can deliver high quality care.

We also asked about the training that had been provided to enable staff to understand the Mental Capacity Act and Deprivation of Liberty Safeguards. We were told that so far 67 staff had received this training – but most of the staff we spoke with did not show a good understanding of this legislation. The wards are however supported by social workers who can assist the ward staff in the use of this legislation. Staff do need more training in order to ensure they uphold people's human rights when important decisions are being made about their care and welfare.

Learning from incidents

Staff said they know how to report incidents. The Head of Patient Safety and Risk reviews these on a daily basis and once a week the Executive Team decided which ones need to be formally investigated. There was a backlog in these investigations but this was being addressed. We found that in some areas staff were able to tell us about incidents that had occurred in their area of work and the lessons learnt. However, staff in other wards were not aware of these and the learning had not been shared.

Governance

Croydon University Hospital has a thorough governance process in place that incorporates a wide range of steering groups, clinical audit groups and taskforces looking at a number of areas that impact on the safety of care received by patients. These carry out audits, review data and feed their findings through a number of committees to the Quality and Clinical Governance Committee. We looked at the minutes of three of these meetings and saw how all the information was given detailed consideration and action plans put into place where needed.

As part of our inspection we asked staff in wards and departments about how this quality assurance process fed back to them and whether they had opportunities to learn from these audits. In some departments staff were able to tell us how they discussed the results of audits, lessons from incidents and complaints as part of team meetings and considered how they would put this learning into practice. In other wards staff had very little awareness and did not understand the quality assurance information displayed in the ward. When we spoke to senior staff they recognised this as an area for further development within the trust.

Accident and emergency

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The Accident and Emergency (A&E) department provides emergency care for local patients and visitors. It works alongside the Urgent Care Centre, which is operated by the private provider Assura Wandle. There is a separate department in A&E for children under 16. We visited all parts of A&E and talked to 15 patients and nine members of staff.

Summary of findings

We consider that A&E must be improved. While staff employed by Croydon University Hospital were well-motivated and tried hard to make the arrangement work, the department has high staff vacancies and the environment in A&E made it hard for staff to deliver good care. The building was badly laid out and lines of sight were poor. The observation ward was very crowded. The trust has applied for funding to rebuild its A&E and we believe this would make a big difference to patients' experience.

In addition we had serious concerns about A&E and the way in which patients move between the Urgent Care Centre (UCC), which sees people when they first arrive, and the hospital. The UCC is run by another provider against whom we are taking action. The commissioners of this service must ensure that what they commission meets the needs of local people.

Staff were, however, positive about changes to care pathways and about the training and support they were receiving. The dementia zone was singled out as an example of good practice.

Accident and emergency

Are accident and emergency services safe?

Patient safety

Adults who walk into A&E (rather than arrive in an ambulance) have to report to a reception desk that is operated by staff who work for Assura Wandle, the separate provider running the trust's Urgent Care Centre. People with certain conditions (for example, chest pain) should be sent straight through to A&E staff. The agreement is that other people must be assessed (that is, have their condition reviewed in order of urgency) within 20 minutes by a care professional from Assura Wandle.

In the children's A&E, a trained nurse employed by the trust provides a formal assessment and triage service between 8:00am and 12:00 midnight. Some staff expressed concern that, on the children's A&E, paediatric trained staff were not available 24 hours a day.

We saw a summary of two serious incidents where patients waiting more than 20 minutes may have contributed to their deterioration. Because of our concerns we arranged an immediate inspection of the UCC. Although Croydon Health Services trust is not responsible for the UCC, we must report that patients were not being seen quickly enough by appropriately qualified staff.

Most of the staff we talked to said that this provision of care for adults is not safe. If patients are not assessed in 20 minutes, some patients who require rapid tests and interventions to prevent their condition from deteriorating may not receive them promptly. Staff also told us that some people were wrongly sent to the UCC instead of A&E.

Staffing

There are staff shortages within A&E. At the time of our inspection, there were six consultants but funding was available for up to 10 consultants. This would bring the department up to the level recommended by the Royal College of Emergency Medicine. The trust was actively recruiting but had not yet been able to fill these roles. They did also explain that although there are only six consultants, they have extra sessions of working time, resulting in the equivalent of eight consultants whole-time cover.

There were 44 nursing vacancies out of a total whole time equivalent (WTE) staffing of 100. Six band 6 nurses were starting work the week following the inspection. The trust also said it had other staff starting shortly, was having an open day, and was confident of filling its Band 5 vacancies.

Staff told us that one of the reasons they had difficulty recruiting staff was because the UCC treats patients with minor injuries and illnesses. This meant that they could not offer staff a full A&E experience, making them less attractive to potential employees. Due to the challenges of recruiting senior nurses, posts had to be filled by more junior staff.

We were told that the trust had adopted a 'grow your own' approach to give junior nurses the skills they might need. It introduced a Foundation of Emergency practice programme with St Georges Hospital in Tooting. Two senior nurses were allowed to spend half of their time developing their roles as practice development nurses.

Are accident and emergency services effective? (for example, treatment is effective)

Hospital premises

In its current state the A&E environment is not suitably designed or adequately maintained. It was generally cramped and lacked some lines of sight between staff and patients. The general decoration was in need of attention. Much of the paintwork was chipped and plaster was crumbling in places.

There is a 16 bed ward for observing patients who are expected to stay less than 24 hours. This observation ward was not suitable for patients. It was very cramped and the layout made it difficult to observe patients. There were no separate male and female bathrooms. Two patients said they found the bathroom area difficult to use. The floor was damaged in places and taped down – making cleaning more difficult and creating a risk of infection.

In a CQC survey of patients in 2012, the trust had performed worse than the national average in terms of cleanliness. However, when we visited A&E was generally clean.

Accident and emergency

The trust has acknowledged that the layout and decoration of the department is not ideal and a bid is being prepared to the trust Development Authority for funds to upgrade the area.

One positive development was the 'blue zone', a newly refurbished area specially designed to meet the needs of people with dementia. For example, it uses different colour paints to make the toilet door easily visible. The area is still not ideal as it is located on a corridor.

The children's A&E area was brightly coloured, with toys for the children to play with.

Are accident and emergency services caring?

Discharge arrangements

The department had a number of positive initiatives to help people be discharged promptly:

- An A&E liaison team, which worked with patients in the first 48 hours after their arrival and making sure they had rapid access to any assessments and support they needed to be discharged.
- Working closely with the elderly care colleagues as part of the Acute Care of the Elderly (ACE) project. This team, which included a nurse, doctor and a care of the elderly consultant, aimed to review elderly people over 80 with a view to discharging them home safely within 24 hours.
- An ACE clinic to follow up on people discharged and make sure their discharge was safe and effective.
- People over the age of 80 being referred directly to a care of the elderly consultant.

Patient feedback

Patients in A&E and patients in the Acute Medical Unit (AMU) who had been treated first in A&E told us they were happy with the care they had received. One person said, "So far the stay has been fairly good. They have kept me informed." Another told us that the staff had been nice. However, one person on the AMU said that they had waited for a long time before they were triaged.

