Care Quality Commission

Croydon Health Services NHS Trust

Croydon University Hospital

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Requires Improvement**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Croydon University Hospital

Requires Improvement  

Croydon Health Services NHS trust was formed in July 2010 with the integration of Mayday Healthcare NHS trust with Croydon Community Health Services. The trust provides integrated NHS services to care for people at home, in schools, and health clinics across the borough as well as at Croydon University Hospital (CUH) and Purley War Memorial Hospital (PWMH).

The trust has 449 inpatient beds, 20 inpatient wards and 37 day case beds. The emergency department is at Croydon University Hospital. Purley War Memorial Hospital does not have any inpatient beds and services provided include phlebotomy and outpatient clinics.

The trust employs more than 3,800 staff and has a dedicated team of 420 volunteers.

We last inspected the trust in October 2019 and it was rated requires improvement overall.

Urgent and emergency services

Inspected but not rated

We carried out an unannounced focused inspection of urgent and emergency care provided by this trust on 09 and 12 October 2020, because we received information of concern about the safety and quality of care provided to patients with mental health problems. We did an unannounced focused inspection of safe, effective and well-led. We did not rate urgent and emergency care at this inspection.

During the inspection, we spoke with seven members of staff, from various disciplines and the leadership team for the department. We reviewed three sets of patient records.

To help maintain patient and staff safety during the COVID-19 restrictions, we followed all relevant guidance and visited selected areas of the hospital only. Some of the discussions we had with staff and leaders were conducted after our visit using secure teleconference facilities.

We found:

- There was an increased risk that people attending the emergency department (ED) could be harmed and there was limited assurance about the safety of care provided to patients with mental health problems.
- Patient record keeping we reviewed was not compliant with trust policy and did not follow Royal College of Emergency Medicine guidance.
- People were at risk of not receiving effective care or treatment. There was a lack of documentary evidence of consistency in the effectiveness of the care, treatment and support that people received.
- The leadership, governance and culture did not always support the delivery of high-quality person-centred care for patients with mental health problems.
- The trust did not have a mental health strategy to support the delivery of safe and effective care to patients with mental health problems.
- The risk to patients increased with the length of time spent in the department. It was acknowledged by staff that the department was not an ideal setting to care for a patient in a mental health crisis for an extended period of time as it was loud and bright. There were challenges with finding suitable places in appropriate hospitals.

Is the service safe?

Inspected but not rated

There was a risk that staff may not recognise or respond appropriately to signs of deteriorating health or medical emergencies in patients with mental health problems. The approach to assessing and managing day-to-day risks to people who used services did not take a holistic view of people's needs.

We were not assured and could not determine what care was being provided to mental health patients during their admission to the emergency department (ED) due to a lack of clear documentation. We reviewed three electronic patient records on the focused inspection carried out on 9 October 2020. These were randomly selected electronic records for patients who attended the emergency department with mental health problems, required 1:1 observation and were admitted for longer than 24 hours in the 3 days before our inspection. All three patient records we reviewed

did not have observation records or records of care provided during 1:1 observation aside from the initial and final shift summaries. We could not be assured and could not determine what care was provided during the 12 hour shifts. We could not find evidence of what arrangements were made when the person responsible for observation was not present. Additionally, in one patient record no documentation was completed at the end of the shift and there were no records of 1:1 care having taken place as identified in the patient's care plan.

Records monitoring the changes in the mental health condition of the patients over the shift period were not recorded in the patients' electronic notes and we did not find records of needs or requests made by patients with mental health problems recorded in these electronic notes. This meant that it was not possible to see if patients had safe, holistic care provided during the shift period and how staff had responded to their needs. This also meant there was an extended period in which possible patterns of deterioration in the condition of the patient with mental health problems were not accounted for.

The information needed to plan and deliver effective care, treatment and support to patients with mental health problems was not available at the right time. Information about people's care and treatment was not appropriately shared between staff or with carers and partner agencies.

Record keeping for patients that we reviewed was not compliant with the trust's policy. We requested evidence of the enhanced care policy and observational policy to identify standards of record keeping for patients with mental health problems who presented to Croydon University Hospital (CUH) ED. The trust did not have a specific observation policy. The enhanced care policy identified that staff must: "Maintain high standards of verbal and written communication at all times with patients, their families and carers and their colleagues both within inside and outside of the team'', "Plan person-centred individualised care for the patient … ensuring that these care plans are documented on the electronic patient record system.", " Carry out regular mental health assessment / reviews of all patients under the care of the team" and "Evaluate and update the patient's enhanced care plans, engaging the patient and any carers in the process as far as possible". Staff had not followed these arrangements in any of the records we reviewed.