Respect, dignity and privacy

We saw for ourselves that staff on the observation ward usually talked to people in a respectful manner and helped people when they needed it. However, we did see one patient walking unsteadily to the toilet without being offered any help.

The trust covers a population that is very culturally diverse. When we asked staff how they met the needs of people whose first language was not English, they explained that there was an interpreting service available and that they used a number of staff who spoke different languages.

Are accident and emergency services responsive to people's needs? (for example, to feedback?)

Response to emergency situations

The Department of Health's national target for A&E is that 95% of people should be seen and treated within four hours. The trust had largely been achieving this target from May 2013 and through the summer – but not in the previous five months. We were told that the trust has carried out winter planning to try and make sure it is able to meet the target this winter (2013/14).

However, in the three weeks before the inspection the 95% target had not been achieved on four days out of 21, in respect of all admissions (including the UCC). For admissions just to the major A&E department (in other words, excluding the UCC's minor injuries and illnesses), the target was missed on 11 days out of 21.

Waiting times

Staff told us that some patients stayed on the observation ward longer than 24 hours, and they were concerned that patients had been inappropriately placed on the ward at times. On the day of our inspection, all of the patients met the admission criteria and only one had been on the ward for more than 24 hours.

Staff felt that most pathways out of A&E were working well. However, the trust may find it useful to hear that, when we asked if there was a specific fast response pathway for patients with a hip (neck of femur) fracture, we were told this was not in place.

Are accident and emergency services well-led?

Training

The nurses we talked to said they felt supported in their roles and they had good access to training.

Accident and emergency

We saw that the trust's management was supporting nursing staff to develop their skills, as well as checking their competency. For example, an audit had looked at the quality of triage. Staff took retraining sessions to make sure they had the necessary skills. When new staff reached the necessary competence, they would receive 20 hours of supervised practice.

We were told that new staff arriving in the department received a two-week induction. A recently qualified member of staff confirmed they had received this.

We were also told that specific subjects would be discussed at team training days – for example, the team recently discussed the recognition and management of patients with sepsis. We were told that staff had received specific training to help them understand the needs of people with dementia, and this was confirmed by the nursing staff we talked to. Staff thought that the 'blue zone' had made a real improvement in how people with dementia were supported.

Medical care (including older people's care)

Safe

Effective

Caring

Responsive

Well-led

Information about the service

A number of wards offer general and specialist medical care to patients, such as people who have had a stroke, people with respiratory illnesses, people with diabetes and frail older people.

We made both announced and unannounced visits as part of our inspection of these wards. We visited the Acute Medical Unit (AMU), often the first ward for patients admitted via A&E, and seven other medical wards: Purley 1, Purley 2, Heathfield 1, Heathfield 2, Fairfield 2, Edgecombe 2 and Duppas wards. We also visited four wards for older people: Purley 3, Wandle 2, Wandle 3 and Queens 3, and a Cardiac Catheter Suite. We visited the discharge lounge where some patients waited for transport to take them home.

We talked to more than 60 patients, 16 relatives and friends, and more than 60 staff, including registered nurses, health care assistants, ward managers, doctors, consultants and receptionists.

Summary of findings

We saw a mixed picture of quality across these wards. While we saw clear evidence of good care and leadership in some wards, quality elsewhere was let down by a lack of attention to good practice or detail (for example, in record-keeping and infection control). The older people's wards were the biggest area for concern, with patients saying there were not enough staff and staff confirming they were always under pressure. The trust is in the process of changing the skill mix and number of staff in these wards to ensure care is delivered safely. We saw many examples of good care, although some patients complained (for example, staff speaking over them in a foreign language) and older people did not always feel involved in their care. Patient records frequently did not include care plans that reflected all the needs of the patient. This meant there was a risk that they would not get the help and care they required.

Medical care (including older people's care)

Are medical care services safe?

Staffing levels and skill mix

Patients on a number of wards commented on how busy the nursing staff were. One patient told us that “the nurses are lovely but rushed off their feet.” Another patient agreed and said, “The nurses have got too much to do, they don’t have enough staff.” Despite this, patients on most wards said that nurses usually responded promptly to call bells.

It was different on the four older people’s wards. Patients consistently told us that there were not enough staff. Nurses and health care assistants said they felt under pressure due to the shortage of staff. Some health care assistants said they could not perform all their tasks on time, such as hourly patient checks or two-hourly repositioning. Some patients told us they had to wait between five to ten minutes to receive help if they used their call bell. When patients did receive care it was often rushed, for example, when they needed help to eat.

The older people’s wards used high levels of bank and agency staff. Both staff and patients told us that the quality of care and team work deteriorated when bank and agency staff were used. One ward manager told us that they always made sure there was at least one permanent nurse and one permanent healthcare assistant on all shifts. However, we found several examples where this was not the case.

Almost all ward staff told us that staffing levels had improved recently. Ward managers said that further new staff had been recruited, although had not yet started. The skill mix (the ratio of qualified nurses to health care assistants) was being changed so that there was a 70:30 ratio of qualified to unqualified staff on the wards.

Patients on the ‘wrong’ ward

The trust gave us information about the number of patients who were admitted to a different ward to the one on which their medical team was based. On average, in the previous six months, 13 medical patients had been sleeping on surgical wards each night. Junior doctors said they could spend up to 30 minutes every morning looking for their patients. We were told that on occasions patients “went missing” and could go for more than a day without being seen by their treating consultant or junior doctor.

Emergencies

All resuscitation trolleys that we checked were stocked with functioning equipment. Staff checks on these were being completed regularly although there were a few gaps.

Medicines

Medicines were appropriately stored on all the wards we visited. However, the door to the clinical room on Wandle 3, where medicines were stored, was left open and unattended during our evening visit to the ward. On the same ward we saw a nurse leaving the medicine trolley open and unattended to take a phone call for several minutes.

Infection prevention and control

All patients we talked to said that the wards were clean. One patient said, “It is all very hygienic.” In contrast a person who had visited Duppas ward before our visit emailed us to say the area was “very dirty”. However, this was not what we found on the day.

Patients and relatives on all the wards we visited said they saw staff washing their hands before carrying out procedures. Most clinical staff displayed good hand hygiene practice in the wards we visited.

We did however see several examples of poor infection control on the wards for older people. On one occasion a member of medical staff gave an injection to a patient without wearing personal protective equipment. In another example a member of staff did not wear gloves when taking a blood sample. Also we saw a nurse using the same tray to carry a set of keys and a needle before giving a patient an injection. The same nurse failed to wash their hands before giving the injection.

Safeguarding

Most patients told us that they felt safe on the ward and able to raise concerns, although a few patients said they found it difficult to raise issues with staff directly. Staff showed us that they knew about the different types of abuse and how to raise any concerns. For example, we heard that staff had raised a safeguarding alert when a patient was admitted with a grade four pressure sore.

Medical care (including older people's care)

Are medical care services effective? (for example, treatment is effective)

Storage and management of patient records

Patients' records were generally kept securely and could be located promptly when needed. However, on some wards records were left in areas where they could be seen. For example, on Queens 3 pictures of patients' pressure sores were kept at the end of their bed and not stored separately or securely. Notes were frequently held together with a tag and easily became separated from the patient's main care records. For example, on Purley 2 we found a fluid balance chart for one patient in the records of another. Junior doctors raised this as an issue in a focus group we held with them.

Most patients' records were accurate and fit for purpose. However, on the wards for older people we found gaps in records. For example, we consistently found gaps in patients' repositioning records, with these sometimes not being completed for up to 12 hours when their care plans stated they needed to be done every two hours.

Some key documents were missing from patients' records. For example, on Fairfield 2 we were told that a comprehensive mental capacity assessment had been undertaken for a particular patient. But staff could not find the completed assessment in the patient's record. This meant it was unclear whether or not the patient had the capacity to make a decision for themselves about their discharge destination.

Are medical care services caring?

Patient feedback

Most patients were positive about the care and treatment they had received. One patient told us they had been very nervous before they came to the ward but had found staff to be "kind and reassuring." Many patients and visitors described staff as "very friendly", "very caring", "compassionate" and "supportive."

Patients who had previously been admitted to the trust said they had seen improvements in care. One patient's comment was typical when they said, "services are improving, I've been pleasantly surprised." We saw many positive, caring and compassionate interactions between

staff and patients. Most patients were given time to do things for themselves and were not rushed. Patients told us that staff asked for their verbal consent before providing any personal care.

However, not all patient experiences had been positive. A patient told us that "one or two nurses shouldn't be in the job." They gave examples of nurses or health care assistants speaking over them in a foreign language and one occasion when a nurse carried out clinical observations on them without saying anything or explaining what they were doing. On the wards for older people, some patients told us their experience of care was usually good when permanent staff attended to them, but that bank and agency staff were not always of the same quality.

Respect, dignity and privacy

Most patients said that their privacy and dignity had been respected by staff. All wards had rooms where patients could be seen individually and where staff could talk with patients and their relatives in private. We heard doctors asking patients whether it was alright for a student doctor to examine them.

Patients' diversity, values and human rights were respected. For example, we observed staff communicating with an older patient who did not speak any English on Fairfield 2. The occupational therapist and ward hostess were both able to communicate with the patient in their first language and reassure them as to where they were and when they would be going home.

Meals

There was a wide choice of meals available to patients, designed to meet a variety of cultural and religious needs and individual preferences, including Halal, vegetarian and African-Caribbean meals. Patients were happy with the size of the meals. However, some older people with dementia were not always adequately supported to make a choice of meals, and choices were only offered verbally, which was not helpful for patients with memory or other cognitive impairment.

We observed the lunchtime meal on Purley 1. It was calm and uninterrupted. Patients were helped to sit in a comfortable position before their meal arrived. Patients needing extra help from staff were identified with a red tray. We saw staff helping patients with their meals. They took

Medical care (including older people's care)

time to explain the importance of eating and drinking to patients who were reluctant to eat. Staff were proactive in opening cartons and placing meals and drinks within reach.

Assessment and care planning

On most medical wards patients' needs were assessed. Risk assessments were reviewed weekly or sooner if a change occurred in the patient's condition.

However, on some wards for older people, detailed assessments had not always been completed. For example, on Purley 3 and Queens 3, some patients' dementia assessments had not been fully completed to determine the level of support they needed. Also risk assessments had not been reviewed frequently enough. For example, where patients were at high risk of developing pressure sores their risk assessment stated they needed to be re-assessed daily. But for some patients, their needs had not been re-assessed on some occasions for more than a week.

We reviewed the care plans of more than 25 patients on different medical and older people's wards. Most of them were not personalised in any way and we saw no evidence of any involvement of patients in the development of the care plans. This lack of involvement was reflected in what several older patients told us: they did not fully understand their care or treatment needs.

Discharge arrangements

We visited the discharge lounge, an area where some patients waited for transport to take them home. Many wards told us they did not send patients there, especially those were vulnerable or receiving palliative or end of life care. The area was well staffed at the time of our visit and the nurse in charge told us the longest any patient had waited that day was two and a half hours. Patients were provided with hot and cold drinks and sandwiches while they waited. Some of the patients waiting in the lounge were not always adequately dressed for the conditions or in a way that was entirely dignified, in pyjamas or gowns that did not always cover them appropriately.

All wards had social workers employed by the local authority to help with the discharge of patients. Social work support was described as very good. There were 18 social workers overall; we were told this was the biggest trust team in London. A social worker told us that the system for discharging patients worked well on the whole.

Are medical care services responsive to people's needs? (for example, to feedback?)

Patient feedback

Most of the patients and relatives we talked to had received the information they needed about their care and treatment. This had been provided in way they could understand. A patient on Edgecombe 2 told us they had been "well-informed about treatment and plans for discharge" and a patient on Heathfield 2 said, "the doctors tell me everything I need to know." Most were also positive about their involvement in their care and treatment.

However, patients and relatives on the four elderly care wards were less positive. One relative said, "it is difficult to get information from the doctors or staff". One patient said, "I don't think they tell me everything." Another said, "I don't think I am part of the decisions made about my care".

Are medical care services well-led?

Leadership

A number of staff said that they thought the leadership of the trust was improving as a result of the new senior management team.

The results of audits and of feedback from the Friends and Family test were on display in all the wards we visited. In June 2013 on the AMU, 81 out of 95 people said they were extremely likely or likely to recommend the ward to friends and family if they needed similar care or treatment. A patient on Edgecombe 2 told us "there are no big faults, just little tiny faults, just like any other hospital."

'Listening Into Action' was a recent initiative that involving staff in identifying how to improve care delivery and the environment. Several staff gave us examples of suggestions they had made which had led to changes. One told us that putting a porter with a wheelchair in the main reception had been a direct result of 'listening into action.'

Training and development

All new clinical staff underwent an induction before starting work in the clinical area. Staff told us they felt supported in their continuing professional development and said they had good access to training. Some staff said they had received training in the Mental Capacity Act 2005 and

Medical care (including older people's care)

demonstrated their understanding of the legislation. However, one ward manager said that most staff only received a basic introduction to the Act and did not think staff understood the implications of this for their day-to-day work with patients.

Surgery

Safe

Effective

Caring

Responsive

Well-led

Information about the service

Croydon University Hospital provides emergency surgical care and treatment to its local population. There are 123 surgical beds across four wards: Fairfield 1, Wandle 1, Queens 1 and Queens 2. We visited all of these wards and talked to 10 patients, two visitors and seven staff.

Summary of findings

We had few concerns with surgery and overall this service was safe, effective and well-led. Patients told us that the surgical wards had enough staff to meet their needs and thought staff were caring. Staff said that the number of permanent nursing staff had recently improved. The wards were visibly clean and good infection control practice was largely followed. Theatre teams were using the World Health Organisation's 'safe surgery checklist' which is designed to prevent avoidable mistakes, and this was a well-managed process. We saw some examples of excellent care and staff were largely positive and aware of good practice (for example, the 'butterfly scheme' for dementia care). One ward, Queens 1, covered a broad range of specialities and staff need more support to cover them all.

Surgery

Are surgery services safe?

Staffing levels and skill mix

Some of the wards did not have enough permanent staff, but recruitment had either taken place recently or was in progress. Staff told us that the numbers of permanent staff had improved recently and by the end of the current recruitment process, the wards would be up to their full establishment.

Staff explained that the skill mix of staff was being changed from a 50:50 ratio of qualified nurses to healthcare assistants, to a ratio of 70:30. Some staff were not happy about the focus being the increase in numbers of qualified staff and said that what the wards needed were more staff. Patients told us that they felt that there were enough staff on the wards to meet their needs.

The contents of the emergency resuscitation trolleys were supposed to be checked twice per day by staff, but this was not always recorded, or often only checked once a day. Some staff had recorded that items were missing on a trolley but had not replaced them, for example a bag of normal saline.

There were enough medical equipment to care for patients on the wards including sliding sheets and hoist slings.

Safe surgery practice and infection control

Theatre teams were using the World Health Organisation's 'safe surgery checklist' which is designed to prevent avoidable mistakes and this was a well-managed process.

The wards were visibly clean. Hand sanitizers were available outside the wards, bays and side rooms. Information on infection control was displayed at strategic points. Personal and protective equipment such as gloves, and aprons were available in sufficient quantities. Commodes were visibly clean and labelled as such following cleaning. However, we observed nurses and healthcare assistants entering an isolation room without first putting on protective equipment, or washing their hands and using alcohol gel after leaving the room. This was noted on three occasions, so staff were not always following infection control procedures.

Are surgery services effective? (for example, treatment is effective)

Patient records

We looked at a number of patient records across the surgical wards. Risk assessments were generally completed for each patient. These included a pain control assessment, pressure area assessment, MRSA screening, communication, eating and drinking and mental health well-being. However, individual care plans were not always related to risk assessments. For example one patient did not have a care plan to manage their catheter. Another who had dementia did not have a specific care plan to manage their dementia.

Some records such as fluid balance charts were not always accurately maintained, with gaps in running totals for some patients. Nurses regularly checked on patients on an hourly basis, but one patient did not have a record of a check for four hours. Dementia screening forms were not always fully completed.

Patients' medical histories and treatment plans were documented in their medical notes. Nurses recorded patients' progress in the relevant section in the nursing folder. Records were clear and legible. The provider may find it useful to note that patient medical records on Fairfields 1 were stored in a trolley that was not lockable, in the ward corridor opposite the nurses' station. This meant that unauthorised people could easily gain access to the records if they wanted to.

Are surgery services caring?

Patient feedback

Patients told us that they were satisfied with their care. They described the doctors and nurses as "caring", "friendly" and "helpful". The call buzzers were within easy reach of the patients and nurses responded in a timely manner. One healthcare assistant told us that their mission was to ensure that all patients were "happy". They stated that they would do that by being reassuring, smiling, being attentive and always introducing themselves to the patients.

Meals

Meals were described as "satisfactory" by patients and there was choice and variety such as culturally-specific

Surgery

meals. One patient told us that they were hungry at 11.00am and that they had not had anything to eat for that day. Staff were unable to confirm if this was accurate and there was no record to confirm or deny this. Staff told us that the patient was “confused”, but that they should have known whether the patient had eaten that day.

Respect, dignity and privacy

Patients and their relatives told us that they were treated with dignity and respect. There were single-sex bays and single side rooms to ensure privacy and dignity for patients. Privacy screens were used by staff when appropriate.

Staff used body language to communicate with a patient who spoke limited English. Translation services were available but other staff members were also often used as translators.

Patients on the ‘wrong’ ward

There were a number of ‘outlier’ patients on the wards when we visited – these were patients that were under the care of the medical teams but temporarily on the surgical wards because a medical bed was not available. In one of the wards, communication between doctors and nurses during ward rounds could be a problem because sometimes there were more medical teams on the ward than there were nurses.

Discharge arrangements

We were told that there were not many delayed discharges of patients. There were two patients on the wards at the time of our visit, whose discharges were delayed; one due to poor mobility and the other due to poor medical progress. Staff were aware of the Red Cross Home Support Scheme and knew how to contact them. The ward manager attended the discharge meetings regularly, alongside occupational therapists, the Red Cross and other managers. We were told that the discharge meetings started about two months ago and had improved the discharge of patients from the trust.

Pressure area care

Pressure area care was carried out when it was identified in the risk assessments. There was one example where a patient had a high waterlow score of 28 and was meant to be re-assessed daily. This hadn’t happened in the previous 12 days. We saw one good example of pressure area care for a patient that contributed to the healing of their pressure sores. The patient had a specific care plan for pressure sores. They also had a repositioning chart which

documented how frequently they were turned or their position changed. This was done every two to three hours. Their care involved being nursed on a pressure relieving mattress and being assessed by the tissue viability nurse the dietician. Special dressings were applied to the affected areas and the pressure sores healed after about four weeks. The patient told us that nurses gave them assistance as required including caring for their pressure sores that contributed to their healing.

Care planning

One patient was being supported on a one-to-one basis by a mental health support worker. The patient was due to have surgery, but this had been cancelled for reasons that were not clearly documented in the patient’s records. We were told that the cancellation was due to the lack of availability of a high dependency unit bed, but the doctor recorded that it was due to waiting the patient’s uncle’s opinion. The doctor had already signed the consent form for the patient with the mental health diagnosis due to their lack of capacity to make the decision to have surgery. A decision-specific mental capacity assessment had been carried out and a best interest decision documented. This stated that medical colleagues and the patient’s relatives had been consulted. There was no specific care plan for the patient that addressed their mental health needs. We were told that this was because the ward did not have care plans that were specific for mental health.

Are surgery services responsive to people’s needs?
(for example, to feedback?)

Patients and their relatives understood the plan of treatment, and they said they were kept informed of progress.

There was a dementia lead nurse as well as a dementia champion on one of the wards. Staff had received recent training on dementia awareness, delivered by the practice development nurse. The “butterfly scheme” had been implemented on the ward, so that patients with dementia could be identified easily.

Surgery

Patients that were not for resuscitation had appropriate forms completed. However in one case, it was not recorded which other professionals or family members had been involved in the initial decision not to resuscitate the patient.

Are surgery services well-led?

Leadership

We were told that surgical teams were independent of each other and worked separately. There was good access to critical care beds and there was good support from line managers.

Staff told us that there were too many specialities on Queens 1 ward, that is orthopaedics, general surgery, gynaecology and medicine. Most nurses were orthopaedic

trained and one said that they did not know much about caring for patients from the other specialities. Staff were not able to be released to attend training courses for the other specialities due to staff shortages.

Training and development

We were told that staff had completed training on safeguarding vulnerable adults (which included dementia awareness and the Mental Capacity Act). Other training attended by most staff included infection control, health and safety, intermediate life support (qualified nurses) and pressure ulcer care. Records supported this.

Staff told us that a root cause analysis was completed if a patient developed a grade 3 or 4 pressure ulcer, but they were unable to describe what this process involved.

Intensive/critical care

Safe

Effective

Caring

Responsive

Well-led

Information about the service

Croydon University Hospital has 10 operating theatres in its main suite, and four theatres in the Day Surgery Unit. The Critical Care Unit has 15 beds. The High Dependency Unit (HDU) was not inspected because at the time of the inspection it had been moved to the Coronary Care Unit so that building work could be carried out.

We spoke to six medical and a number of nursing staff working in theatres and the Critical Care Unit.

Summary of findings

More can be done to improve quality in this area, particularly on the Critical Care Unit. The unit was using high numbers of agency and bank staff (non-permanent staff) at weekends and nights. We had concerns about the lack of space in the unit. The admission areas for the theatres were breaching single-sex guidelines. The trust was not, however, using the Intensive Care National Audit and Research Centre audits programme and we believe it should do this to make sure services are being delivered in line with best practice.

Intensive/critical care

Are intensive/critical services safe?

Staffing levels and skill mix

We looked at the staff rota for the Critical Care Unit. For the 15 critical care beds they aimed to have 12 qualified staff working. The rota showed that they need to use high numbers of agency or bank staff (usually four to five) at weekends and at night. We were told that the nursing levels in critical care were being reviewed.

In the Critical Care Unit there were two side rooms which could be used to manage patients if they developed infectious illnesses. From May to July 2013, 13 patients in intensive care were found to be infected with bacteria called Glycopeptide Resistant Enterocci. This had been reviewed and a number of measures introduced to manage the outbreak. This had been appropriately discussed at the For Learning and Action Group and reported to the trust's board.

The theatre teams were using the World Health Organisation safe surgery checklist. This sets out the three phases of an operation, each corresponding to a specific period in the normal flow of work. A senior nurse was accountable for completing the checklist. There was good management of the checklist and all staff were present when it was completed.

Are intensive/critical services effective? (for example, treatment is effective)

Infection control

We were concerned about the limited space in the Critical Care Unit and the effect this could have on the spread of infections and staff having enough space to deliver care. We were told that the unit has been prioritised for redevelopment. The pre-admission assessment unit was well designed and had plenty of space.

Are intensive/critical services caring?

Hospital premises and environment

The admission area of the theatres was breaching the Department of Health's guidelines on ensuring single sex accommodation. Therefore patients' privacy and dignity were not being respected. Staff told us that they were going to install privacy screens the day after our visit.

Staffing levels and mix

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Are intensive/critical services responsive to people's needs? (for example, to feedback?)

We found that services were responsive to people's needs.

Are intensive/critical services well-led?

We looked at the audit processes being used in the Critical Care Unit. We were told the department was not using the audits designed for these services by the Intensive Care National Audit and Research Centre. This would help to ensure services were being delivered in line with good practice.

Maternity and family planning

Safe

Effective

Caring

Responsive

Well-led

Information about the service

Croydon University Hospital provides inpatient maternity services. There are around 4,500 births a year. Facilities include a labour ward with 11 delivery rooms and a birthing centre with five rooms. The birthing centre offers midwife-led care for women with low risk pregnancy who want an active labour and delivery. It had recently reopened following refurbishment. There are two dedicated operating theatres and a special care baby unit on site.

We visited the antenatal clinic, the antenatal, labour and postnatal wards, the birthing centre and the special care baby unit. We talked to 12 women and two relatives and used information from six comment cards from the antenatal clinic. We talked to 20 members of staff including the Director of Midwifery.

Summary of findings

Most women and family members were happy with the maternity services and we saw evidence that they were both safe and caring. The unit was well-led and positive changes were being made and sustained. Women were offered choices and most found doctors and midwives caring, with some exceptions at night. Systems were in place to recognise and respond to emergencies quickly. The hospital cares for a relatively high number of high-risk pregnancies and the midwives we spoke to were passionate about ensuring women got the right care and support. The staff team included a range of specialists to meet the diverse needs of local women. Staffing levels were improving and staff were positive about the service they offered. Some women mentioned delays in the antenatal clinic.

Maternity and family planning

Are maternity and family planning services safe?

Patient feedback

Most of the women and relatives we talked to were happy with the maternity service and had confidence in the quality and safety of their care.

Women praised the doctors, midwives and other staff. One woman said, “The care has been really good this time.” Another said, “I’m generally really happy. The staff are really helpful and some went above and beyond to help me.” Midwives and maternity support workers were enthusiastic about their work and the difference they could make to women’s experiences. We did, however, receive negative comments about the attitude of some midwives at night. One woman told us that she had to ask staff talking at the desk to respond to another person who had rung the call bell. Managers were aware of this issue and in a recent newsletter had included a reminder to staff on duty at night.

Staffing levels and skills mix

The trust was in the process of recruiting more midwives and doctors to maternity services. The number of midwives was increasing to meet the regionally agreed ratio of 1 midwife to 28 births. The trust had also increased the numbers of supervisors of midwives (experienced midwives who support other midwives to provide excellence in care) to make sure midwives had access to effective clinical supervision.

Both the doctors and midwives told us that communication and team working on the labour ward were good, with effective consultant and anaesthetist cover and a clear referral pathway for women who needed surgery. There were effective systems to enable staff to recognise and respond to emergencies promptly – for example staff took part in “skills and drills” simulation and learning events. The doctors on the labour ward said the multidisciplinary handover meetings between shifts worked well. The consultant we spoke with said that patient safety was taken seriously and any issues were openly discussed and addressed.

We talked to several women who had experienced complications during delivery and had had a difficult delivery. Some of the women said that their experience was

frightening and upsetting and they had not been offered counselling afterwards. However, women in this situation also praised the actions of staff to deliver their babies safely.

Equipment

We saw that some emergency trolleys on the labour ward were not being checked daily in line with the department’s own procedures. This increased the risk that equipment would not be available when needed.

Environment

Women and staff both said that the environment was clean. One woman whose baby was staying on the special care baby unit said, “Staff explained all the infection control procedures and the importance of them.” The unit had recently experienced three cases of respiratory syncytial virus (RSV) infection and had worked with the trust’s central infection control team to reduce the risk of it happening again. Staff compliance with infection control procedures was monitored and the results displayed. We saw that compliance with hand washing procedures on the wards had improved over the previous three months.

Clinical management and guidelines

We checked a number of their clinical policies and procedures, including how staff identified and cared for women who had developed gestational diabetes. The guidelines for staff were clear. They included the trust’s screening policy and criteria for glucose tolerance testing, to make sure that women with diabetes were not missed.

Out of hours consultant cover to the special care baby unit and children’s departments was shared between the neonatal consultants and the general paediatric consultants. We queried this and were told that staff had access to specialist advice at all hours from another specialised hospital unit and could refer patients there in an emergency. This consultant also said he attended the department out of hours if a baby needed this attention.

Are maternity and family planning services effective?

(for example, treatment is effective)

Equipment

The maternity and special care baby services were appropriately equipped and maintained. The birthing centre had recently been refurbished. The rooms here were

Maternity and family planning

large with plenty of space for women to move around and were well equipped with a birthing pool, bean bags and mood lighting that women could use if they wanted. The midwife in charge explained how she had been able to influence the design of the refurbished rooms for the benefit of women using the service.

Staff skills

Some of the midwives had specialist areas of expertise to meet the diverse needs of women using the service. The team included specialists in bereavement, infant feeding, diabetes, safeguarding, antenatal screening, HIV and infectious diseases. Staff across the department were able to describe their procedures for protecting women and babies at risk of abuse. Staff valued the support they received from the safeguarding midwife team, which we thought was proactive and well coordinated.

Service culture and development

We visited the antenatal clinic and saw the receptionists greeting people and being welcoming. There was adequate seating. The staff said they were able to use telephone interpreters when women were not fluent in English. This was important to ensure women understood the results of diagnostic tests and scans.

Are maternity and family planning services caring?

Managing risks

The trust cares for a relatively high proportion of high risk pregnancies or women experiencing complications. The midwives spoke compassionately about caring for women in difficult circumstances or with complex needs. One midwife said, "They can miss out on pregnancy as something normal. I try and give them time just to talk, a little bit of TLC."

Patient feedback

The special care baby unit organised the doctors' shifts so that the same doctor was on duty for consecutive days for two weeks at a time. We were told this helped to develop trust between parents and the team caring for their babies. Women on the unit said the staff were approachable and communication was "excellent". The unit had introduced a communication diary that doctors, nurses and parents

completed. We saw an example which included daily entries, written in a personalised and informative way by staff. The diary provided parents with a clear record of their baby's progress.

Waiting times

People at the antenatal clinic complained about long waits at the clinic. One person said in a comment card, "I have been here from 11:50 to 1:10. With a toddler that is unacceptable." Staff used a notice board to tell people about any delays. At the time of our visit, the delay was 45 minutes and staff confirmed that there were sometimes delays of up to two hours. Some people's experience of the clinic did not therefore match one of the trust's five patient promises: "You feel we value your time".

Are maternity and family planning services responsive to people's needs? (for example, to feedback?)

Service culture

Women were encouraged to visit the trust before deciding where they wanted to give birth or to familiarise themselves with the facilities. We saw the midwives welcoming one woman and her partner who had dropped in to view the birthing centre. The trust produced a wide range of written information about antenatal tests, pregnancy, caring for new babies and the services on offer at the trust.

Patient feedback

Women told us they had received enough support from their healthcare professionals to help them make informed decisions about their care. One woman staying on the antenatal ward said, "They give you good information about the tests." Another woman who was preparing for a planned Caesarean delivery said, "They explained everything. They explained the risks and options in great detail." Most women and their partners felt involved in their care.

Are maternity and family planning services well-led?

Training and development

All the staff we talked to said they felt well trained for their roles and we heard positive comments about the impact of

Maternity and family planning

the practice development team in the department. The junior doctors had recently started their rotation. They described their work as “daunting” but said they were well supported. The midwives rotated (worked in different parts) through the department which enabled them to keep their skills up to date. Staff attendance at mandatory training was monitored.

Clinical management and guidelines

We reviewed a number of documents to check how the quality of care was monitored and learning passed on to staff. The senior managers monitored progress against identified risks to the service. Doctors and senior midwives regularly attended quality meetings and risk meetings. We reviewed the minutes of a number of these recent

meetings. Items discussed included patient feedback, performance data, any incidents, complaints and errors, and changes to policy or guidance. Information from these meetings, good practice examples, training and events were shared with staff through newsletters and by email. We saw a copy of the first supervisors of midwives’ newsletter which had recently been produced. The midwives we spoke with had read this and found it helpful.

Staff were positive about senior managers and described the service as well-led. Staff members consistently told us the maternity service had improved and this process was continuing. One doctor said, “There’s a belief that things can be better. We are on a journey. There’s motivation amongst the staff.”

Services for children & young people

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Croydon University Hospital provides a children's A&E service, a dedicated day surgery ward and an inpatient ward for children, outpatients and a range of community children's services. We talked to eight parents and their children about the service on the inpatient and day surgery wards. We also talked to five members of staff and observed lunchtime on the ward.

Summary of findings

Overall this was a safe, caring and well-led service, with some issues around premises. We found contrasts in this area between a well-equipped modern day surgery unit with good facilities, and a cramped and inadequate inpatient ward that staff told us was always, 'very busy.' Recruitment was under way to help with this. Parents and children were happy with the care they received and we saw good examples of care, compassion and communication. Doctors were visible on the wards and staff told us communication between nurses and doctors was very good.

Discharge arrangements were good and parents said they were well-informed about what was going on. We saw clear evidence that the service was responsive to patient's needs, including clinical governance meetings that included learning from patient feedback and building on lessons learned. We reviewed a number of policies and procedures that reflected best practice guidelines.

Services for children & young people

Are services for children & young people safe?

Staffing levels

The trust was recruiting more children's nursing staff. The matron told us this was a relatively slow process, because they need to make sure they recruit high quality staff. The nurses welcomed the recruitment and described the inpatient ward as "very busy". They said they sometimes struggled to take their breaks.

Patient safety

The ward staff had good links with the trust safeguarding team. They were alerted when children were admitted who were known to be at risk of abuse. Staff were trained in safeguarding children and knew how to raise an alert if they had any concerns about a child.

Are services for children & young people effective? (for example, treatment is effective)

Hospital premises

The day surgery unit is a modern facility. The theatre was clean, appropriately equipped and well maintained. There were facilities for parents while they waited. In contrast, the inpatient ward was in an older part of the trust and the environment not ideal for the number of beds. It was cramped, with limited space for staff to move between the beds. The bathrooms needed refurbishing. Some of the bedside televisions did not work. Staff on both the inpatient and day surgery wards told us they had access to the equipment they needed.

Parents were able to stay with their children overnight on the inpatient ward. There were also single rooms that could be used for babies or children with special or complex needs and their parents. Children over the age of 10 stayed in single-sex bays.

Communication

The staff told us that communication and team working on the ward were good. Doctors were visible on the ward. One nurse described the doctors as "brilliant. They are on the ward all day. We meet the juniors and then they come back

as seniors." We saw nurses attending the ward round with the doctor. Nurses confirmed that they routinely monitored 'early warning scores', which come from a number of routine observations of the child.

Clinical management and guidelines

We reviewed a number of the unit's clinical policies and procedures. They included new draft guidelines on inserting a feeding tube through a child's nose and stomach. These guidelines had been developed by the practice development nurse, a way of working that was becoming a more common procedure on the ward. The guidelines were clear and in line with the national guidelines published by the National Institute for Health and Care Excellence.

Are services for children & young people caring?

Patient feedback

We talked to two parents on the day surgery ward. They said the nurses were "friendly" and "caring". They said they had been given enough information about the procedures their children were receiving. They had discussed any risks, how to prepare for the operation and what to do following discharge. One parent summed up their experience by saying, "we've no concerns."

Support for children and their families

Parents and children staying on the inpatient ward were also happy with the service. One father said, "It's been fine. We've been allocated a nurse – she came and introduced herself." Another mother, who had also experienced paediatric care at other hospitals, said, "I'm impressed with the care, friendliness and information. The doctor talked me through preventative information for the future – it wasn't just about the here and now. I learned something new." One young person who had been admitted through children's A&E said he had been looked after "very well". Staff interacted positively with children and young people and involved them in their care. We saw some good examples of compassionate care and communication from the student nurses on the ward.

Meals

We observed lunchtime on the ward. All the children we spoke with said they had been able to choose something

Services for children & young people

they liked for lunch. Parents bought sandwiches or refreshments outside the ward. One parent of a very young child said that this was an awkward arrangement, because they didn't like to leave their child alone for long.

Patient experience

The ward team included play specialists. There was a playroom and also on-site school facilities provided in partnership with the local authority. We were told that on occasion patients had successfully sat GCSE exams while staying on the ward. We talked to two children who had attended the school room on the morning of our visit. They had really enjoyed this experience.

Are services for children & young people responsive to people's needs?
(for example, to feedback?)

Discharge arrangements

We looked at the discharge planning process. This was very good. Most children were discharged within a couple of days of admission. All the parents we talked to said that the

doctors had discussed when their children might be discharged, and they felt well informed about this. Delays with discharge were rare. The ward had effective links with the hospital pharmacists.

Are services for children & young people well-led?

Staff training and development

Staff members we spoke with said they felt well trained for their roles. The paediatric practice development nurse showed us how she monitored staff attendance at mandatory training and described the support available for newly qualified nurses and new staff.

We reviewed a number of documents to check how the quality of care was monitored. Doctors and senior nurses regularly attended quality and risk meetings. We reviewed the minutes of a recent half-day clinical governance meeting. The items discussed included patient feedback, performance data, any incidents, complaints and errors, and changes in relevant policy and guidelines. Staff felt listened to and were able to give us examples where improvements were being made in response to their feedback.

End of life care

Safe

Effective

Caring

Responsive

Well-led

Information about the service

Croydon University Hospital has access to a palliative care team that works across the trust and community. In the event that a patient requires end of life care, the team offers support to the patient and their carers to coordinate their care either at hospital or in the community.

The team also supports trust staff and other professionals to improve any of the patient's symptoms. It provides training in palliative care and specialist nursing procedures. The team is available five days a week to see patients on all inpatient wards.

We talked to staff from the palliative care team as well as staff who were receiving their support.

Summary of findings

We found that this service was generally safe, effective and well-led, with multi-disciplinary teams meeting daily to discuss people's needs. The palliative care team had links with the local hospice and we heard examples about where the hospice had worked with hospital staff to help people understand choices about end of life care and treatment. The trust was using the Liverpool Care Pathway Version 12 and had taken steps to make sure it was correctly implemented. The trust has an end of life care steering group that oversees good practice. We saw evidence of learning from audits of recent deaths to ensure that care and treatment had been appropriately delivered.

There were some areas for improvement. We saw that not all 'do not attempt cardiopulmonary resuscitation' orders were properly completed. The trust must address this. We also saw an example of a family, whose relative had just died, who were not given enough privacy.

End of life care

Are end of life care services safe?

The palliative care team supports staff working across the trust to deliver appropriate end of life care.

Are end of life care services effective? (for example, treatment is effective)

Meeting patient needs

We found that on each ward a multi-disciplinary team would discuss the needs of patients on a daily basis. If the person needed support with their end of life care, they could access the palliative care team.

The palliative care team coordinated people's care from different trust departments to make sure their needs were met. For example, the team worked with a young patient to help control their pain, and help them work out a coordinated discharge so that they received appropriate support in the community.

Equipment

They also made sure that the palliative care was in line with current good practice and used appropriate and safe equipment.

Are end of life care services caring?

Accessible information

The palliative care team provided information to people who were nearing the end of their lives, to support them with decisions about different types of treatments and medication. In some cases, this was done in partnership with the local hospice.

The palliative care team also supports the ward staff to care for patients with complex needs and make sure their care plans reflect good practice. They provide information for ward staff on how to support patients from different religious or cultural backgrounds, to ensure their end of life care was tailored to their specific needs.

Respect, dignity and privacy

Staff told us that when people were nearing the end of their lives, they tried to care for them in side rooms rather than the main ward, to give them and their families some privacy. We found this had been the case for some people at the time of our inspection. However, when one person

died we found that staff had closed the curtain around their bed but left a gap in the curtain which meant other people or visitors could see into the cubicle. When the person's family arrived, they were given an office to wait in – but then not given privacy as staff continued to use the office.

The trust has a chaplaincy service that offers bereavement counselling and support for families. In addition some families also received emotional support through the hospice.

Discharge arrangements

The palliative care consultant told us that there were sometimes problems with discharges for people who received palliative care. On occasions these delays were up to two to three days, while people were reassessed and the district nursing service was put in place.

Are end of life care services responsive to people's needs? (for example, to feedback?)

Leadership

We were told that the trust's senior management had agreed to the continued use of the Liverpool Care Pathway but on the condition that consent was obtained from people's families before it was implemented.

Do not resuscitate decisions

We checked that, where people had a 'do not attempt cardiopulmonary resuscitation' order in place, this was done so correctly. In some cases we saw that doctors had appropriately filled out and signed the form, following consultation with people's families but we also saw examples of where this had not been done correctly.

Are end of life care services well-led?

Staff development and training

End of life training provided at the trust includes general palliative care and some specific nurse training to enable staff to correctly assess patients and use equipment such as syringe drivers. The palliative care team told us that staff needed more confidence with syringe drivers and they had identified a need for further staff training and development in this area.

End of life care

As not all staff had received training, the palliative care team created palliative care champions. These were trained staff who could offer advice and support to colleagues.

We were told that all nursing staff had received training in the Liverpool Care Pathway, and this formed part of their nursing induction.

There is an End of Life Care Steering Group that oversees practice within the trust and feeds into the Quality and Clinical Governance Committee.

We were also told that the palliative care team carries out quality audits. It carried out a random sample of 10 patients who had died and who had received care on the Liverpool Care Pathway. The audit found that in all cases the care was applied correctly and appropriately. The team also audits other aspects of the service, including prescribing and the use of sedation.

Outpatients

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Croydon Health Services trust runs a wide range of outpatient services. We visited the orthopaedic, fracture, chest, dental, neurology, cardiac, ante-natal and eye clinics. We also visited the main outpatients department that hosts a number of clinics such as oncology and haematology clinics; the old eye unit that hosts clinics such as urology and endocrinology; and the clinic for people with minor strokes. We talked to 12 patients and 24 members of staff and received 20 comment cards. We also looked at the computerised appointments system.

Summary of findings

The premises and facilities in some outpatients departments were inadequate. In busy periods people were left without seats and, in some clinics (notably orthopaedics), this meant people were uncomfortable and waiting too long. Some waiting lists were poorly managed and many patients were arriving expecting to wait for many hours beyond their appointment time. Although staff knew there was a regular problem with overbooking, they did not seem to understand why or how this could be better managed. This was not responsive to people's needs.

We saw examples of good care throughout the inspection once people were actually seen. For example, the Chronic Obstructive Pulmonary Disease clinic was run by caring, passionate staff who were having a marked impact on preventing readmissions. Staff across outpatients were caring and friendly, and patients were positive about the care they had received. Comment cards were largely positive and staff liked working there. Services are being transferred from Croydon to Purley Memorial Hospital and this move should result in improvements.

Outpatients

Are outpatients services safe?

Managing quality and performance

The Department of Health introduced a target of 18 weeks for the maximum time it should take from a patient being referred by a doctor or GP to the start of their treatment. Three separate members of staff told us the trust had an internal target of 13 weeks, and rarely exceeded it. We were aware, however, that the orthopaedic clinic was not achieving the non-admitted standard for 18 weeks referral to treatment. The appointment of an additional consultant and additional outpatient clinics is helping to address this shortfall.

Are outpatients services effective? (for example, treatment is effective)

Trust premises

The premises and facilities in some of the outpatient clinics were not adequate. For example, the afternoon fracture clinic had 58 appointments. It started at 1.30pm. By 2.00pm the waiting room was crowded. Some people were having to stand up as there were not enough seats. It was not easy to walk between the rows of seats because they were too close together. One patient had a heavily bandaged leg that couldn't be bent. Whenever someone wanted to pass by, the patient had to turn to the side to protect their leg.

There were similar issues at one of the orthopaedic clinics. Two people with crutches were standing. Although there were some seats left, it was difficult for people with walking difficulties to squeeze past other people to reach them. There were people waiting in the foyer. One elderly person had found a seat there; their elderly partner had to stand. Other patients were standing in the corridor by the entrance to the clinic. One person was visibly angry and stormed down the corridor.

Are outpatients services caring?

Staff feedback

We saw examples of good care throughout the inspection. A nurse told us, "Some patients complain about waiting times. But we explain that doctors try to spend time with each patient. Doctors are very caring and take time to

explain things to patients." Staff remained patient and friendly despite a number of people being unhappy with delays. One patient said, "The staff are good, never had a problem."

We observed a doctor speaking to a patient and their partner. The doctor was calm and reassuring and asked them if they had any questions. We spoke with the doctor who said, "I really like working in this hospital, it's like a family." The comment cards we collected mainly had positive responses about staff and the care and treatment that patients had received from them.

Waiting times

Although patients were positive about the care they received, the outpatient clinics were not functioning effectively. Clinics were running late, they became overcrowded and appointments were often cancelled. This impacted on the quality of patients' experiences.

The failure to keep to appointment times was a recurring theme when we talked to patients and staff, and also on the comment cards:

- "The eye clinic was very badly organised. I went there five times and was lucky if I was seen within two hours of my appointment time. On one occasion it was almost four hours."
- "With that volume of people how can anybody be seen and treated properly. Then there's the car park, £2.50 for an hour. You turn up to that and you are worrying about parking."
- "I'm just really fed up, you have an early appointment and you still end up waiting."
- "Quite happy with the service. You just have to be patient some times."

One example was the morning orthopaedic clinic, which we visited at 9.25am. It was already running late and the waiting room was very busy. One of the consultants was late and none of their patients had been seen. We returned at 9.50am to find that none of the patients with a 9.00am appointment had been seen. At 10.30am there were still some 9.00am patients waiting to be seen. One patient said, "Getting the appointment was not a problem. I thought they would be late, it's what you expect."

We were told by three members of staff that consultants and doctors were often late for the start of clinics. Start times were not coordinated with the timetables of clinical

Outpatients

staff. One nurse told us that they were overworked. Another said, “Some days we only have a few patients and other days are overbooked. They don’t seem to spread appointments equally.”

Are outpatients services responsive to people’s needs?

(for example, to feedback?)

Meeting patient needs

We talked to reception staff at all of the clinics. They told us that patients were not offered a choice of dates or times for follow-up appointments. The receptionist allocated an appointment where there was a space because clinics were booked up quickly.

Are outpatients services well-led?

A number of outpatient clinics were not running smoothly and certain clinics were regularly over-booked. Although staff were aware of which clinics had delays, they couldn’t tell us how this was being resolved. We couldn’t see any quality assurance information in the clinics such as how clinics were performing against targets. The Chief Executive explained that management of the clinics falls across a number of directorates, which makes implementing change a challenge. He did, however, tell us how the clinics at Purley War Memorial Hospital will lead to improvements at Croydon University Hospital.

Good practice and areas for improvement

Areas of good practice

- The trust faces a significant challenge to improve the quality of care, and needs to change the culture of the organisation and engage staff in this process. They are using the 'Listening into Action' approach which is succeeding in involving staff and allowing them to contribute to finding solutions. We saw widespread evidence that this was bringing about positive changes for patients and staff. CQC inspection team members were consistently impressed by awareness of this initiative and the ability of staff to point to improvements it was making in the quality of care. The open and transparent leadership demonstrated by leaders in the trust was recognised by staff and is to be applauded, although the proof will be in the delivery.
- Sustained improvements in maternity services.
- The care of people with dementia in A&E.
- The new Acute Medical Unit.
- The way the trust works with social services to support people to go home.
- The Chronic Obstructive Pulmonary Disease clinic, which was working well to prevent avoidable respiratory admissions.
- The palliative care team, who carried out good joint working with a local hospice.
- The enthusiasm of staff for working at Croydon.
- The caring and passionate attitudes of many staff.

Areas in need of improvement

Action the hospital **MUST** take to improve

- Arrangements between A&E and the Urgent Care Centre, as far as it can.
- Staffing levels to provide care in older people's wards.
- Reduce discharges in the evening, especially for older people, and make sure people are properly dressed before they go home.
- Improve outpatients to reduce waits, ensure there is enough seating, and tell people why they are waiting and for how long.
- Improve care plans to make sure they involve people and reflect their needs.

Action the hospital **COULD** take to improve

- Staffing, cover and skills mix (detailed in the report across a number of services).
- Improve continuity of care for patients who are not in the right ward for their condition.
- Develop a stronger attention to detail on key practices – for example infection control, checking fridge temperatures, and responding to equipment audits.
- Improve the accuracy and storage of patient records.
- Support staff to learn from audits, incidents and quality assurance processes.
- Monitor the availability of pain relief – especially for people moving between wards.
- Implement their new 'Do not attempt Cardio Pulmonary Resuscitation' policy.
- Support food choices for people with dementia.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Care and Welfare of Service Users.</p> <p>Improvements are needed to the care and welfare of patients, particularly in respect of:</p> <ul style="list-style-type: none">• The care they receive in outpatients.• The numbers of older people being discharged in the evening and at night.• Care plans recognising the assessed needs of people.• The care patients receive on wards for older people and the staffing levels available to support them.