Staff did not always have access to key treatment plans and patient records for patients with mental health problems. For example, care plans were not always available to staff. Of the patient records we reviewed one did not have the care plan available in the electronic patient notes as per the enhanced care policy guideline. In this case a mental health trained nurse was assigned for 1:1 observation but, there was no clear or evident record of the care plan to follow. Additionally, the risk assessment matrix for this patient was not completed. We also found that staff employed by CUH ED were unable to access the electronic record system used by their partner mental health NHS trust. Therefore, any documentation of care plans that was not recorded on the CUH's electronic record system could not be accessed by CUH staff.

Is the service effective?

Inspected but not rated

Care and treatment did not always reflect current evidence-based guidance, standards and best practice.

We did not observe guidance from the Royal College of Emergency Medicine (RCEM) about the care of patients with mental health problems being followed. For example, in the 'Mental Health in Emergency Department: a toolkit for

improving care (2019)', Section 1, point 3 (pg.3) it is stated that "Patients at medium or high risk of suicide or of leaving before assessment and treatment are complete should be observed closely whilst in the emergency department (ED). There should be documented evidence of either continuous observation or intermittent checks (recommended every 15 minutes), whichever is most appropriate". This was not followed in any of the records we reviewed.

There was very limited, or no monitoring of the outcomes of care and treatment provided to patients with mental health problems. Participation in audits and benchmarking was also limited.

We did not find evidence of a monitoring and reporting system that could effectively account for the quality and safe care of patients with mental health problems who attended the Croydon University Hospital (CUH) ED. We requested and did not receive evidence of any recording or monitoring process to assure that initial care plans developed by the psychiatric liaison nurses, who worked for the partner mental health NHS trust, were always made available for CUH ED staff.

We requested an audit plan and schedule for audits regarding the care of patients with mental health problems as an additional data request following our focused inspection on 09 October 2020. We were told there was no audit plan or schedule, but an ad hoc quality round was carried out by the head of nursing for mental health in ED. We were also told a specific mental health 'perfect ward' audit had been developed and would be carried out weekly within the ED once the questions had been uploaded to the electronic system. The time scale for completing this action was anticipated to be November 2020. We were not told which questions would be part of this audit programme.

We requested evidence of monitoring and quality assurance of the psychiatric liaison nurses care plan completion and sign off on CUH's electronic record system. We also asked for evidence of the completion of the mental health risk matrix in the CUH ED. We were told these were not being monitored. We were advised that once the new ED mental health triage risk assessment went 'live' on CUH's electronic record system it would enable compliance to be monitored and audited. We were not informed of a timeline for the implementation of this risk assessment to be carried out.

We had no assurances that the quality and effectiveness of recorded care provided to patients with mental health problems was being reviewed. We were told hourly quality notes of care were recorded for all patients using an adapted version of a safety checklist which was now in place in the ED. This was used for all patients attending the ED and included aspects of care such as mental health needs, basic needs, vital signs and toileting needs, as an example. These quality notes had been introduced in July 2020 with the first audit round covering one week per month in July and August 2020 to set a base line. A review of the data collected in this audit did not provide assurance that contemporaneous note keeping for patients with mental health problems was being recorded or monitored because the audit did not identify if the reviewed notes belonged to mental health patients or other admissions.

Discharge, transition and referral planning for patients with mental health problems was undertaken but we could not be assured it was always timely or considered all of the person's needs. This could result in delays or poor coordination when patients with mental health problems were referred or when they transitioned to other services or healthcare professionals.

We did not observe staff handovers in this inspection however, staff told us that handovers from shifts were verbal and consisted of identifying the patient and their location in the ED, reason for admission, time spent in ED and expected discharge time, if applicable. We were told handovers included specific information to the patient such as challenging behaviour, changes in their presentation or if they were accompanied by family. Staff said they would also read the shift summaries if they needed more information.

Urgent and emergency services

Staff said they worked closely with the partner mental health NHS trust's psychiatric liaison nurses and with colleagues within the department. We were told a brief handover was completed after any assessment and an initial assessment was uploaded to the electronic patient record. However, as identified above of the three records we reviewed one did not have the care plan available in the electronic patient notes. Additionally, the risk assessment matrix for this patient was not completed. We also found that staff employed by CUH ED were unable to access the electronic record system used by their partner mental health NHS trust. Therefore, any documentation of care plans that was not recorded on the CUH's electronic record system could not be accessed by CUH ED staff.

We were told that meetings with partner organisations about the care of patients with mental health problems in the ED took place. However, meetings such as that between the ED and their partner mental health NHS trust were not recorded by the ED. This meant that there was no available record of the discussions held and it was not possible to monitor action plans against identified risks and targets. Additionally, crucial information for the joint care of patients with mental health problems could be lost.

There were twice daily calls with other health care providers and stakeholders in South West London to discuss patients and to ensure they were being cared for in the right place for them. These calls included discussion of any actions needed to make transfers more efficient. There was also an email circulated twice daily with the actions confirmed, this happened seven days a week.

Is the service well-led?

Inspected but not rated

The arrangements for governance and performance management for patients with mental health problems were not fully clear or did not always operate effectively. We saw no evidence of recent reviews of the governance arrangements, the strategy, or plans.

We were not assured governance processes gave an accurate account of the quality and safety of care provided to patients with mental health problems in the emergency department (ED). They did not identify suitable outcomes and accountability to manage and mitigate risks to mental health patients attending ED.

We were not assured that formal meetings discussed and recorded relevant information regarding the safety and quality of care provided to patients with mental health problems in the ED. In addition, where risk was identified it was not escalated to the risk register. We reviewed the meeting minutes of the ED management meeting and minutes from the autism and learning disabilities and mental health meeting from July to September 2020. In one ED management meeting it was discussed how the general manager was very concerned about the number and acuity of patients with mental health problems currently attending the ED. This led the department to use an area previously designated for patients with COVID-19 to provide care for patients with mental health problems. It was recorded that everyone at the meeting had concerns regarding this decision. However, the action plan produced as a result of these concerns was vague and unclear and did not address the issues raised regarding the use of this area or how to safely manage the increased numbers of patients with mental health problems attending the ED.

We could not be assured that the leadership team had enough information to support decisions and changes that needed to be implemented to improve the quality of care for patients with mental health problems attending the ED. This is because we were not assured there were effective monitoring, reporting and assurance processes to assess and improve the safety, quality and effectiveness of care provided to mental health patients.

Urgent and emergency services

Risks and issues were not always dealt with appropriately or quickly enough. The risk management approach was applied inconsistently or was not linked effectively into planning processes. The approach to service delivery and improvement was mostly reactive and focused on short-term resolutions. Clinical and internal audit processes were inconsistent in their implementation and impact.

We were not assured there was an effective and timely review of the risk register for the ED particularly concerning risks associated with patients with mental health problems. The risk register presented to us following the focused inspection on 09 October 2020 did not assure us that risks were regularly reviewed. As an example, one risk raised concerns that the acute ward environment contained a number of ligatures and ligature points which could be used by patients for purposes of self-harm and attempted suicide. This risk was due for review on 07 April 2020. We were not assured this review had taken place as the information on the risk register did not reflect it had taken place. Additionally, there was not an action plan and no accountable individuals or governance structures named to address this risk. We were later informed that a ligature risk assessment for the ED department was completed in August 2020 however, the risk register had not been updated to reflect this.

We were not assured risks identified in the ED risk register for patients with mental health problems were accurately described and able to address the whole concern raised by the risk. We identified a risk relating to patients with mental health problems that was not complete. The description of the risk was not fully described, and it was not possible to get a full picture of the risk. This risk had a review date of 28 August 2020 and despite being identified as an 'above tolerable' risk there was no action plan and no clear accountability. Additionally, there was no clarity in the standing of the risk as comments were not dated and we could not be assured they reflected the findings of the review date. This risk was only linked to a specific area in the ED and did not account for other areas where treatment of mental health patients in the ED took place.

We were not assured risks related to the provision of care for patients with mental health problems in the Croydon University Hospital (CUH) ED were being effectively managed and monitored through the risk register. The ED leadership team told us there had been an increase in the number of patients with mental health problems attending the ED, of which there was an estimated 50% rise in non-frequent attendees to the service and that this was a risk for the service. We were also told this was not recorded as a risk on the risk register as other risks overlapped with this risk. We reviewed the risk register and none of the mental health risks identified on the risk register correlated, accounted or mitigated the risks associated with the increase in the number of patients with mental health problems attending all areas of the ED.

We were not assured the trust was able to react sufficiently to risks and relied on external parties to identify risks. It has been discussed above how the trust did not have the information and were not using their risk register to identify risks effectively. Additionally, in our previous inspection report published in February 2020 it was recorded that the ED must ensure it maintains accurate, complete and contemporaneous records for all patients, must implement a local audit plan to effectively improve and monitor patient outcomes and must ensure that risks to the department are reviewed regularly and that there are timely plans to eliminate or reduce them. These actions were not followed effectively concerning patients with mental health problems who accessed the ED.

The information used in reporting and delivering quality care was not always reliable, timely or relevant. Leaders and staff did not always receive information to enable them to challenge and improve performance.

Urgent and emergency services

We did not find evidence of a monitoring and reporting system that could effectively account for the quality and safe care of patients with mental health problems who attended the CUH ED. We requested an audit plan and schedule for audits regarding the care of patients with mental health problems as an additional data request following our focused inspection on 09 October 2020. We were told there was no audit plan or schedule for patients with mental health problems.

We had no assurances that the quality and effectiveness of recorded care provided to patients with mental health problems was also being reviewed. An hourly quality notes audit was introduced in July 2020 with the first audit round covering one week per month in July and August 2020 to set a base line. A review of the data collected in this audit did not provide assurance that standards of note keeping for patients with mental health problems was being recorded or monitored because the audit did not identify if the reviewed notes belonged to mental health patients or other admissions.

There was a limited approach to recording and acting on shared information with people who use services, external partners and other stakeholders.

We could not be assured plans and actions on information exchanged between partner organisations would be followed up and acted on. We were informed that several informal meetings about the care of patients with mental health problems in the ED were taking place. As an example, the meetings between the ED and their partner mental health NHS trust were not recorded. This meant that there was no record of the discussions held and it was not possible to monitor action plans against identified risks and performance targets as there was no audit trail of conversations regarding the joint care of patients with mental health problems.

We found no evidence of agreements and terms of reference between the ED and their partner mental health NHS trust regarding multidisciplinary team meetings about the care of patients with mental health problems. We requested evidence of these agreements and terms of reference regarding the recording of care plans by the psychiatric liaison nurses on the CUH electronic record system. We were provided with and reviewed email conversations held in December 2017 where connection and access to electronic systems through both partner organisations was discussed. Conversations were held about information governance and making the partner mental health NHS trust's electronic record system available to their own staff in the ED. However, there were no standard operating procedure for this joint work, including identifying what should be included in the uploaded care plans to the ED electronic records system. We also found no evidence of whether CUH ED staff could access the mental health NHS trust partner's electronic system. We received no further information regarding this matter through our additional data request.

Following inspection we were sent the terms of reference for a "mental health monitoring group". This group had agreed terms of reference and included both Croydon Health Services NHS Trust and their partner mental health trust. The group was in place to promote the safe and coordinated care of patients with mental health concerns. We were also sent the most recent minutes of this group and the minutes of the "mental health, learning disabilities and autism board" from the trust. These minutes reflected that there had been meetings to discuss the health needs of patients and that there was work ongoing to improve services for them.

The trust did not have a strategy for patients with mental health problems that was sustainable and aligned to local plans within the wider health economy. We were not assured the ED had a strategy for what it wanted to achieve and a plan to turn it into action.

Urgent and emergency services

The trust did not have a mental health strategy to support the delivery of care for patients with mental health problems. Following the interview with the recently appointed head of nursing for mental health we requested a draft version of the mental health strategy for the trust. We were told a version of the trust's mental health strategy was being scoped for discussion and approval at the mental health board prior to being drafted, and that an initial draft would be available by November 2020. We were not told what the target date for the delivery of the mental health strategy was.

We were not assured risks related to the provision of care for patients with mental health problems in the CUH ED were being effectively managed and monitored through the risk register or formal governance processes. We received no evidence of an ED service strategy or action plan that addressed these risks and aimed to improve the quality of care for patients with mental health problems.

Areas for improvement

We told the trust that it should take action to improve services. This action is related to one service.

Urgent and emergency services:

- The service should continue to work collaboratively with partner agencies to decrease both the volume and duration of stay of mental health patients in the ED.

We told the trust that it must take action to bring services into line with two legal requirements. This action is related to one service.

Urgent and emergency services:

- The service must review and implement effective strategies so that record keeping and information needed to plan and deliver effective care, treatment and support is available at the right time to all staff and can be shared between staff and partner agencies. (Regulations 12(1)(2);17(1)(2)).
- The service must improve and implement an effective monitoring system to assure outcomes of care and treatment are in line with national guidance and readily available to improve the safety of care for mental health patients in the ED. (Regulations 12(1)(2);17(1)(2)).
- The service must review and implement active arrangements for governance, performance and risk management so that these are clear and always operate effectively and in a timely manner. (Regulations 17(1)(2)(3)).

Our inspection team

The team that inspected the service comprised of one CQC inspection manager and two CQC inspectors. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection for London.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment