

Croydon Health Services NHS Trust

# Croydon University Hospital and Purley War Memorial 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

### Overall rating for this hospital

Requires improvement



Urgent and emergency services

Good



Medical care

Requires improvement



Surgery

Requires improvement



Critical care

Requires improvement



Maternity and gynaecology

Good



Services for children and young people

Good



End of life care

Requires improvement



# Summary of findings

Outpatients and diagnostic imaging

**Requires improvement**



# Summary of findings

## Letter from the Chief Inspector of Hospitals

Croydon Health Services NHS Trust provides local services, primarily for people living in and around Croydon from the two locations, Croydon University Hospital and Purley War Memorial Hospital. The Purley Memorial hospital provides outpatient and diagnostic services only. Croydon University Hospital provides acute services to a population of 383,000. The trust also runs 15 community clinics across the area.

The trust employs approximately 3,640 staff and has a team of 300 volunteers supporting the services.

We carried out an announced inspection visit to the hospital services and community clinics between 16 and 19 June 2015. We also undertook an unannounced visit to the hospital and community clinics on 23 June 2015.

Overall, this hospital requires improvements.

Our key findings were as follows:

### Safe

- The trust had reported fewer incidents than other trusts of its size and some incidents may not have been reported.
- Staff were encouraged and supported to report incidents when they occurred. However, staff working in operating theatres did not always complete incident reports.
- Incidents were not always recorded and categorised as serious until after a complaint had been received.
- Investigations in the majority of instances had been undertaken in an open and transparent manner. Review processes in the surgical division did not always include adequate examination of the root causes of the incident, and did not explain the consequences in a way that relatives could understand.
- Patients were informed when a serious incident had happened and were updated on the progress of the investigation.
- The service arrangements in the Emergency Department (ED) did not always enhance patient safety. Patients who did not arrive by ambulance were not always clinically assessed as soon as they arrived. Some ED patients were sent in error to the urgent care centre following an initial assessment by staff running the adjacent urgent care centre.
- Although it had been difficult to recruit and retain nursing staff, there were adequate arrangements to ensure safe nursing staff levels.
- There were sufficient medical staff to provide safe treatment and care to patients, although the availability of surgical cover on Sundays did not support the delivery of a trauma service.
- There were arrangements to minimise risks of infections to patients, the public and staff. However, equipment used by patients had not always been cleaned to the required standards in the Emergency Department. The environment in Cardiology was not sufficiently clean or well maintained. Operating theatres were in a poor state of repair.
- Elective orthopaedic cases were nursed on the mixed surgical speciality wards, which did not reflect recommendations for delivery of safe surgical services by the Royal College of Surgeons.
- Arrangements for medicines optimisation ensured the safe and effective use of medicines for the best possible patient outcomes. However, medicine fridge temperature checks were not done regularly in some surgical areas.
- Patient risk assessments were undertaken and where patients' conditions deteriorated, their needs were responded to by appropriately skilled staff.
- Staff had access to safeguarding information and had a good awareness of this area of patient safety; however, safeguarding of vulnerable adult training was not always up to date across the various departments.
- Staff compliance with mandatory patient safety related training was often below target levels.
- Equipment used for surgery was sometimes inadequate or unavailable.

### Effective

- Where possible, staff followed best practice standards and professional guidance for clinical practice.

# Summary of findings

- There was no trauma service on a Sunday, which was not in line with Fractured Neck of Femur (NOF) guidelines.
- There was a collaborative and multidisciplinary approach to the delivery of patient treatment and care from clinical and allied healthcare professionals. The exchange of patient information was not optimised on surgical wards, where consultant ward rounds often took place without a nurse present.
- Access to services and clinical experts outside normal working hours in the main supported the effective delivery of care.
- Patient outcomes were generally in line with or better than the national average except for emergency trauma and orthopaedic surgery. Readmissions following emergency trauma and orthopaedic surgery were worse than expected.
- Staff had access to training and opportunities to gain competencies related to their area of work.
- The assessment of patients' pain was carried out and the majority of patients reported having timely pain relief.
- The individual nutritional needs of patients in ward areas and the Emergency Department were considered and acted upon. However, there was no standardised protocol to ensure patients did not become unnecessarily dehydrated before surgery.
- Staff sought consent from patients before undertaking treatment and care. Consent took into account the best interests of individuals who were not able to make informed decisions for themselves. However, in medical services there was a lack of assurance that capacity assessments were always being carried out when needed and consent was not always recorded in medical notes.
- There was no formal arrangement to access anaesthetic review of surgical patients at pre-assessment. Procedures were sometimes cancelled as a result of patients not having been reviewed by an anaesthetist.
- There was no agreed process for radiological investigations required by the day surgery unit.

## Caring

- Staff provided physical and emotional care to patients in a kind, considerate and compassionate manner. Patients were treated with dignity and respect and were supported with their individual needs. Those people who were important to the patient were involved in their care where wished.
- The needs of patients living with dementia or having learning disabilities were considered and addressed.
- Multidisciplinary meetings included discussion of the patient's choice and relatives' involvement when planning discharge and follow-up care arrangements.
- Patients and their families felt involved and listened to but medical patients said there was a lack of information related to their treatment. Staff respected decisions and choices, and were supportive of varying cultures, backgrounds and faiths.

## Responsive

- Services had been planned and arranged to meet the needs of the local population.
- Some patients spent too long in the Emergency Department before being admitted to a ward.
- Elderly care pathways ensured that elderly patients were assessed and supported with all their medical and social needs.
- The acute liaison nurse for patients with a learning disability worked closely with staff to improve the patient experience and the effectiveness of treatment.
- Theatres were under used and scheduling of operations was not planned to take account of demands on the day surgery unit or on the Intensive Care Unit.
- Some surgical procedures were cancelled on the day as a result of a lack of equipment availability.
- The length of time from referral to treatment for surgery was now generally in line with, or better than, the national average.
- Care pathways for surgical patients were enhanced by multidisciplinary working with specialist nurses and links with the trust community health services.
- Volunteers worked closely with staff to ensure people's needs were responded to.

# Summary of findings

- Discharge arrangements were not always efficient, with patients waiting too long in the discharge lounge and waiting too long for their prescriptions. There were blockages in the discharge of surgical patients due to lack of rehabilitation beds in the community.
- Staff understood the complaints reporting and investigation process. Work to improve the complaints management process had taken place but there remained some delays in updating people on the progress of investigations.

## Well led

- The majority of clinical areas were well led, with strong and effective governance arrangements in place. There was efficient and effective leadership and teamwork in most areas. However, the clinical governance structures in surgery were weak, with a lack of reliable information about services. There was no joined up approach or standardisation across surgical services.
- Risk management, incident reporting and shared learning from these was happening across the majority of areas, with the exception of surgery. Issues affecting the smooth delivery of services or for shared learning around risks were not always discussed.
- The board meetings were not attended by surgical or medical consultants. Minutes of these meetings did not demonstrate an understanding of risks that would benefit from being shared with staff.
- Surgery services had new leadership, who recognised the need to engage staff in developing a strategy and improving services.
- Most staff said they were respected and valued by their colleagues, and that the leadership encouraged candour, openness and honesty.
- The culture in the hospital was centred on the needs and experience of people who used the service and promoted the delivery of high quality, person-centred care. However, some staff in surgical areas felt they had not been able to contribute to improvements and that concerns were not always listened to.
- Where changes happened in theatres as a result of external recommendations these had been changed by subsequent external consultation. Some changes were made without staff consultation.
- Local initiatives to improve patient experiences and to motivate staff were taking place through 'listening into action'.

Areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Improve clinical governance and risk management in the surgical directorate.
- Implement promptly plans to refurbish theatres and to put in place an equipment replacement programme.
- Ensure that 90% of staff receive up-to-date safeguarding and mandatory training.

In addition, the trust should:

- Ensure that mental capacity assessments are completed and that consent is recorded in patient notes.
- Continue to recruit to vacancies across all staff groups in all areas and ensure staffing levels are reviewed in line with increased demand for services
- Ensure the environment in all clinical areas complies with national guidance and promotes privacy and dignity.
- Review with staff the results of the 2014 staff survey and develop an improvement plan.
- Ensure that Emergency Department patients are assessed and treated within the nationally agreed standards by an appropriately qualified member of staff.
- Ensure that all equipment used by patients in the Emergency Department is clean.
- Fully implement the Emergency Department computer system functionality to allow contemporaneous recording of accurate patient records and patient risk assessments.
- Improve the processes for recording mortality and morbidity meetings.
- Involve all relevant staff in reviewing the scheduling of operations to maximise efficiency and improve the patient experience.
- Consider how it to make a trauma service available on Sundays.

# Summary of findings

- Ensure that all work streams in the outpatients transformation programme are completed.
- Ensure that medicines are correctly stored and are in date.
- Improve bed flow between the critical care unit and medical wards.
- Provide a specific risk register for end of life care.
- Review resources for end of life care to provide a seven day service.
- Review how it ensures patients and their families are kept informed about their care.
- Develop a range of health-related leaflets in child-friendly formats for Children's Services.
- Provide a fridge suitable for the storage of expressed breast milk on Rupert Bear ward.
- Ensure that the planned improvements to parent accommodation in children's services is completed on time.
- Ensure that the planned maintenance work and equipment replacement in maternity are completed in a timely fashion.
- Review midwifery staff's awareness of the action to take in the event of activity levels escalating outside normal working hours.
- Improve the experiences of women being cared for on the gynaecology ward after a pregnancy loss.
- Improve the level and range of information available to women following pregnancy loss regarding the disposal of the pregnancy remains.
- Consider how to meet its internal objectives to monitor compliance with guidelines on an annual basis.

We saw several areas of outstanding practice, including:

- The Specialist Palliative Care team had engaged with the public and staff to inform the development of the 'care of the dying person care plan.' This included new prescribing guidance for symptoms that occur at the end of life, as well as new medical guidance.
- The trust was involved in the LEGACY study for secondary breast cancer, in collaboration with the Royal Marsden and the Institute of Cancer Research. The objectives of the LEGACY study are to provide researchers with the best opportunity to understand secondary breast cancer, how it works and how to stop it.
- The diabetes team for children and young people was recognised for providing excellent care.
- The special care baby unit had level 2 UNICEF accredited baby-friendly status where breast feeding was actively encouraged and mothers were given every opportunity to breast feed their babies.
- The urogynaecology and pelvic floor reconstruction unit at Croydon Healthcare had an international profile in relation to research, provided courses to the obstetric community and had won many awards.
- The maternity service was currently developing and piloting a programme of antenatal courses designed to support women with limited English.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

#### Urgent and emergency services

### Rating

Good



### Why have we given this rating?

Overall, we have rated the Accident and Emergency Department also known as the Emergency Department (ED) at Croydon University Hospital as good. Staff who worked in the department demonstrated a multi-disciplinary approach to caring for their patients. They worked cohesively together, respecting each other's skills, experience and competencies in a professional manner that benefited the patients they cared for.

Safety in the department required improvement. The environment did not always enhance patient safety and equipment was not always cleaned properly.

Patients arriving by ambulance were assessed and treated quickly but other patients were not always clinically assessed as soon as they arrived in the department. It was possible for their condition to deteriorate while they were waiting to be seen. This was partly caused by the fact that the Emergency Department shared reception facilities with the adjacent urgent care centre, which was run by another organisation. On arrival at the reception, some patients were sent in error to the urgent care centre, which had an adverse impact on some of their patients.

Staffing levels for both medical and nursing staff also needed to improve. Care and treatment was effective and delivered in line with current evidence based guidance and standards. The trust used national and local clinical audits to monitor the effectiveness of care and treatment.

The department was responsive to the needs of local people and had particularly good facilities for patients with dementia. The ED was better than many other hospitals in meeting the national target of admitting or discharging 95% of patients within four hours. The department itself was well-led. The leadership actively shaped the culture through effective engagement with staff and patients. They Demonstrated the skills, knowledge and experience needed for their roles.

# Summary of findings

## Medical care

### Requires improvement



Patients were kept safe whilst they were receiving medical treatment and care. Patients who were at risk of deteriorating were monitored and there were systems to ensure that appropriate medical or specialist nurses responded.

There was an open culture, with learning from clinical incidents. There were enough doctors and nurses available to keep people safe.

Although the trust found it difficult to recruit and retain nursing staff, it was able to fill gaps effectively using bank staff.

Care was provided in line with national and local best practice guidelines. Clinical audits had been undertaken, and national and local audit demonstrated good outcomes for patients, with the exception of diabetes care and treatment.

We observed good clinical practice by clinicians.

Patient morbidity and mortality outcomes were broadly within what would be expected for a hospital of this size and complexity and no mortality outliers had been identified.

Although staff had a good knowledge of the issues around capacity and consent, the trust was unable to provide any assurance that capacity assessments were always being carried out when needed and that consent was being recorded in medical notes. Patients received compassionate care and were treated with dignity and respect. Most of the patients and relatives we spoke with said they felt involved in their care and were full of praise for the staff looking after them. A number of patients raised concerns that they were not always kept informed about their treatment.

The medical services had mixed results in patient surveys but results indicated an improvement in the views of patients over the last 12 months. The medical division was effective at responding to the needs of its community and very responsive to its elderly community.

The hospital operational management team had an excellent grip on the status of the hospital at any given time. Bed availability was well managed.

Discharges were still not fully effective, with patients waiting too long in the discharge lounge and waiting too long for their prescriptions.

Elderly care pathways had been well designed to ensure that elderly patients were assessed and



# Summary of findings

supported with all their medical and social needs. Patients who were living with dementia were accommodated on two specifically adapted 'dementia friendly' wards.

The hospital had designed pathways that, where if possible, kept patients out of the Emergency Department. The Ambulatory Care Unit provided effective alternate pathways for GPs and other referrers.

The medical services were very well led; divisional senior managers had a clear understanding of the key risks and issues in their area. The medical areas had an effective meeting structure for managing the key clinical and non-clinical operational issues on a day-to-day basis.

The hospital had a risk register that covered key risks but was still being developed to accommodate the recent changes to the divisional structure.

There was a clear drive and enthusiasm among managers to innovate services for patients and particularly elderly patients. Staff spoke positively about the high quality care and services they provided for patients and were proud to work for the hospital. They described the hospital as a good place to work and as having an open culture. The most consistent comment we received was that the hospital was a friendly place to work and people enjoyed working with their teams.

## Surgery

### Requires improvement



The clinical governance structures in surgery were weak and there was a lack of reliable information about the performance of services. The services were disjointed and suffered from a lack of standardisation. There was good team work within specific parts of the service, but communication was sometimes weak, with few forums for multidisciplinary discussion of issues affecting the smooth delivery of services or for shared learning. Service related risks were not always formally identified and addressed. Where risks had been recognised, such as faulty theatre equipment and poor theatre environment these were being addressed. However, the promptness of resolving some risks was often slow, and there remained a lack of a shared understanding of risks and how these should be tackled and monitored.

# Summary of findings

Equipment was not always readily available to support the delivery of services, which combined with equipment failures impacted on patient safety and cancellations.

The investigation of serious incidents and the response to complaints had improved, but it was not clear that incidents were being consistently reported, categorised, or learned from.

Staff did not always complete the required safety related mandatory training. However, new staff and doctors in training were well supported.

Initiatives, such as the opening of a surgical assessment unit, demonstrated a desire to improve patient experience, but the unit was not yet able to follow the operating policy.

Patients praised the responsiveness and kindness of staff on the wards. Patients we spoke with who had been to the hospital before remarked on improvements in the attitude of staff and the efficiency of services. Patients' individual needs were generally met and there was excellent practice to ensure that patients with learning disabilities received responsive and effective care.

Surgery services adhered to best practice standards, and staff had worked hard to reduce referral to treatment waiting times. Care pathways for patients were enhanced by multidisciplinary working with specialist nurses and links with the trust community health services.

Outcomes, such as readmissions following surgery were generally in line with or better than the national average except for emergency trauma and orthopaedic surgery. There had been notable improvements since our last inspection in infection control processes and aspects of patient care.

The trust performed poorly in the cancer patient experience survey results for inpatient stays. They were in the top 20% of trusts for three areas, but were in the bottom 20% of trusts for 19 areas.

Discharge was better coordinated, but there remained some blockages in the process, such as the lack of rehabilitation beds in the community.

A new electronic patient record system had been effectively implemented. There were some disruptions to the service at times, which were being addressed.

# Summary of findings

## Critical care

### Requires improvement



Following a recent restructuring, surgery services had new leadership, who understood the need to engage staff in developing a strategy and improving services.

The critical care service required improvement in a number of areas but was going in a positive direction. There were a few issues, particularly with medicines management, the environment of the unit, staffing skill mix, both nursing and medical, and discharges. Performance monitoring also needed to improve. However, patient feedback and observations of care were positive.

The unit mostly learned from incidents, national guidelines were mostly met, and infection control was improving despite being challenged by the environment.

Governance arrangements were clear and the new leadership team were valued and approachable. There were appropriate relatives' facilities and support for people in vulnerable circumstances. Patient outcomes were mostly around the national average and the outreach team were having a positive impact on these in the rest of the hospital.

## Maternity and gynaecology

### Good



We found that maternity and gynaecology services were provided to a good standard. There had been continued and sustained improvements to maternity services. Women who had previously given birth at the hospital commented positively on the improvements to maternity services and told us staff were caring, responsive and knowledgeable. We found an integrated clinical governance system in use and action was taken when non-compliance with standards was identified. The risk register was active and regularly updated and plans for mitigation put in place pending action to eliminate the risk. Information about performance and risk was communicated through the governance arrangements to the trust board.

There were robust arrangements in place for recording adverse events and near misses, and investigating and learning from these. There was an expectation of openness and honesty. When outcomes were worse than expected, staff met women, and their families when appropriate, to provide a full explanation.

# Summary of findings

Staff did not always complete the required safety related mandatory training.

Agreed staffing levels were appropriate to meet current demand. However, improvements were needed in the use of the maternity services escalation policy at busy times. New staff were well supported, and there was a comprehensive mandatory training programme, with opportunities for development. The directorate had identified that appraisal rates for midwifery staff were low and action had been taken to improve this. Staff we spoke with said there was effective communication in maternity and gynaecology services.

There was easy access to services for women and there individualised care plans were developed for each woman.

There was adherence to good practice guidelines and outcomes for women met expectations.

## Services for children and young people

Good



Children's services at Croydon University Hospital provided effective, caring and responsive support to premature babies, sick children and their families. Patient safety was assured through vigilant monitoring and responding to any deteriorating child.

Staff were required to complete safety related subjects but targets were not always met, particularly within the paediatric medical staff. There were some discrepancies in staffing levels of doctors and nurses due to vacancies, which were managed to ensure patient safety was not compromised.

There was an open and transparent approach to reporting and learning from incidents. Infection prevention and control measures were in place to minimise risks to those who used the service. Effectiveness of services were geared to reducing emergency readmission rates and delivering the best treatment and care outcomes for children and young people, in accordance with best practice. A multidisciplinary team approach to patient care prevailed, and our observations and feedback from people using the services demonstrated that care was delivered in a kind, compassionate, respectful and friendly manner.

# Summary of findings

Responsiveness of the service was achieved through close working arrangements with community-based services, which ensured that children could expect to be cared for at home via community nursing services.

The service was well-led and staff spoke positively about providing high quality care that was aligned to the trust-wide vision of ensuring that patients received safe, clean and personal care. Whilst the overall care environment and ambiance of the Rupert Bear Ward and Special Care Baby Unit were tired and in need of refurbishment especially with regard to parent accommodation, the trust had acknowledged this was an area of concern and had developed action plans to improve facilities for babies and sick children.

## End of life care

### Requires improvement



The end of life care (EoLC) service at Croydon University Hospital (CUH) had a track record of steady improvements in patient safety. There were systems to ensure an appropriate review or investigation and lessons learned were communicated widely to support improvement across the trust.

Risks to patients were assessed, monitored and managed on a day-to-day basis. We found issues with the consistency of staff recording 'do not attempt cardiopulmonary resuscitation' (DNA CPR) form on the trust's electronic patient records (EPR). Some staff were also unable to open the DNA CPR records on patient's EPR.

Openness and transparency was encouraged and staff understood their responsibilities to raise concerns and report and near misses. There were clearly defined and embedded systems, processes and procedures to keep patients safe and safeguarded from abuse.

The SPC teams staffing levels and skill mix were planned, implemented and reviewed to keep patients' safe. Any staff shortages were responded to quickly and adequately. There were effective handovers and shift changes, to ensure staff could manage risks to patients receiving EoLC.

Patients in receipt of EoLC received effective care and treatment that met their needs. EoLC patients

# Summary of findings

care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice. The trust's 'care of the dying person' care planning was based on the General Medical Council's (GMC) '5 priorities for end of life care'. The care plan provided comprehensive assessment of patients' needs. Information about patient's care and treatment, and their outcomes, was routinely collected and monitored. This information was used to improve EoLC.

There was participation in relevant local and national audits. Outcomes were used to improve patients care and treatment. End of life care patients were supported, treated with dignity and respect, and were involved as partners in their care. Patients and relatives were encouraged to make decisions, and were supported to do so. Staff helped patients and those close to them to cope emotionally with their care and treatment. Patients were supported to maintain and develop their relationships with their families, social networks and community.

Work was in progress for EoLC services to be planned and delivered in a way that met the needs of local people. A steering group had been established in late 2014, and a non-executive director (NED) for EoLC was appointed, but the strategy was recent and not embedded.

The leadership, governance and culture in EoLC services promoted the delivery of person-centred care. There was a clear statement of vision and values for EoLC, driven by quality and safety. The vision, values and strategy had been developed through a structured planning process with regular engagement from internal and external stakeholders at 'Listening into Action', (LiA) events, which included patients and staff. EoLC strategic objectives were supported by measurable outcomes, which were cascaded throughout the organisation. The challenges to achieving the strategy, including seven day working, were understood and an action plan was in place.

# Summary of findings

The board and other levels of governance within the hospital functioned effectively in regards to EoLC. Structures, processes and systems of accountability were clearly set out, understood and effective.

## Outpatients and diagnostic imaging

### Requires improvement



Outpatients and diagnostic imaging were not always safe or well led and required improvement to address this. The service was caring and responsive. There was a gap in leadership at matron level and some staffing shortages both in nurses and administrative staff. There was inconsistency in infection prevention measures and safety checks, with a variance in safeguarding and mandatory training compliance. Some clinic accommodation was inappropriate.

Compliance actions had been set from the previous inspection of the trust in September 2013 in relation to the care and welfare of people in outpatients. The main concerns had been the environment and patient flow through outpatients. There had been physical improvements in main outpatients and the fracture clinic and patient flow had improved. Most of the tasks from the outpatient transformation programme were on schedule.

There were effective systems for managing referrals, making appointments and collecting data. The hospital was meeting the majority of the national waiting time targets. Patients and staff spoke about delays and waits in outpatients and diagnostic imaging ranging from 30 minutes to over an hour.

Staff were caring; patients told us that staff always kept them informed and were kind and approachable.

The majority of the performance targets in referral to treatment times were being met. The trust learnt from complaints and sought people's views on how to improve the experience.

There was a comprehensive plan guiding the improvement and sustainability of outpatients, with systems in place to monitor the performance.

# Croydon University Hospital and Purley War Memorial Hospital.

## Detailed findings

### Services we looked at

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



# Detailed findings

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### Detailed findings from this inspection

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## Background to Croydon University Hospital and Purley War Memorial Hospital.

There are 670 hospital beds, 589 of which are for acute admissions, 66 for maternity and 15 for critical care.

The trust employs approximately 3,640 staff.

The trust serves the borough of Croydon and is one of the largest and most diverse London boroughs, having a population of over 360,000 people in an area covering 87 square kilometres.

Inspection teams always inspect the following core services:

- Urgent and emergency care.
- Medical care
- Surgical care.
- Maternity and gynaecology.
- Children and young people.
- Outpatients and diagnostics.
- End of life care.

## Our inspection team

Our inspection team was led by:

Chair: Mr Jan Filoshowski

Head of Hospital Inspection: Margaret McGlynn, Care Quality Commission (CQC).

The acute hospital services were visited by a team of 44 people, including CQC inspectors and a variety of specialists, including a medical director and a director and an assistant director of nursing. Our team was supported by a range of individuals with medical expertise, covering specialisms in dermatology, general medicine, critical care, end of life and outpatients, in addition to emergency care, paediatrics and palliative medicine. Surgical expertise was supported by representatives from the speciality areas of surgery, anaesthetics and obstetrics.

Nursing expertise was provided to the team from individuals practising in the areas of emergency nursing, theatres, maternity, critical care, children's nursing, end of life care, outpatients and medicine. We also had one student nurse on the team and an individual with safeguarding expertise.

We were accompanied by two experts by experience (members of the public who have developed expertise in relation to health services by experience of them through using them or contact with those using them, for example as a carer).

# Detailed findings

## How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?
- Is it well led?

Before our inspection visit, we reviewed information provided to us by the trust. We reviewed public and staff notifications received through our national enquiries channel, which included whistleblowing information. In addition, we reviewed reported incidents, safeguarding reports and complaints.

We held a public listening event on 3 June 2015, during which we listened to the experiences of attendees.

We asked in advance of the inspection visit for information from stakeholders. Information was received from clinical commissioning groups, the NHS Trust Development Authority, Healthwatch, General Medical Council, Nursing and Midwifery Council, Royal College of Nursing, NHS Litigation Authority and Health Education England.

During the week before the inspection we held a number of focus group discussions with staff members. These included representative staff groups from administrative staff, student nurses and midwives, nurses and midwives across the banding structure, and allied healthcare professionals (such as dietitians, pharmacy, occupational and physiotherapists).

The announced inspection visit took place from 16 to 19 June inclusive. An unannounced inspection took place out of hours on 30 June 2015.

During the inspection visit a further three focus group meetings took place with medical and surgical consultants and trainee doctors. We also interviewed senior members of staff at the hospital and undertook one interview following our visit.

We made observations in clinical, ward and theatre areas. Our inspectors spoke with patients and family members, as well as reviewing treatment and care records. Inspectors also reviewed documentation provided to them whilst on site.

## Facts and data about Croydon University Hospital and Purley War Memorial Hospital.

### Context

Croydon Health Services NHS Trust is based in Croydon, Surrey, and serves a population exceeding 360,000, providing acute care from Croydon University Hospital and outpatient services from Purley War Memorial Hospital, Croydon. In addition, there are 15 community clinics providing a range of services as part of the trust across an area of 87 square kilometres.

Croydon University Hospital offers a range of local services, including: a 24-hour Emergency Department (ED), medicine, surgery, intensive and high dependency care, children and young people's services, maternity and outpatient clinics.

The Indices of Multiple Deprivation indicate that Croydon is the eighth borough out of 326 in terms of deprivation, (the first being the most deprived).

Croydon has the highest proportion of hard-to-reach black and minority ethnic groups in South London at 44.9%.

The number of people not registered with a GP in the north of the borough is 6.3%, which represents the worst in London and is more than three times the national average.

# Detailed findings

Children and young people under 20 make up 26.9% of the population of Croydon and 66.2% of children are from a minority ethnic group. There is also a high number of frail elderly within the population.

Croydon has the highest number of 'looked after children' within the London boroughs and three out of 10 children under the age of five live in the most deprived parts of the borough. Child poverty in the borough is worse than the England average, with 25.2% of children under 16 living in poverty. The rate of family homelessness is worse than the England average, as is violent crime.

Figures for 2012/13 indicate that almost a quarter of children in the school reception year were obese or overweight. Figures for 2014 indicate that 10.3% of children aged four to five were obese or overweight. Almost 22% of children aged 10 to 11 were classified as obese.

Disease and poor health indicators show diabetes, incidence of TB and acute sexually transmitted infections to be worse than the England average.

During 2012/13 there were 327 emergency admissions to Croydon University Hospital because of asthma, which is higher than the average for England.

The number of 16-18 year olds not in education, employment or training in 2014 was slightly less than London at 3.3%. The number of 16 to 17-year-olds whose activity was not known in Croydon was 18.2%, compared with the London percentage of 10.4%.

## Activity

At the date of inspection, Croydon University Hospital had approximately 670 beds; 589 general and acute, 66 maternity and 15 critical care.

The trust employed approximately 3,209 staff, supported by 300 volunteers.

During 2013/14 there were 3,047 inpatient admissions and 67,159 emergency department attendances. Outpatient attendances were 324,440.

The number of births in the 2014/2015 was 3,833.

## Inspection history

This was the second inspection of Croydon University Hospital using our new methodology and the first to include Purley War Memorial Hospital. Our findings from the previous inspection resulted in compliance action as follows:

Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Care and Welfare of Service Users.

Improvements were needed to the care and welfare of patients, particularly in respect of:

- 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.

Specifically, our concerns were identified as follows:

## Safety

- Our findings following the previous inspection were that the Emergency Department needed to improve, as it was crowded, badly designed, and staff vacancies were high. We were concerned about staffing levels in some parts of the hospital and whether they always had enough skilled, experienced staff to deliver safe care. There were not enough staff in wards for older people.

## Effective

- At our previous inspection we found services were largely delivered effectively and outcomes for patients were within expected ranges. We found no evidence of concerns about mortality rates or infection rates. Quality assurance, including audit findings and lessons learned, was not always well understood at ward level.

## Caring

- Our previous inspection findings were that most people were positive about their care. Much of the care we observed during the inspection was good. However, we had concerns about outpatients and about there being too many discharges, particularly of older people, in the evening.

## Responsive

- Following our last inspection we reported that the hospital needed to do more to be responsive to people's

# Detailed findings

needs, particularly in the Emergency Department, where a high number of people were being discharged just before the target of four hours was up. Some parts of the hospital were in poor condition, preventing care from being delivered as effectively as it could be.

## Well-led

- We found during the last inspection that the trust's new senior management team were making progress on the necessary changes and staff wanted to tell us about the impact they had made. However, more evidence of sustained improvement was needed, but we saw and heard many positives. Complaints were not always responded to within an appropriate timescale, and some patients told us staff were defensive when responding to their concerns.

Key intelligence indicators

## Safe

- There had been four reported cases of Meticillin Resistant Staphylococcus Aureus (MRSA), 24 cases of Clostridium Difficile (C. Diff) and nine cases of Meticillin Susceptible Staphylococcus Aureus (MSSA). The trust had been below the England average for the majority of the 18 months reported.
- The trust had recorded 43 hospital-acquired pressure ulcers, 20 Falls and 30 catheter-related urinary tract infections in the 18 months reported. There had been little fluctuation on the numbers per month.
- There was a slightly lower percentage of consultants at this trust compared to the England average. This meant there was a slight increase to the percentage of Junior positions and middle career positions.
- The trust had reported two Never Events, (Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers). They reported 225 serious incidents requiring investigation and 4,273 incidents. Intelligence monitoring flagged the number of incidents as a risk.
- The trust used nearly 10% more bank and agency staff than the national average.

## Effective

- There was no evidence of risk from mortality indicators in the last version of intelligent monitoring for December 2014.

## Caring

- Patient Led Assessment of the Care Environment (PLACE) indicated the trust as slightly below the England average in all measures, though compared to 2013 scores the trust had improved.
- The trust was rated in the bottom 20% for 18 of the 34 indicators and were rated in the top 20% for three of the indicators in the Cancer Patient Experience Survey 2013/14.
- Trust scores were amongst the worst performing trusts for nine of the 12 questions asked in the CQC patient experience survey.
- Trust percentages were consistently below the England average in the Friends and Family Test related to recommending the trust.
- Written complaints had increased by 34% between 2011 and 2014. In 2013/14 there was an increase of 119 written complaints compared to the previous year.

## Responsive

- The trust had 5,486 instances of delayed transfer of care between April 2013 and November 2014. The top three reasons were patient or family choice, incompleteness of assessment, and waiting for further NHS non-acute care. This was in line with the top three reasons nationally.
- The trust's bed occupancy had fluctuated between 85.3% and 90.2% for the last six quarters.

## Well led

- The trust had consistently been under the national average for sickness absence rates for the last four years.
- The trust was performing as expected in nine of the 12 survey areas of the General Medical Council National Training Scheme and performing better than expected in the remaining three.
- Of the 31 indicators within the NHS Staff Survey, the trust had 10 negative findings, five positive findings and 16 findings within expectations. However, 20 of the 29 indicators previously used in 2013 achieved a lower score in 2014.

# Detailed findings







## Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Good	Good
Medical care	Requires improvement	Good	Requires improvement	Good	Good	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Inadequate	Requires improvement
Critical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

## Notes

# Urgent and emergency services

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

## Information about the service

The accident and emergency department (A&E) at Croydon University Hospital is open twenty-four hours a day, seven days a week. It treats people with serious and life threatening emergencies and those with less serious injuries, which need prompt treatment, such as lacerations and suspected broken bones. The A&E department is a recognised trauma unit although major trauma cases go directly to St. George's Hospital in Tooting.

The department has a five-bay resuscitation area with one bay designated for children. There is a major treatment area with eighteenseventeen cubicles and a six-bay rapid assessment and treatment area for ambulance patients. There is a small children's A&E department within the main department. There are separate rooms for patients with mental health needs and for relatives of patients who require resuscitation.

Adjacent to the A&E department is a 12 bed and four chair observation ward for seated patients. Reception facilities are provided by the adjacent urgent care centre (UCC) which is not run by Croydon University Hospital. The UCC has been inspected separately.

n 14 n bed observation ward with 12 beds and four bays for seated patie Reception facilities are provided by the adjacent urgent care centre (UCC) which is not run by Croydon University Hospital. The UCC has been inspected separately and we have only referred to it in this report where it has a direct impact on A&E patients.

We visited between 16 and 19 June 2015. We observed care and treatment from the time the patients arrived in the

department. We looked at 21 treatment records and spoke with approximately 30 members of staff including nurses, consultants, doctors, receptionists, managers, support staff and ambulance crews. We talked with 17 patients and four relatives. We received comments from patients and the public at our listening events, and we reviewed performance information about the department.

# Urgent and emergency services

## Summary of findings

Overall, we have rated the Accident and Emergency Department also known as the Emergency Department (ED) at Croydon University Hospital as good. Staff who worked in the department demonstrated a multidisciplinary approach to caring for their patients. They worked cohesively together, respecting each other's skills, experience and competencies in a professional manner that benefited the patients they cared for.

Safety in the department required improvement. The environment did not always enhance patient safety and equipment was not always cleaned properly. Patients arriving by ambulance were assessed and treated quickly but other patients were not always clinically assessed as soon as they arrived in the department. It was possible for their condition to deteriorate while they were waiting to be seen. This was partly caused by the fact that the Emergency Department shared reception facilities with the adjacent urgent care centre, which was run by another organisation. Reception processes meant that some patients were not sent to be assessed by ED staff which had an adverse impact on their treatment. On arrival at the reception, some patients were sent in error to the urgent care centre, which had an adverse impact on some of their patients. Staffing levels for both medical and nursing staff also needed to improve.

Care and treatment was effective and delivered in line with current evidence based guidance and standards. The trust used national and local clinical audits to monitor the effectiveness of care and treatment.

The department was responsive to the needs of local people and had particularly good facilities for patients with dementia. The ED was better than many other hospitals in meeting the national target of admitting or discharging 95% of patients within four hours.

The department itself was well-led. The leadership actively shaped the culture through effective engagement with staff and patients. They demonstrated the skills, knowledge and experience needed for their roles.

## Are urgent and emergency services safe?

Requires improvement



Patients arriving by ambulance were assessed and treated promptly but other patients sometimes experienced long delays before being assessed by an appropriately qualified member of staff. Staffing levels needed to improve and the department was poorly designed but staff worked hard to reduce the risks that resulted from this. Although all staff had undertaken infection control training, patient trolleys and commodes were not always suitably clean.

The computer system made it difficult to maintain accurate patient records and to carry out risk assessments. Staff received appropriate training and were competent but there was a shortage of senior nurses to take charge of the department. Clinical staff knew how to ensure safeguards for vulnerable people. There was good reporting of incidents, although feedback to staff was limited.

Staff in the Emergency Department reported incidents using the trust wide electronic reporting system. There were approximately 300 incident reports a year, which demonstrated a good level of reporting. There were four serious incidents in the year ending February 2015. These had been swiftly and thoroughly investigated by senior staff. Action plans had been put in place to prevent similar incidents happening in the future. For example, the lead ED consultant for each shift now reviewed all patients in the resuscitation area in detail before starting other duties.

### Incidents

- We looked at the incidents that had been reported between December 2014 and March 2015. Of those, 22% were patients who had been brought to the department with pressure ulcers acquired at home. The remainder were a mixture of staff, patient and organisational incidents, which resulted in no harm or minor harm such as a short delay in treatment.
- Senior staff had addressed the incident reports promptly and had taken action when necessary.
- Learning from incidents and “near-misses” was not formally cascaded to all staff in the department. We were told that learning was by “word of mouth” or when changes to protocols or professional guidance took place.



# Urgent and emergency services

- Mortality and morbidity meetings were held twice a month and were well attended. The minutes of these meetings, which we reviewed, lacked detail of learning points. However, discussion with staff showed that practice had been changed where necessary and that learning was well-embedded. For example, a falls care plan had been implemented in the observation ward.
- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person'. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have, occurred.
- We discussed the duty of candour with staff who had investigated the serious incidents noted above. They described the discussions that had taken place with the patients concerned and their families and it was clear that they had fulfilled the requirements of the legislation.
- All staff that we spoke with understood the principles of openness and transparency that are encompassed by the duty of candour. Senior staff demonstrated detailed knowledge of the practical application of this new responsibility.

## Cleanliness, infection control and hygiene

- We observed support staff cleaning the department throughout the day and walls, floors and surfaces were visibly clean. We observed nurses cleaning the mattresses on trolleys between patients but noticed spots of blood on the under-surfaces of four patient trolleys. There was also a build up of matted fibres stuck to the wheels of two trolleys.
- A patient drew our attention to a chair in the cubicle which had a green label stating that it was clean. However, it had a visible smear of blood on it. When we inspected the dDirty uUtility rRoom we found one of the two commodes with a small smear of faeces on it.
- We pointed out these issues to the nurse-in-charge who took immediate action to remedy the situation. We were told that the housekeeping department had been asked to "jet-wash" the A&E trolleys two weeks previously.

However, the trolleys were used throughout the hospital and it was possible that those in the department during our inspection were not the same as those that were cleaned two weeks previously.

- We asked the hospital for a copy of the service level agreement for the cleaning of this equipment. Instead we were sent a document entitled 'Total cleaning responsibility framework', which stated whether clinical staff or the domestic contractor were responsible for cleaning various items of equipment. However, neither patient trolleys nor commodes were on the list and so it was not clear who was responsible for cleaning these items.
- Hand washing facilities and hand cleaning gels were available throughout the department and we saw good examples of hand hygiene by all staff. This helped to prevent the spread of infection.
- The department had an infection prevention link nurse who undertook hand hygiene and other audits. Unfortunately she was not present during our inspection to speak with.
- We observed staff treating a patient in isolation in accordance with trust policies and procedures. This included the appropriate use of gloves and disposable aprons.
- Staff were aware of the actions necessary to look after someone with, or who may have been involved in, the recent Ebola outbreak. There were notices in the entrance asking people to inform the receptionists if they had recently travelled to the affected countries

## Environment and equipment

- As noted in our previous inspection in 2013, the department was poorly designed and, in places, cramped. For example, there was insufficient space for ambulance crew to draw up outside the ambulance entrance. Instead, they had to reverse into an adjacent parking space, which may be some distance from the entrance. Staff could not see the ambulance entrance and there was no member of staff designated to greet crews when they arrived. Ambulance crews from outside Croydon had to find someone and ask where to go. During our inspection, we observed delays experienced by an injured child because it was not clear to the ambulance crew where the children's treatment area was.
- The design of the major treatment area meant that it was not possible to observe all of the patients. To



# Urgent and emergency services

mitigate this, we observed the nurse in charge undertaking an hourly round of all patients to ensure that they were safe, comfortable and that their treatment was progressing.

- There was a small X-ray department adjacent to A&E. It was well equipped and easily accessible from all areas.
- Patients in the waiting room could not easily be observed by receptionists or clinical staff. This meant that their condition could deteriorate without staff noticing. We observed a patient vomiting and in severe pain in the waiting room for more than 15 minutes without any member of staff coming to help. We drew this to the attention of the triage nurse who then assessed the patient and arranged for further treatment.
- There was a separate quiet room for people suffering with mental health problems. This was appropriately furnished and the alarm system allowed people to call for help from all parts of the room.
- There was sufficient resuscitation, monitoring and decontamination equipment. Such equipment was clean, well maintained, regularly checked and ready for use.
- There was poor ventilation throughout the department. We inspected in June 2015 and the environment became uncomfortably warm during the afternoon, particularly in the waiting room.

## Medicines

- Medicines were stored correctly in locked cupboards or fridges. Controlled drugs were checked regularly and recorded accurately in a register.
- Unused drugs were disposed of in accordance with hospital policy.
- We observed staff administer intravenous fluids safely and correctly. They methodically completed details on the medication chart.
- We looked at four other prescription records and found them to be completed accurately and legibly.

## Records

- The staff in the Emergency Department used a combination of computer and paper records. The computer system produced a paper record and was able to record key events such as when a patient was seen by a doctor, physical observations such as temperature and heart rate and investigations such as blood tests and X-rays.
- However, several staff told us they found the computers slow and difficult to use. As a result, most clinical

information was written on the ED record card and then had to be entered on to the computer by administration staff after the patient had left. There was a risk that key information could be entered incorrectly or missed altogether.

- It was difficult to review patients as some information was only recorded on the computer and different information was only recorded on the paper record.
- Some aspects of the computer system did not work at all. For example, the risk assessment for pressure ulcers. This involved detailed calculations resulting in a risk score. In order to calculate the score nurses had to download the calculations from the internet before recording them on the paper record. The details could not be saved and so it was not possible to later assess whether the score had been calculated correctly.
- When patients were admitted to a ward, the information contained on the paper record had to be scanned into the hospital computer system. The scanning equipment was not easy to use and we saw that it resulted in computer records that were sometimes difficult to read.

## Safeguarding

- Staff that we spoke with were aware of their responsibilities to protect vulnerable adults and children. They understood the safeguarding procedures that were in place and how to report concerns. The 'At risk' register was checked for all children up to and including the age of eighteen.
- All clinical records for children contained a risk assessment tool aimed at quickly identifying any concerns regarding child welfare.
- At the time of our inspection 93% of staff had completed annual training in adult safeguarding and 95% had completed children's safeguarding training.
- All staff (including administrative staff) were expected to do level 2 child protection training and senior clinical staff were expected to undertake level 3 training. We were told that medical consultants' appraisals could not be completed without evidence of a level 3 update in the last 12 months.

## Mandatory training

- Mandatory training included essential topics such as fire training, health and safety, infection control and manual handling. We saw training records up to May 2015 which showed good uptake of this annual training. Rates of attendance varied from 87% for fire training to 96% for manual handling.

# Urgent and emergency services

## Assessing and responding to patient risk

- Patients arriving by ambulance as a priority (blue light) call were taken immediately to the resuscitation area. Such calls were phoned through in advance so that an appropriate team could be alerted and prepared for the arrival of the patient.
- Other adult patients arriving by ambulance were taken to the rapid assessment and treatment (R.A.T.) area where diagnostic tests and initial treatment were undertaken by senior nursing and medical staff. Once the patient's condition had been assessed and stabilised they were transferred to another treatment area within the department.
- The R.A.T. area had a large computer screen displaying the details of ambulance patients that were en-route to the Emergency Department and their estimated time of arrival. This meant that staff could ensure that a treatment bay was free when the next ambulance arrived.
- Senior staff told us that, since this new area had been established, delays for ambulance patients had reduced significantly. Hospital figures showed that, during April and May 2015, four or five ambulance patients a week waited 30-60 minutes to be handed over to Emergency Department staff. This was better than many other hospitals in England and during our inspection we saw no delays at all.
- Children arriving by ambulance were taken to the children's ED where they were rapidly assessed by an experienced nurse.
- Patients who walked into the ED, or who were brought by families or friends, reported to the reception desk. This was shared with, and run by the adjacent urgent care centre (UCC), which was run by a separate organisation. Once initial details had been recorded patients were asked to sit in the waiting room while they waited to be assessed by a nurse. This assessment was required in order to determine the seriousness of the patient's condition and to make plans for their on-going care. This is often known as triage. Guidance from the Royal College of Nursing (RCN) and Royal College of Emergency Medicine (RCEM) states that "Triage is a face to face encounter which should occur within 15 minutes of arrival." The Emergency Department at Croydon University Hospital was not meeting this standard.
- During our inspection we observed frequent delays of 20-30 minutes, particularly at the beginning of the day and in the evenings. Figures supplied by the hospital showed that only 48% of adult patients were clinically assessed within fifteen minutes during April and May 2015. These delays meant that patients with serious conditions could deteriorate while they were waiting. Children were assessed separately by a specialist children's nurse and 89% were seen within 15 minutes. It should be noted that it was difficult to enter triage times onto the computer system and therefore these figures may not have been accurate.
- Some patients were not triaged by a nurse at all. If the receptionist thought their injury or ailment was a minor one they would be placed in a queue (known as "streaming") for the urgent care centre (UCC). Following the inspection trust told us the UCC receptionists based their decisions from jointly agreed protocols with Croydon Health Services, provided for them by the UCC.
- However, the system did not work well and figures supplied by the hospital showed that, in April and May 2015, up to 10 patients a day were incorrectly sent to the UCC.
- Although a basic assessment of a patient's physical state was later undertaken by a healthcare assistant, we could see no evidence that this prioritised care or treatment. For example, during the evening of our inspection two patients, one with a significant head injury and another with a serious infection, were transferred to A&E after three hours because they had been incorrectly streamed to the UCC. Both required specialist treatment and admission to hospital.
- A position statement issued by the RCN and RCEM states that 'Staff undertaking this role (triage) should be registered healthcare professionals experienced in emergency/urgent care who have received specific training and can demonstrate developed interpersonal skills so that they are able to communicate effectively with patients and their families in what is often a stressful situation'. This means that triage should not be carried out by a receptionist or a healthcare assistant, however experienced.
- We saw reports of two recent incidents where risk to ED patients and others had been increased because of this method of streaming.
- Although Croydon University Hospital was not responsible for the urgent care centre, patients were not being seen quickly enough by appropriately qualified staff. This has not changed since our last inspection in September 2013.

# Urgent and emergency services

- Staff in the Emergency Department had recognised that assessment of patients by the UCC sometimes caused difficulties for patients. They had arranged joint clinical governance meetings with senior staff from the UCC with the aim of reducing risk to A&E patients. However, these meetings rarely took place because no-one from the UCC was available to attend. The hospital had confirmed that none of these meetings had taken place in the last six months, despite communications to relevant individuals reminding them of the importance of attending.
- Patient early warning scores (EWS) were used throughout the department. This was a quick and systematic way of identifying patients who were at risk of deteriorating. Once a certain score was reached a clear escalation of treatment was commenced.

## Nursing staffing

- We looked at nurse staffing for the two days prior to our inspection and compared it to the staffing recommendations issued by the National Institute for health and Clinical Excellence (NICE). Most treatment areas complied with the recommendations apart from adult triage. Although there were two triage rooms there was usually only one nurse present. As a result, less than 50% of adult patients were triaged within 15 minutes. The Emergency Department matron had identified this as a concern and told us that there were plans to have two triage nurses on duty from 8am until midnight. However, current staffing levels did not yet allow this. There were 20% vacancies in the senior nurse group, with only two band 8 when there should be four.
- The resuscitation room had sufficient staffing. A new role of emergency care practitioner had been created with specific competencies in resuscitation skills. Together with experienced nurses they maintained a patient:staff ratio of 2:1 at all times. Nurses that we spoke with told us that they had undertaken the Resuscitation Council's Intermediate Life Support course and others had also attended paediatric resuscitation training. This was confirmed by the training records.
- There were not enough band 7 sisters to take charge of the department on every shift. Band 6 nurses were in charge approximately 50% of the time.
- There was at least one registered sick children's nurse on duty at all times.

- On most shifts 15%-20% of nurses were from an agency. However, permanent nursing staff told us that the majority worked in the department on a regular basis and were aware of local working practices. We were shown an informative orientation pack that was given to nurses when they came to work in the department for the first time.

## Medical staffing

- The department employed sixteen consultant doctors, which less when compared with the national average (14% of doctors compared to 23%). There is also a higher ratio of junior doctors compared with the national average (40% to 25%). The rota ensured a consultant presence from 8am until midnight on weekdays and at weekends. There was always a consultant on-call at night. This was in line with recommendations from the Royal College of Emergency Medicine
- The national standards for children in emergency care settings states that any department seeing more than 16,000 children a year should employ a specialist children's consultant. For the first time last year this number was exceeded in Croydon. We received confirmation that there was a Consultant in Paediatric Emergency Medicine who commenced in a locum post in December 2014 and then went into the substantive role in January 2015.
- We were told that the department had difficulties recruiting middle grade doctors and there were only two who were permanently employed at the time of our inspection. The remaining posts were filled by temporary locum doctors. However, the locum doctors had worked in the department for several months and were familiar with local working practices. We were shown the induction programme that they undertook when they started which was detailed and appropriate.
- Junior doctors spoke positively about working in the ED. They told us that the consultants were supportive and always accessible. In-house teaching was well-organised and comprehensive.
- We saw consultants working clinically in the department. They led the treatment of the sickest patients, advised more junior doctors and ensured a structured clinical handover of patient's treatment when shifts changed.

# Urgent and emergency services

## Major incident awareness and training

- The hospital had a major incident plan (MIP), which was up-to-date and detailed. The MIP provided clinical guidance and support to staff on treating patients of all age groups and included information on the triaging and management of patients suffering a range of injuries, including those caused by burns or blasts and chemical contamination.
- Staff in the Emergency Department were well-briefed and prepared for a major incident and could describe the processes and triggers for escalation. Similarly they described the arrangements to deal with casualties contaminated with chemical, biological or radiological material, otherwise known as Hazardous Material (HAZMAT).
- Emergency Department staff told us there were sufficient security staff in the hospital and they responded rapidly when called to the department. We observed regular patrols throughout the department and waiting room. They were carried out in a calm and reassuring manner.
- We spoke with two security guards who were able to speak confidently about defusing aggressive situations and safe restraint techniques.

## Are urgent and emergency services effective?

(for example, treatment is effective)

Good



The Emergency Department had good governance arrangements and took part in both national and local audits. Policies and procedures were developed in conjunction with national guidance and best practice evidence from professional bodies such as the Royal College of Emergency Medicine, the National Institute for Health and Care Excellence (NICE) and the Resuscitation Council UK. Local audits were undertaken in order to assess the effectiveness of treatment delivered in the A&E department. Pain relief was offered appropriately in most cases. Patients were offered food and drink, and these were documented in the patient record.

Staff were competent and had undertaken appropriate specialist training. Multidisciplinary working was in evidence so that the needs of each patient were prioritised. Staff had a good understanding of consent and the Mental Capacity Act.

## Evidence-based care and treatment

- Staff used a combination of National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines to determine the treatment that was provided. Guidance was regularly discussed at governance meetings, disseminated and acted upon as appropriate. For example, guidelines on the reporting of radiological images had recently been updated.
- A range of clinical care pathways and proformas had been developed in accordance with guidance produced by NICE. These included treatment of strokes, asthma and feverish children. At fortnightly governance meetings any changes to guidance and the impact that it would have on their practice was discussed. Recently there had been changes regarding pregnancy tests.
- Staff in the department undertook audits to monitor the compliance with these guidelines. Following a recent audit of the diagnosis and treatment of serious head injuries, protocols had been revised. This had resulted in faster diagnosis and treatment.

## Pain relief

- We observed that nurses administered rapid pain relief when they assessed patients who had walked into the department and those who had arrived by ambulance.
- During our inspection we observed timely pain relief administered to children. The results of the pain relief were monitored and additional treatment given if necessary.
- The computer system made it difficult for us to see whether formal pain scores had been assessed but eight of the nine patients that we spoke with reported that they had been offered appropriate pain relief. Records showed that this had been administered promptly and in line with hospital policy.

## Nutrition and hydration

- Following the assessment of a patient, intravenous fluids were prescribed and administered and recorded when clinically indicated.
- Patients that we spoke with told us that they had been offered drinks and snacks where appropriate.

# Urgent and emergency services

## Patient outcomes

- The department was aware of the requirements of the national intercollegiate 'Standards for children and young people in Emergency Care settings'. It had recently started to see more than 16,000 children a year which meant that there should be a specialist children's consultant in place and a play therapist. The matron for the children's A&E told us that work on a proposal to implement these new posts had commenced.
- The department participated in a number of national audits, including those carried out on behalf of the Royal College of Emergency Medicine (RCEM). Results from the 2013 College of Emergency Medicine clinical audit relating to renal colic showed poor compliance with the administration of pain relief. An audit of the treatment of fractured necks of femur (broken hips) in 2014 demonstrated similar problems. Senior staff told us that the introduction of the rapid assessment and treatment area had improved the speed of pain relief. They showed us the results of internal audits that confirmed this and we observed the administration of rapid pain relief during our inspection.
- A 2014 audit of patients with sepsis (a life-threatening condition which can result from a severe infection) showed that vital blood tests and the administration of intravenous fluids did not happen as quickly as required. As a result, patients showing signs of sepsis were being treated in the resuscitation room and treatment was happening much faster and more effectively.
- In 2014 the number of patients who returned to the department within seven days with the same problem was higher than the national average. Departmental managers told us that the figures were not accurate as the computer system was unable to capture sufficient information about these patients. However, a small internal audit indicated that the real figure was 5.8% of all patients, which was lower than the national average of 7%.

## Competent staff

- Appraisals of both medical and nursing staff were being undertaken and staff spoke positively about the process.
- All band 5 and 6 nurses had received an appraisal in the last year, as had HCAs. Only 50% of band 7 sisters had an up-to-date appraisal because the band 8 matron had only been in post for 8 weeks.

- Teaching and staff development was a priority in the department. There were two practice development nurses who helped to ensure the competency of nursing staff and doctors had protected learning time for their professional development.
- Staff told us that there was a structured competency framework so that nurses and their managers knew when they were ready for increased levels of responsibility. Training records kept by the practice development nurses showed that competencies included suturing, application of plaster casts and the use of Entonox for pain relief.
- We spoke with junior doctors, who told us that they received regular supervision from the emergency department consultants, as well as twice weekly teaching sessions.

## Multidisciplinary working

- There was effective multidisciplinary working within the ED. This included effective working relations with speciality doctors and nurses, social workers, community outreach teams, therapists and GPs.
- Medical, nursing staff and support workers worked well together as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- Nursing and medical staff told us there was a good working relationship with the child safeguarding team and with the community paediatric team.

## Seven-day services

- The department had access to radiology support 24 hours each day, with rapid access to CT scanning when indicated.
- There was an on-call pharmacy service outside of normal working hours.
- Emergency Department consultants provided cover 24 hours per day, 7 days per week, either directly within the department or on-call.

## Access to information

- Information needed to deliver effective care and treatment was well organised and accessible. Treatment protocols and clinical guidelines were computer based and we observed staff referring to them when necessary.
- Discharge letters were clear and comprehensive and were sent to GPs on a daily basis.



# Urgent and emergency services

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed that consent was obtained for any procedures undertaken by the staff. This included both written and verbal consent.
- Consent forms were available for people with parental responsibility to consent on behalf of children. The staff we spoke with understood their responsibilities in relation to consent and mental capacity.
- Senior staff told us they used the new mental capacity assessment forms, although they were not able to show us any examples during the inspection.
- Where patients lacked the capacity to make decisions for themselves, such as those who were unconscious, we observed staff making decisions which were considered to be in the best interest of the patient. We found that any decisions made were appropriately recorded within the medical records.

## Are urgent and emergency services caring?

Good



The Emergency Department staff provided compassionate care and ensured that patients were treated with dignity and respect. There were positive comments from patients about the care received, and the attitude of motivated and considerate staff.

Patients and their relatives and families were kept informed of on-going plans and treatment. They told us they felt involved in the decision-making process and had been given clear information about treatment options. Nurses in the children's treatment area provided distraction from potentially upsetting treatment such as injections and blood tests.

## Compassionate care

- During our inspection we saw many examples of patients being treated with compassion, dignity and respect. Staff introduced themselves by name and explained treatment plans in terms that were easily understood. One patient told us "The staff always take time to explain. They don't talk down to you."
- People living with dementia or who had a learning difficulty were given special consideration. They were cared for in a separate quiet treatment area, which was

decorated in soothing pastel colours. This produced a calm atmosphere, which helped to reduce anxiety and confusion. Conversations were held at a pace that suited the individual and simple terms were used to help people understand what was happening.

- Staff took time to distract and comfort children during injections and blood tests. Parents were involved in the assessment and treatment of their children and clear explanations were given. One father told us "Now I know the problem, I feel better."
- We spoke with seventeen patients and a number of family members. They all reported a positive experience. One said "These people have been amazing. Although the nurse was very busy she took me to the toilet and waited for me." Another said "I am confident about the care here and I do feel safe."
- Two patients had been to the department on more than one occasion. One told us that it was "better than it used to be. I think this is a good hospital now." The other said "The staff are brilliant – so friendly and polite."
- The results of the NHS friends and family test scores were consistently higher than the national average during 2014/15. For the year ending March 2015, 92% of people would recommend the ED compared to a national average of 87%. Although the response rate was relatively low (27% of people who attended) it was higher than the national average of 87%.
- The results of the 2014 national A&E survey indicated that Croydon Emergency Department staff were not as caring as many other departments. There were 10 questions about caring in the survey where the department scored less than other hospitals. They mainly related to issues about communication and explanation of care and treatment. However, when we asked patients similar questions during our inspection the responses were overwhelmingly positive. This helped to demonstrate that improvements have taken place since the last survey.

## Understanding and involvement of patients and those close to them

- There was clear information on the notice board in the reception area about the department. This included details of the patient advice and liaison service.
- Patients that we spoke with all said that they had been involved in the planning of their care and had understood what had been said to them.

# Urgent and emergency services

- Patients in the observation ward told us that they had been consulted about their treatment and felt involved in their care.
- We spoke with 10 patients in the major treatment area who told us they had been well informed about their care and treatment.

## Emotional support

- We observed staff giving emotional support to patients and their families. They gave open and honest answers to questions and provided as much reassurance as possible.
- Support was particularly strong for relatives of patients who needed to be in the resuscitation room. We observed nurses preparing relatives before they entered the resuscitation room and then carefully explaining what had happened and the details of the immediate treatment plan.
- There was a quiet sitting room where distressed relatives could sit in a private space. This was large enough to accommodate several people and was appropriately equipped.
- Multi-faith chaplaincy services were available day and night for people who would benefit from spiritual support.

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

Good



On the whole the department responded to patients' needs in a timely fashion. The national standard for admitting or discharging patients within four hours was better than many other Emergency Departments. Ambulance patients were assessed and treated promptly but there were sometimes delays in the initial assessment of other patients.

Staff responded well to patient's individual needs. There was a clear understanding of the requirements of people living with dementia and learning disabilities. Relatives were encouraged to stay with them whilst in the department. Patients of 80 years or more were referred to

the acute care of the elderly team to ensure that their complex needs were expertly addressed. Complaints were handled in a timely and sympathetic fashion and were used to improve future care and treatment.

## Service planning and delivery to meet the needs of local people

- Plans were well advanced for a new and larger emergency department designed to meet the increasing population of the Croydon area.
- The department would need to be moved to temporary accommodation during the building works. We were shown the plans for this accommodation which had taken into account the needs of all the services that were to be provided. The building and move to temporary accommodation will be scheduled to commence in Autumn 2015.

## Meeting people's individual needs

- Staff that we spoke with demonstrated a good understanding of the requirements of patients with complex needs. There was an assessment tool that helped to identify immediate treatment needs.
- All patients of 80 years or over, who did not require admission by the acute medical team, were referred to the Acute Care of the Elderly team before being discharged. This was a multidisciplinary team with close links to community services. They undertook a detailed assessment of people's needs in the community and ensured these were in place before they went home. Records demonstrated that family members were also consulted before an elderly person was discharged home.
- The majority of staff had undertaken training in the specific needs of people with dementia and learning disabilities and the involvement of families was encouraged. The appointment of a trust-wide learning disabilities nurse had improved awareness and staff felt able to contact her for advice.
- Staff were able to describe the translation services that were available to the department. They were familiar with their use. Signs in the waiting room were displayed in the four main languages spoken in the Croydon area.
- Special attention was paid to people who had suffered domestic violence. They were offered support and counselling and were given the telephone number of a crisis line should they need help in the future.

# Urgent and emergency services

## Access and flow

- During the last year (June 2014 to May 2015) the emergency department, had not always met the national standard to treat, discharge or admit 95% of patients within four hours of arrival. In April and May 2015, 91% of patient were admitted or discharged within four hours. This was slightly better than the national average of 90%.
- However, some patients spent a long time in the department before being admitted to a ward. In 2014 the time patients spent in the department was consistently higher than other hospitals in England. Figures provided to us indicated that the four-hour total time in the department year to date (May 2015) was at 90.64% against a target of 95%.
- During one evening of our inspection we followed the progress of the eight patients who had been in the department for more than four hours. Of the eight, four were being assessed by or were waiting for specialist doctors; one was waiting for a bed to be available on a ward; one had waited more than an hour to see an ED doctor and two had been transferred to A&E from the UCC after three hours. We were told the ED “inherits” the UCC waiting time when patients were transferred which made the stay in A&E look longer than it actually was.
- Emergency Department managers monitored the causes of patients staying in the department for more than four hours. Recent figures (April and May 2015) showed that the most common cause (24% or seven patients a day) was caused by delays of more than an hour to see an Emergency Department doctor. The next most common causes were ED patients being delayed in the UCC (20%) and waiting for an assessment bed (17%).
- Delays in admitting patients to a ward had been consistently less than other hospitals in England. The latest information (January 2015) showed that 3% of patients waited between four and 10 hours to be admitted compared to 10% in the rest of England. For the year ending January 2015 an average of 4% of patients had waited between four and twelve hours to be admitted after the decision to admit had been taken. This was better than the national average of 6%.
- Data provided to us indicated that there had not been any 12 hour trolley waits year to date.

## Learning from complaints and concerns

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint they were directed to the nurse in charge of the department. If the concern was not able to be resolved locally, patients were referred to the Patient Advice and Liaison Service, who would formally log their complaint and would attempt to resolve their issue within a set period of time. PALS information was available within the main department.
- Formal complaints were investigated by a consultant or the nurse manager and replies were sent to the complainant in an agreed timeframe. Minutes from A&E governance meetings confirmed that learning points from complaints were discussed.

## Are urgent and emergency services well-led?

Good



The Emergency Department had an energetic and well-motivated leadership team. They were highly visible in the clinical environment and had established an effective governance framework to support the delivery of high quality care. They demonstrated the skills, knowledge and experience needed for their roles. Staff told us that the emergency department had an open and honest culture with good teamwork.

## Vision and strategy for this service

- We were shown the strategic plan for the ED department, which was aimed at putting the patient at 'the heart of the care being provided to them'. Staff that we spoke with identified with this aim and described some of the changes that were already happening.
- Plans for the building of a new department were well advanced and a move to temporary accommodation was due to start in November 2015. The needs of the people using the department had been taken into account when planning the move.

## Governance, risk management and quality measurement

- There were effective processes in place to identify, understand, monitor and address current and future challenges to high quality care and treatment.



# Urgent and emergency services

- The department maintained a risk register, which defined the severity and likelihood of risks in the department causing harm to patients or staff. It documented the measures to be taken to reduce the risk. We saw that the risks described accurately reflected the concerns described by staff in the department. The risk register was reviewed at least monthly by the leadership team.
- Arrangements had been made to hold regular meetings with the provider of the adjacent urgent care centre in order to identify and manage risks to patients more effectively. However, these meetings were not taking place as intended due to lack of attendance by urgent care centre staff. This was despite communications to relevant individuals to remind them of meetings.
- Fortnightly governance meetings were held and all staff were encouraged to attend, including junior members of staff and students. We saw from minutes that complaints, incidents, audits and quality improvement projects were discussed.
- Staff told us they felt fully supported by their clinical leads and senior managers and they were confident that they would address any concerns reported to them.

## Leadership of service

- Leadership and management of ED were shared between a senior consultant (Clinical lead), the A&E matron and the directorate manager.
- Staff told us that the leadership team had the skills, knowledge, experience and integrity required to carry out their roles.
- The Emergency Department matron had been in post for eight weeks and was consulting with nursing staff about future plans. Nurses told us that she was approachable and understanding.
- Governance mechanisms had been established to monitor and improve standards of patient care.
- We saw documents confirming that debrief sessions were held by senior clinicians after difficult clinical situations.

## Culture within the service

- Staff told us that they felt respected and valued by their colleagues and the leadership team within the department.

- There was a strong sense of teamwork which encouraged candour, openness and honesty.
- The culture within the department was centred on the needs and experience of people who used the service.

## Public engagement

- In each area of the department, there were public information boards containing information such as safety information, Friends and Family test results and maps of the hospital.
- Senior staff had recently invited the local paper into the department to improve understanding of working practices.







## Staff engagement

- Staff felt actively engaged in the planning and delivery of services. They spoke enthusiastically about plans for the new department.
- The department had recently won a hospital award for the introduction of a patient flow co-ordinator. Staff told us this was a senior nurse who constantly monitored patients' progress through the department. If any delays were detected the co-ordinator took immediate action to overcome them. This had improved the patient experience. Following the inspection the trust told us this role was carried out by an administrator.

## Innovation, improvement and sustainability

- Plans were well advanced for the building of a new Emergency Department with up-to-date facilities. The department had recently won a hospital award for the introduction of a patient flow co-ordinator. This was a senior nurse who constantly monitored patients' progress through the department. If any delays were detected the co-ordinator took immediate action to overcome them. This had improved the patient experience.
- A shared learning programme with a hospital regarded as a centre of excellence had introduced ideas for new ways of working that would benefit patients.
- A pilot scheme was about to take place to evaluate a GP treating patients within the treatment of patients who needed to be treated in the ED but who could avoid a hospital admission and enable them to continue their treatment in the community. The scheme was due to last for three months.

# Medical care (including older people's care)

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

## Information about the service

We inspected all of the medical wards within the Integrated Adult Care directorate which covers most medical areas at Croydon Hospital which were: Acute Medical Unit (AMU); Coronary Care Unit; Coronary Department; Duppas ward; Edgecombe Bay one ward; Edgecombe Bay two ward; Fairfield two ward; Heathfield one ward; Heathfield two ward; Purley one ward; Purley two ward; Wandle one ward; Wandle two ward; Wandle three ward and the ambulatory care unit.

We spoke with 32 patients, 13 family members and 58 staff members that included: clinical leads; service managers, matrons, ward staff, therapists, junior doctors, consultants, and other non-clinical staff. We observed interactions between patients and staff, considered the environment including medical equipment and looked at 43 medical records and attended medical and nursing handovers. We reviewed other documentation from stakeholders and performance information from the trust.

## Summary of findings

Patients were kept safe while they were being cared for at Croydon Hospital. Patients who were at risk of deteriorating were monitored and systems were in place to ensure that a doctor or specialist nurse was called to provide the patient and ward staff with additional support. The trust had an open culture and was prepared to learn from clinical incidents.

There were enough doctors and nurses available to keep people safe. Although the trust found it difficult to recruit and retain nursing staff, it was able to effectively fill gaps using bank staff.

One area that requires further improvement is staff attendance at mandatory training. Attendance at training was below the 90% trust target.

We found that care was provided in line with national and local best practice guidelines. Clinical audit was being undertaken and there was good participation in national and local audit that demonstrated good outcomes for patients with the exception of diabetes care and treatment. We observed good clinical practice by clinicians during our inspection. Patient morbidity and mortality outcomes were broadly within what would be expected for a hospital of this size and complexity and no mortality outliers had been identified. Although there was a good knowledge of the issues around capacity and consent among staff the

# Medical care (including older people's care)

trust was unable to provide any assurance that capacity assessments were always being carried out when needed and that consent was being recorded in medical notes.

Patients received compassionate care and were treated with dignity and respect. Most of the patients and relatives we spoke with said they felt involved in their care and were complimentary and full of praise for the staff looking after them. One person told us: "it's fine, I have no complaints, the staff are friendly and always come when I call them." A number of patients raised concerns that they were not always kept informed about their treatment. The medical services had mixed results in patient surveys but results indicated an improvement in the views of patients over the last 12 months.

The medical services were effective at responding to the needs of its community and very responsive to its elderly community. The hospital operational management team had an excellent grip on the status of the hospital at any given time. Bed availability was well managed. Discharges were still not fully effective with patients waiting too long in the discharge lounge and waiting too long for their prescriptions. Elderly care pathways had been well designed to ensure that elderly patients were assessed and supported with all their medical and social needs. Patients who were living with dementia were accommodated on two specifically adapted 'dementia friendly' wards. The hospital had designed pathways that where possible kept patients out of the Emergency Department (ED). The Ambulatory Care Unit and AMU provided effective alternate pathways for GPs and other referrers.

The medical services were very well led; divisional senior managers had a clear understanding of the key risks and issues in their area. The medical areas had an effective meeting structure for managing the key clinical and non-clinical operational issues on a day to day basis. The hospital had a risk register which covered key risks but was still being developed to accommodate the recent changes to the directorate structure. There was a clear drive and enthusiasm among managers to innovate services for patients and particularly elderly patients. Staff spoke positively about the high quality care and services they provided for patients and were proud to work for the hospital. They described the

hospital as a good place to work and as having an open culture. The most consistent comment we received was that the hospital was a friendly place to work and people enjoyed working with their teams.

# Medical care (including older people's care)

## Are medical care services safe?

Requires improvement



Staff reported incidents when things went wrong. The trust had effective processes in place for reporting, investigating and learning from incidents.

We observed that clinical staff regularly washed their hands in between seeing patients, used personal protective equipment (PPE) such as gloves and aprons and adhered to the trust's bare below the elbows policy. However we noted that staff visitors to wards such as maintenance and medical records staff did not always use the hand sanitisers as they entered the wards.

Although staff we spoke with understood the issues with regards safeguarding, the level of training was too low at 62% compared to a trust target of 90%. The levels of compliance with mandatory training was too low at 63% overall against a 90% target.

There were enough medical and nursing staff to keep patients safe at all times. Staff handovers were well managed with key issues identified, recorded and action to ensure patients who were unwell were monitored and supported.

### Incidents

- Staff we spoke with stated they were encouraged to report incidents. Staff knew how to report an incident and said they reported incidents frequently. Nursing staff told us they received feedback on the incidents they had reported. For example, a nurse was able to describe an incident where a patient had been given an overdose of insulin and the procedure that had since been put in place to prevent such an error happening again.
- Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. There had been one never event relating to a mole removal from the wrong part of the body in the medical division between April 2013 and March 2014. One never event is what would be an expected number compared to other similar trusts in England.

- The medical wards/areas had reported 38 serious events through the Strategic Executive Information System, (STEIS). Serious events are those that require notification and investigation. Analysis showed that of the three most prevalent causes; 13 concerned pressure ulcers; seven were falls and four infection control issues.
- Staff we spoke with did not have a good understanding of the recent duty of candour legislation and its requirements. However, we found that the principles were being followed by staff. Staff were able to give examples of where things had gone wrong and how patients and families had been immediately informed and provided with support.

### Safety thermometer

- We found that on every ward there was a 'Know how you're doing' notice board. This had up to date safety thermometer information such as numbers of patient falls, pressure ulcers and urinary tract infections.
- Staff we spoke with told us that the boards were only a few weeks old but they had been collecting and displaying the information on the previous notice boards for some time. Staff we spoke with knew how well their ward was performing in their safety thermometer.

### Cleanliness, infection control and hygiene

- All of the wards we visited were visibly clean and cleaning schedules were clearly displayed on the wards. We found that weekly cleaning schedules for wards had been properly completed.
- Hand hygiene audits were carried out monthly with the results being placed on the 'What you need to know' ward notice board. We found compliance rates of between 85% and 100%.
- Staff followed the trust infection control policy. We observed that most staff regularly washed their hands in between seeing patients, used personal protective equipment (PPE), such as gloves and aprons when needed, and adhered to the trust's 'bare below the elbows' policy. We observed that support staff, such as maintenance and medical records personnel, did not always use hand sanitisers on entering wards.
- There have been four reported cases of Meticillin-Resistant Staphylococcus Aureus (MRSA), 24 cases of Clostridium Difficile (C.Diff) and no cases of

# Medical care (including older people's care)

Meticillin-Sensitive Staphylococcus Aureus (MSSA) in the integrated adult care directorate. The trust had been below the England average for the majority of the last 18 months.

## Environment and equipment

- Equipment was maintained and checked regularly to ensure it continued to be safe to use. The equipment was clearly labelled stating the date when the next service was due.
- We examined the resuscitation equipment on each medical ward. We found that there had been daily checks of resuscitation equipment, which had been documented. All staff we spoke with knew where the resuscitation trolley was located.
- We undertook an inspection of the Endoscopy unit, which has its own designated area with separate male and female facilities. The unit had Joint Advisory Group (JAG) accreditation which meant that it was meeting a national agreed set of quality criteria for endoscopy. We found the unit to be clean and tidy. Equipment was stored safely and had been serviced regularly.

## Medicines

- Medication was stored securely. Rooms where medicines were stored were almost always locked when not in use and drugs cabinets were locked and secured so that they could not be removed from the ward.
- Fridges that were being used to store medicines were secured and we found that there had been regular checks to ensure temperatures were appropriately maintained.
- We found that some medicines, such as Adrenaline stored in the cardiology department, were out of date by up to two months.
- Medicines administrations records (MARs) we examined had been properly completed with the correct doses and administration times.

## Records

- The trust had recently moved to an almost paperless patient record system. Some records, such as Endoscopy and echocardiogram (ECG), were still kept on paper notes, but the vast majority of medical and nursing notes were being made directly onto the computer system.

- Staff we spoke with were generally supportive of the new system, but felt there had not been enough training before the implementation. Staff in Endoscopy told us that the system did not allow them to know when a patient had arrived in the unit. Other staff told us that on one occasion, because the system had not been available, medicines had been delayed for some patients by up to two hours.
- We examined a number of notes on the electronic patient record system (EPR) for each ward we visited. We found that in most cases nutritional charts, pain assessment tools and care plans had been completed. Safeguarding information was present and comprehensive. We observed that staff found it difficult to find on the notes where consent had been recorded for a particular procedure.
- The EPR system could only be accessed by staff using a swipe card and was also password protected. This meant that patient information and records were stored securely on all wards we visited.

## Safeguarding

- There was a safeguarding policy and procedure in place and staff were aware of it and where they could get further advice and support if they needed it. Each ward had a safeguarding resource file, which had appropriate guidance and advice. Staff told us that the central safeguarding team was under resourced with only one lead nurse covering the whole trust.
- Information provided by the trust showed that, in the medical division, there was a training completion rate for adult safeguarding of 67% and 60% for children's safeguarding against a trust target of 90%.
- Staff we spoke with were able to describe situations in which they would raise a safeguarding concern and how they would escalate any concerns. Staff we spoke with were able to give examples of when they had used the trust's safeguarding policy to raise concerns. For example, one nurse told us of a case where she raised a safeguarding alert to support a patient with learning disabilities.

# Medical care (including older people's care)

## Mandatory training

- Mandatory training covered a range of topics including fire awareness, infection control, emergency life support, safeguarding, manual handling, and equality and health and safety. Most staff we spoke with told us they were up to date with their mandatory training.
- Managers told us that it was difficult to get staff booked onto emergency life support courses with bookings having to be made at least three months in advance.
- Mandatory training rates for staff in the medical division as of April 2015 were overall 63% against the trust target of 90%. Individual areas had the following compliance rates; 81% for health and safety; 64% for moving and handling; 61% for resuscitation and 74% for infection control.
- There was an induction programme for all new staff and staff who had attended this programme felt it met their needs. All new staff we spoke with said they had completed the induction programme.

## Assessing and responding to patient risk

- Staff used an adapted version of the National Early Warning Score (NEWS) process and medical and nursing staff were aware of the appropriate action to be taken if patients scored higher than expected. We examined a number of NEWS records during our unannounced visit. We found that scores had been totalled correctly, and where concerns had been raised by a high score the issue had been escalated.
- Staff told us they felt well supported by doctors when a patient's deterioration was severe and resulted in an emergency. Medical staff we spoke with told us that they were called appropriately by nursing staff when patients had deteriorated.
- The trust had a Critical Care Outreach team consisting of two senior nursing staff during the day and one at night who were available 24/7. Patient notes we saw showed outreach reviewed a patient very quickly after being alerted. However, outreach staff said that alerts went through switchboard and patient names were not highlighted; only the ward, so outreach sometimes had to find the patients when they arrived at the ward.
- The clinical site practitioners' team consisted of senior nurses who were able to provide support to nursing staff

who were caring for very sick patients. The members of the clinical site teams we spoke with knew exactly where the very ill patients were and had plans in place to provide extra support if needed.

## Nursing staffing

- Nursing staffing levels had been reviewed and assessed using the National Safer Nursing Care Tool. Staff felt that senior managers would listen to their concerns about staffing levels. The trust used 10% more bank staff than the average for England. Managers told us that when there were nursing shortages on the roster, these would usually be made up from bank or agency staff from NHS Professionals. Managers told us they were trying to reduce the number of agency staff needed by increasing recruitment.
- Nursing staff we spoke with told us that they felt there were enough nurses to keep patients safe. One nurse told us "There are just enough nurses on the ward, we can't do everything but safety comes first." Another member of staff told us, "It's hard to keep staff here at Croydon, they often stay for a while but move into London where they get paid more."
- The trust had high levels of turnover among many of its staff with particular concern for nursing and other clinical staff.
- Of the 15 units within the Medicine Core Service, 13 of them were running with lower staffing levels than their establishment. The majority of these were down to shortages in nursing staff. Only three units had the expected whole time equivalent (WTE) or more. The biggest shortages were seen in the elderly care wards and in Intermediate Care. Overall nursing numbers were just under 4% short of their establishment.
- The trust had a very low sickness absence rate of about 2.5 days per year compared to the England average of about four.

## Medical staffing

- There were enough doctors to keep patients safe at all times. The hospital had 140 medical doctors to cover 449 in-patient beds. Of these, 32% of doctors were consultants compared to an NHS average for England of 33%. The hospital had a slightly larger percentage of junior doctors making up 24% of doctors compared to an NHS average of 22%.



# Medical care (including older people's care)

- Doctors we spoke with felt there were adequate numbers of doctors on the wards during the day and out of hours and that consultants were supportive when present and contactable by phone if they were needed for support out of hours.
- The AMU had consultant cover from 8am to 8pm Monday to Friday and is covered by on call medical consultants at weekends. The medical division had recently increased the number of elderly care consultants from 7.4 to 12 to deal with the increase in demand. There was a duty Cardiologist throughout the day and an off-duty cardiologist was on-call between the hours of 5pm and 9am and at weekends.
- The medical handover in the morning and at night with the 'hospital at night team' was observed. The process was led by the day acute medical consultant. The hospital at night team medical cover consists of one registrar and two senior house officers, in addition, there were two SHO working a twilight shift until 1am. We found that the handover covered all the key issues relating to the care and safety of patients

## Major incident awareness and training

- Emergency plans and evacuation procedures were in place. Many of the staff we spoke with had not had recent training in major incident preparation.
- There was an effective bed management system in place that ensured managers had a clear picture of where the demands and spare beds were in the hospital at any given time. This meant that in the case of space being needed in an emergency, the hospital was able to respond quickly and effectively.
- The hospital had opened two wards to deal with winter pressures. During the time of our inspection, both of these wards were still in use. The trust was trying to close one of the wards which had been reduced to only four patients.

## Are medical care services effective?

Good



Care was provided in line with national and local best practice guidelines. Clinical audit was being undertaken and there was good participation in national and local audit that demonstrated good outcomes for patients with the exception of diabetes care and treatment.

We observed good clinical practice by clinicians during our inspection. Nursing and medical handovers provided evidence that key issues in patient care were being handed over and acted on. Senior clinical staff gave clear direction and support to junior staff to ensure patients received appropriate care.

Patient morbidity and mortality outcomes were broadly within what would be expected for a hospital of this size and complexity and no mortality outliers had been identified.

There was good multidisciplinary team (MDT) working within the hospital part of the medical division but there were gaps in MDT working with community members of the trust, particularly at the point of discharge and continuing care.

Staff had a good knowledge of the issues around capacity and consent. However the trust was unable to assure itself that capacity assessments were always being carried out when needed and that consent was being recorded in medical notes. The trust had recently appointed a geriatric consultant to review this area.

## Evidence-based care and treatment

- The medical division adhered to National Institute for Health and Care Excellence (NICE) guidelines for the treatment of patients. The trust had an effective process of monitoring the implementation of NICE guidance.
- NICE and trust guidelines were available on the trust intranet. Staff we spoke with told us that guidance was easy to access, comprehensive and clear. Nurses and Doctors were able to find guidance easily on the intranet when we asked them. For example, a doctor was able to describe NICE guidance on Statins and how this was complied with. A nurse was able to describe and show how she applied the guidelines on Oxygen Therapy for COPD patients.

# Medical care (including older people's care)

## Pain relief

- The hospital had a pain service available for patients on referral from medical clinicians. This was staffed by a small team of nurses. Patients we spoke with told us that their pain was well managed and staff would respond promptly if they needed pain relief.
- We observed staff monitoring the pain levels of patients and recording the information. Pain scores were recorded in most of the patients' notes we examined. Staff told us that the pain team were very responsive, one ward manager told us, "They are really good, they always come the same day that we call them."

## Nutrition and hydration

- A dietitian was available on referral for the service and all the nutrition assessments and fluid balance charts we examined in patients' records were complete and up to date with documented dietitian reviews. Nutrition and fluid plans were followed with fluid balances totalled and acted upon appropriately.
- Staff told us that patients were offered seven hot drinks a day and in addition, there were regular water rounds. Patients were offered three main meals and two snacks each day. We observed that the trust was using the 'Red Tray' system to identify patients who may have needed support with eating. Patients we spoke with were generally positive about the quantity and quality of the food they received.

## Patient outcomes

- The trust had not recently been identified by the Dr Foster/CQC Outliers programme, which identifies mortality outliers for a range of clinical issues.
- Croydon University Hospital showed continued improvement in Sentinel Stroke National Audit Programme (SSNAP) (Oct13 - Sep14) and was rated as "B" for both patient and team centred Key Indicators, which was better than the England average.
- The hospital performed better than the England average in the Myocardial Ischaemia National Audit Project (MINAP) in both 2012/13 and 2013/14.
- The National Diabetes Inpatient Audit (NaDIA) – September 2013 showed performance as "worse than other trusts" for 16 of the 21 indicators. Comparison between 2012 and 2013 showed that percentages had

decreased for 12 of the 21 indicators. The clinical lead was aware that performance for diabetic patients needed to be improved and had developed an action plan.

- The hospital had significant challenges with providing a comprehensive diabetic acute service for patients. The service should have three diabetic consultants and a diabetic nurse to deal with GP, community and hospital based referrals. Although it had managed to maintain the number of consultants, staff turnover had meant cover was often being provided with the support of a locum consultant. This impacted on the leadership of the service and continuity of care.
- The relative risk of re-admission (elective admissions) for Clinical Haematology were better than the England average.
- The relative re-admission risk for elective admissions were in line with the England average but non elective for Cardiology were significantly higher (worse) than the England average.
- Trust percentages were mostly in line with England and Wales average in the Heart failure audit for in hospital care with the exception of "input from consultant cardiologist" which were worse.
- Trust percentages in the Heart failure audit discharge care were mostly better than the England and Wales average.
- The cardiographers in the cardiology department held a weekly 'Echo Review' meeting chaired by an imaging consultant to review cardiac echo's, with a view to identifying any errors and improving practice.
- The average length of stay (ALOS) for the trust was similar to the England average for non-elective and better than average for elective days.

## Competent staff

- Staff we spoke with told us that the trust's initial induction programme was detailed and comprehensive.
- Information from the trust indicated that trust wide training modules had a target completion rate of 90%. However, there were 60% of modules which were not hitting their target.



# Medical care (including older people's care)

- Managers told us that doctors were given financial and professional support and encouragement to develop. For example, two doctors had recently presented papers at a European conference.
- Nurses told us that they were given developmental opportunities, for example; nurses in the cardiology unit and AMU had undertaken the (Acute Intensive Medical) AIMS course which further developed their skills in supporting medical patients.

## Multidisciplinary working

- Throughout our inspection, we saw evidence of multidisciplinary team working in the ward areas. Clinical staff told us nurses and doctors worked well together within the medical speciality. There was a daily multidisciplinary board round which included, doctors, nurses, social workers and either an occupational or physiotherapist.
- Physiotherapists, occupational therapists, pharmacists, dietitians, and social workers we spoke with all told us that multi agency working was generally effective. Most of the allied healthcare professionals we spoke with told us that they felt part of the team.
- Mental Health services were provided by the South London and Maudsley (SLAM) Mental Health Trust. Staff we spoke with were aware of the steps they needed to take to access support from SLAM.

## Seven-day services

- There were medical consultants working seven days a week in the trust. At weekends, consultant cover was eight hours a day. All medical admissions were seen by a consultant within 12 hours of admissions. The Acute medical unit had dedicated consultant cover seven days a week. At other times, a consultant was always available for advice or to attend the hospital in an emergency.
- The pharmacy department was open seven days a week but with limited hours on Saturday and Sunday. Staff said that there were sometimes delays in receiving medication for patients who were due to be discharged.
- The radiography department was open seven days a week, but with limited hours on Saturday and Sunday. A

radiologist was on call at home and available to attend the hospital if needed. Staff we spoke with said that the radiography department was responsive to their needs and results were available promptly.

## Access to information

- Although staff were generally supportive of the recently implemented electronic patient record, explaining that it made information usually quicker to find, concerns were raised about system outages. We were told that, on a number of occasions in the weeks prior to our inspection, the system had not been available and this had led to a delay in patients receiving medicines as drug charts were not available.
- Managers told us that each ward had a back-up computer that was available when the main system was off line. However, staff did not seem clear how to use and access the alternative system. Staff said they received information via e mails and newsletters, in addition information would be placed on the intranet 'Desk Top', however some staff said there was too much information on the desk top to take it all in.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We found that staff had a good understanding of capacity and consent issues and were able to describe the correct process for establishing capacity and obtaining consent. They were also able to describe where they would get further advice and support if needed.
- However, staff were not always able to show us in patients' notes where consent had been recorded. For example, we found a patient who was known to have dementia and had been supported in their feeding with a Naso-Gastric (NG) tube. However, staff were unable to find any record of consent to the procedure.
- Capacity assessments were not always being undertaken. For example, during a nursing handover in the AMU, the communication needs of patients were not covered. We examined the medical records for a 90 year old and a 99 year old patient and found that no evidence that a capacity assessment had been considered or undertaken.
- Managers told us that a doctor should undertake a memory assessment for all patients 75 years or older. If this assessment raised concerns, then the doctor should

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undertake a full capacity assessment. Out of 48 patient records only 20 had comprehensive assessments in place. Managers acknowledged that they had identified prior to our inspection that there was no assurance process in place to monitor compliance in this area. Managers had as a result, appointed a geriatric consultant to lead on safeguarding and undertake a review in this area.

- We looked at the records for two patients who had been subject to deprivation of liberty safeguards, (DoLS). We found that the appropriate documentation had been completed correctly and the correct authority obtained. Nurses we spoke with were clear about the procedure they would follow to initiate the safeguards; they told us this subject was covered during their safeguarding training.

## Are medical care services caring?

Requires improvement



The Integrated Adult Care Directorate had mixed results in patient surveys and had a high response rate for the Friends and Family Test. Surveys indicated an improvement in the views of patients over the last 12 months.

Patients received compassionate care and patients were treated with dignity and respect. Staff were focused on the needs of patients and improving services for them. Most patients and relatives we spoke with said they felt involved in their care and were complimentary and full of praise for the staff looking after them. One person told us: "it's fine, I have no complaints, the staff are friendly and always come when I call them." However, a number of patients raised concerns that they were not always kept informed about their treatment.

### Compassionate care

- Trust scores were amongst the worst performing for 5 of the 11 questions asked in the NHS Inpatient Survey published in May 2015. However, this was an improvement on the previous survey.
- Responses to the Friends and Family Test (FFT) about their experience as in patients. The response rate to the Family and Friends Test (FTT) in medical services was 40% compared to a national average of 30%.

- To the core FFT question "How likely are you to recommend our ward to friends and family if they needed similar care or treatment?" The trust performed very well with responses of between 88% and 100% of respondents saying they were likely or very likely to recommend the hospital.
- Patient-led assessments of the care environment (PLACE) assessments scores had improved but were still generally below the England average.
- Throughout our inspection, we observed patients being treated with compassion, dignity and respect. The patients and families we spoke with were generally pleased with the care provided. They told us doctors, nurses and other staff were caring, compassionate, and responded quickly to their needs.
- About 80% of the patients and families we spoke with were all positive about the care they had received, one patient told us, "It's fine I have no complaints, the staff are friendly and always come when I call them." Another patient told us, "They are all very kind and considerate."
- About 20% of the patients we spoke with raised concerns about their care. One patient told us, "The staff are Ok but there is nothing to do, there is no TV and no papers or books to read." One relative said, "They don't tell me what is going on, and everything takes so long to get done."
- Nurses we spoke with told us that there were not always enough of them to give everyone the care they would like to give. One nurse told us, "Sometimes we get too busy and we cannot be everywhere at once. We focus on the medical care first so we don't always get the time to talk to patients and see how they are feeling."

### Understanding and involvement of patients and those close to them

- Patients and families we spoke with did not always feel involved in their care. One patient told us, "The care is good here, but I don't always know what is going on."
- We observed nurses, doctors and therapists introducing themselves to patients at all times, and explaining to patients and their families about the care and treatment options.

# Medical care (including older people's care)

## Emotional support

- We observed patients receiving emotional support from staff. However, when we asked staff what external or internal people they used to provide emotional support, such as counsellors, they were unable to tell us what was available other than the chaplaincy service.
- Nurses told us that if a patient was going to receive bad news from a consultant then they would always make sure that there was a nurse present as well to provide additional support.
- Chaplaincy details were advertised in the relatives' booklet which was available at the trust.

## Are medical care services responsive?

Good



The Integrated Adult Care Directorate was effective at managing inpatient admissions that either required emergency admission from ED or referral from a range of other sources, which included direct referral from GPs.

The hospital had designed pathways that, if possible, kept patients out of the ED department. The Ambulatory Care Unit was open on week days from 8.30am to 7.30pm and dealt effectively with a large number of people in a more suitable environment for non-acute patients than the ED.

The hospital operational management team had an excellent grip on the status of the hospital at any given time. Bed availability was well managed. Discharges were still not fully effective with patients waiting too long in the discharge lounge and waiting too long for their prescriptions.

The Integrated Adult Care Directorate met the needs of its elderly community. Elderly care pathways had been well designed to ensure that elderly patients were assessed and supported with all their medical and social needs. Patients who were living with dementia were accommodated on two specifically adapted 'dementia friendly' wards. These two wards had décor that was homely with paintings hanging on the wall, different coloured bays and a matted floor surface. The environment was well suited to the needs of people living with dementia.

## Service planning and delivery to meet the needs of local people

- The Integrated Adult Care Directorate met the needs of its elderly community. Elderly care pathways had been well thought out and designed to either avoid elderly patients having to go to ED or if they did, making sure that their medical and social care needs were quickly assessed. This meant that elderly patients spent less time in the ED and were either admitted to the ward or supported in going home.
- The hospital had significant challenges with providing a comprehensive diabetic acute service for patients. The service should have three diabetic consultants and a diabetic nurse to deal with GP, community and hospital based referrals. Although it had managed to maintain the number of consultants, staff turnover had meant cover was often being provided with the support of a locum consultant. This impacted on the leadership of the service and continuity of care.
- The Integrated Adult Care Directorate ran a COPD 'Hot Clinic', which allowed patients to access COPD specialist treatment at short notice without having to go through the ED.

## Access and flow

- There were about 20,000 medical admissions each year. Most of these patients were admitted through the ED department, but there were a number of admissions from GPs and other hospitals.
- There was a trust wide discharge planning and bed management team who were responsible for the co-ordination of capacity and bed availability. They liaised daily with individual wards to establish the numbers of patients on the ward and how many beds were available for new patients to be admitted into. Bed meetings were held throughout the day at 10.30am, 12.30pm, 2.30pm, 4.30pm and 6.30pm.
- The trust had four levels of alert for the bed status, Green (business as usual/beds were available), Amber (40 patients or more in ED), Red (well over 40 patients in ED no beds available) Black (Internal incident). During our inspection the trust was operating at Amber level with 25 available beds in the hospital.
- Bed occupancy rates had been slightly above England average for the first two quarters of 2014/15.

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- Demand had increased for the cardiac catheter laboratory and additional staff appointed to expand the range of interventions provided. There were two treatment rooms, one of which was a small room used primarily for diagnostics, and this meant that elective procedures were sometimes cancelled when there was an emergency patient. The service ran an additional list on Saturday to address the backlog of elective procedures.
- The trust was effective at managing the flow of patients through the hospital. The trust had developed pathways that reduced the need for patients to access services through the ED. For example, they had established an Ambulatory Care Unit, which was open on week days from 8am to 6pm. The unit saw about 25 patients a day, most of whom would have previously been seen in the Emergency Department. The unit dealt with a wide variety of complaints including, pulmonary embolism, blood transfusions, fast atrial fibrillation and cellulitis. GPs could directly access the unit and could telephone the units consultant directly on their mobile phone.
- Stroke patients were first treated and stabilised at other hospitals which had Hyper Acute treatment centres. After about 72 hours at these centres, they were then transferred to Heathfield one Ward, where they continue their recovery for up to a further six weeks before moving back into the community.
- Staff we spoke with told us the main reasons that delayed a patient from being discharged were that prescriptions took too long; sometimes up to four hours to get ready and there was no one at home to care for a patient, for example, a family member was at work until the evening. Some staff told us that patients were sent to the discharge lounge before all the paperwork, including the discharge summary, had been completed. This meant some patients may have spent too long waiting in the lounge.
- The trust had recently recruited three discharge coordinators in an attempt to increase the quality and timeliness of patients' discharges. They were working to the motto 'home for lunch' but staff told us this was rarely the case in practice. There were also 'Golden' patients who the trust aimed to get into the discharge

lounge by 10am. Concern had been raised about the number of inappropriate late discharges in the evening and the trust had an objective not to discharge anyone over 65 years after 6.30pm.

- Referral to treatment within 18 weeks percentages were consistently above the standard for all specialities.

## Meeting people's individual needs

- Appropriate information was available in English as a matter of routine. Information in other languages could be provided on request. Staff told us and gave examples where interpreters were available both in person and on the telephone.
- The hospital provided 'Passports' for patients living with a learning disability, which allowed them to identify to staff their likes and dislikes in a pictorial format. There was also an 'Easy Read' menu for patients.
- The trust used the 'Forget Me Not' scheme, which helped to identify and support people who were living with dementia.
- Wandle Wards one and two had been specifically adapted to be 'dementia friendly'. We found that these two wards had a quiet room and a day room where meals could be eaten. The décor was homely with paintings hanging on the wall different coloured bays and a matted floor surface. The environment was well suited to the needs of people living with dementia.
- Many patients told us that they were frustrated by the fact there were no facilities in the hospital to watch television, this included the fact that there was no facility to rent a TV set for a patient's personal use.

## Learning from complaints and concerns

- Staff told us that they did their best to deal with issues and complaints at a ward level. In the first instance, the ward manager would speak to the patient and their family and attempt to resolve the concern at an early stage. If the ward manager was unable to resolve the complaint then the matron would usually arrange to have a meeting with the patient and their family.
- Since 2010/11 there had been an increase to the number of complaints by 34% of which, almost 2/3rds have been in 2013/14. In 2013/14 there was an increase of 119 written complaints compared to the previous year. Most complaints involved poor communication to patients and their families and poor attitudes by staff.

# Medical care (including older people's care)

- Patients and family members we spoke to were felt able to raise issues with staff. We observed that complaints leaflets were available in wards and public areas within the hospital.

## Are medical care services well-led?

Good



The Integrated Adult Care Directorate was well led; divisional senior managers had a clear understanding of the key risks and issues in their area. They were able to describe the complex health and social care landscape they were operating in, and how they fitted into it. Managers we spoke with were open and honest about where they needed to improve and usually had a plan to make the necessary changes. There was a clear drive and enthusiasm among managers to innovate services for patients and particularly elderly patients.

There was a clear process to identify performance concerns and develop plans to improve performance and keep patients safe. Managers were also committed to developing greater links with community services to ensure appropriate holistic care was provided for patients.

Staff and managers we spoke with were aware that the trust had performed poorly in the last NHS staff survey in 2014 but were not able to describe the details. None of the managers we spoke with were aware of a plan to address the concerns raised in the staff survey.

Ward staff felt well supported by their ward sisters and matrons, and they told us they could raise concerns with them. Staff told us that they regularly saw divisional managers and clinical leads on the wards. Most ward managers and sisters we spoke with were passionate about improving services for patients and delivering a high quality service.

## Vision and strategy for this service

- The leadership team of the Integrated Adult Care Directorate had a clear vision of the health and social care landscape in their area and how their services fitted into it. They had a clear vision of where the division needed to get to in the future.

- The leadership team stated that their three main objectives for development in the next few years would be to, develop the gastroenterology service, improve patients' pathways and move as much care as possible from the acute to the community setting.
- The leadership team had an advanced and clear and detailed vision for how they would improve elderly care within the hospital and develop the system within the community.
- Most of the clinical areas we spoke with also had a clear vision for how they would develop their specific services in the future. For example, the Acute Medical Unit and Ambulatory Care service had a clear joint vision to expand and enhance their service.

## Governance, risk management and quality measurement

- We found that there was clear governance arrangements within the medical division. Regular meetings ensured that key risks and performance issues were identified and acted upon. The risk management process had fallen behind the structural changes that had been made within the hospital and was still a work in progress. This meant that although obvious clinical risks were identified, there was no clear process of identifying and grading business risks. For example, the prioritising of refurbishment projects within the division.
- The Integrated Adult Care Directorate held a monthly management meeting with agenda items including: performance against CQC areas. The performance dashboard, risks, learning, and budget were discussed.
- The governance process had identified a high number of pressure sores being reported on Wandle Ward and the directorate had increased the number of Health Care Assistants to improve patients' care. As a result, the number of pressure sores had reduced.
- Each clinical area held a monthly meeting attended by the managers, clinical lead, nursing lead and ward managers. The board looked at risk, finance and key performance indicators on the medical 'Dashboard'. Ward boards were then held to disseminate information at ward level. We observed that there was a good focus on clinical risk and performance.



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- The wards we visited had regular team meetings at which performance issues, concerns and complaints were discussed. Where staff were unable to attend ward meetings, steps were taken to communicate key messages to them.

## Leadership of service

- Ward staff felt well supported by their ward sisters and matrons and told us they could raise concerns with them. Staff told us that they regularly saw divisional managers and clinical leads on the wards. The Director of Nursing, Chief Operating Officer (COO) and Chief Executive were visible to staff on the wards. The board members had a 'Visible Wednesday' initiative where they encourage departments to invite board members to spend the day with them.
- We found that, throughout the medical division, clinical and non-clinical managers worked well together to identify risks and make improvements.
- We spoke with a number of divisional managers who had a good understanding of the issues in their clinical areas. For example, managers had identified that there was a need to improve the interventional radiology service and an action plan had been implemented.
- Junior and middle grade doctors felt well supported by their consultants and other senior colleagues. Medical services staff felt supported by the medical leadership in the Integrated Adult Care Directorate division and the trust.
- We observed good leadership skills during medical and nursing handovers. Senior staff were visible in leading these meetings and giving clear direction and support to junior colleagues.

## Culture within the service

- Throughout our inspection it was clear that there was a patient centred culture within the service which had a clear focus on meeting the needs of elderly patients. Staff we spoke with were proud to work at the trust and felt they gave patients good care.

## Public engagement

- Patients were engaged through feedback from the NHS Friends and Family test and complaints and concerns

raised from PALS. Clinical governance meetings showed patient experience data was reviewed and monitored. However, there was no evidence of action plans to address issues raised by the public.

## Staff engagement

- The trust performed well in the General Medical Council (GMC) 2014 survey of doctors' opinions with three of 12 areas better than would be expected. The areas were workload, access to educational resources and regional teaching.
- Staff and managers we spoke with were aware that the trust had performed poorly in the last NHS staff survey but were not able to describe the details. None of the staff or managers we spoke with were aware of a plan to address the concerns raised in the staff survey.
- A Listening in Action (LiA) workshops were used to seek people's views following the Cancer Patient Experience survey 2014, which highlighted key areas where the trust was not performing well. These areas included: when communicating bad news what would this look like, how can we make people aware of financial help & free prescriptions. Another LiA had been used to get people's views on the outpatients' department in 2014 for them to give suggestions on how to improve the environment and experience.
- The Chief Executive held regular staff open meetings where staff were free to raise any issue they liked. We spoke with many staff who had been to these meetings and they told us they felt able to raise issues and that the Chief Executive had been open and transparent in his approach.

## Innovation, improvement and sustainability

- The trust had an innovative approach to ensuring that elderly care pathways were patient focused. Firstly patients were encouraged to receive treatment in the community through the use of GP advice lines and community response teams. Secondly, elderly patients who did attend the hospital were quickly assessed and supported by a multidisciplinary team, including clinical and social work staff to ensure their social and medical need were addressed. Elderly patients who did need to be admitted and who were living with dementia were usually accommodated on the specially designed 'dementia friendly' wards.
- The trust was developing the AMU and Ambulatory Care Unit into a new Rapid Assessment Medical Unit, which







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was to be located on Edgecombe one and two wards. This was to be available from 8am – 10pm weekdays

and 8am – 4pm at weekends. The service would include GP, an acute frail elderly unit and an outreach team, with the aim of improving the services available to patients.



# Surgery

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

## Information about the service

There are more than 23,000 operations each year at Croydon University Hospital, of which about 15,000 are day-cases.

The surgical services provided to the local population include general, breast, vascular, ear nose and throat (ENT), trauma and orthopaedics, colorectal, dental and maxillofacial specialties.

There are 10 operating theatres in the hospital's main theatre suite, and a day surgery unit with four theatres. There is an area for pre-assessment and admissions of surgical patients and five surgical wards although Queens 3, which treated patients with fractured neck of femur, was not governed within the directorate that covered surgery. , a

We talked with 35 patients and over 50 members of staff, including administrators, domestic staff, porters, healthcare assistants, nurses, theatre staff, doctors in training, consultant surgeons and anaesthetists, senior nurses, managers, clinical nurse specialists and therapists. We visited clinical areas, observed care and looked at the electronic systems for storing patient information. We reviewed national data and information provided by the trust and ran focus groups to hear the views of staff.

## Summary of findings

The clinical governance structures in surgery were weak and there was a lack of reliable information about the performance of services. The service was disjointed and suffered from a lack of standardisation. There was good team work within specific parts of the service, but communication was sometimes weak, with few forums for multidisciplinary discussion of issues affecting the smooth delivery of services or for shared learning.

Service related risks were not always formally identified and addressed. Where risks had been recognised, such as faulty theatre equipment and poor theatre environment these were being addressed. However, the promptness of resolving some risks was often slow, and there remained a lack of a shared understanding of risks and how these should be tackled and monitored.

Equipment was not always readily available to support the delivery of services, which combined with equipment failures impacted on patient safety and cancellations. The investigation of serious incidents and the response to complaints had improved, but it was not clear that incidents were being consistently reported, categorised, or learned from.

Staff did not always complete the required safety related mandatory training. However, new staff and doctors in training were well supported.

# Surgery

Initiatives, such as the opening of a surgical assessment unit, demonstrated a desire to improve patient experience, but the unit was not yet able to follow the operating policy.

Patients praised the responsiveness and kindness of staff on the wards. Patients we spoke with who had been to the hospital before remarked on improvements in the attitude of staff and the efficiency of services. Patients' individual needs were generally met and there was excellent practice to ensure that patients with learning disabilities received responsive and effective care.

Surgery services adhered to best practice standards, and staff had worked hard to reduce referral to treatment waiting times. Care pathways for patients were enhanced by multidisciplinary working with specialist nurses and links with the trust community health services. Outcomes, such as readmissions following surgery were generally in line with or better than the national average except for emergency trauma and orthopaedic surgery. There had been notable improvements since our last inspection in infection control processes and aspects of patient care.

The trust performed poorly in the cancer patient experience survey results for inpatient stays. They were in the top 20% of trusts for three areas, but were in the bottom 20% of trusts for 19 areas.

Discharge was better coordinated, but there remained some blockages in the process, such as the lack of rehabilitation beds in the community. A new electronic patient record system had been effectively implemented. There were some disruptions to the service at times, which were being addressed.

Following a recent restructuring, surgery services had new leadership, who understood the need to engage staff in developing a strategy and improving services

## Are surgery services safe?

Requires improvement



### Summary

Safety within the surgical services required improvement. This was because staff had not received all the mandatory safety training required to support the delivery of safe care and treatment to patients. There was a particularly low rate of training with respect to infection prevention and control.

There was a formal process for reporting incidents and most staff received feedback, although the reporting and feedback was not consistent among different staff groups.

Lack of equipment availability, inadequacy of some items of equipment and equipment failures presented a risk to patient safety within theatres. Surgical instrumentation sets were not always reprocessed after the expiry date.

Each surgical speciality and anaesthetics had clinical governance and mortality and morbidity meetings monthly, but no minutes were available so we were unable to judge whether appropriate learning took place from those meetings.

There were effective arrangements in place to minimise risks of infection to patients and staff on the surgical wards. However, we observed a poor state of repair to theatres and were shown evidence of low results for surgeons from a recent scrub audit.

Medicines were managed safely, with the exception of temperature checks on fridges used to store some medicines. These checks were not always undertaken.

Staff monitored patients' well-being and acted when a deterioration was identified. The critical care outreach team was available 24 hours a day to support ward staff in caring for the deteriorating patient.

Arrangements were in place to ensure staffing numbers and skill mix was appropriate to support the delivery of patient care safely.

### Incidents

- Incidents were reported using an electronic system and staff we spoke to were able to describe examples of incidents they had reported. Staff in theatres and the Day Surgery Unit (DSU) told us they reported incidents

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that might affect patient care, including the late arrival of consultants for pre-operative assessment or for lists. However, some staff we spoke with told us that they did not always complete incidents forms. The trust reported fewer incidents than other trust of its size, which suggested staff did not have a shared view of what incidents should be reported. We saw that an incident was not recorded and categorised as serious until after a complaint had been received, indicating the process of identifying, reporting and categorising incidents was not robust.

- Staff on the surgical wards and theatres received feedback from incidents at daily team briefs, but the medical staff we spoke with told us they did not always receive feedback from incidents they reported. The matron and ward managers for the surgical wards attended a monthly meeting where incidents were reviewed and the learning was shared across the four wards.
- Clinical care forums, attended by the head of nursing, ward managers and matrons, took place monthly. Incidents, along with root cause analysis and actions, were discussed. These meeting had been introduced three months prior to our inspection by the new head of nursing. Mortality and Morbidity meetings took place for each surgical specialty and the anaesthetic department on a monthly basis.
- The trust had reported one 'Never Event' in surgical services in the year leading up to the inspection. (Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.) We saw documentation of this investigation, which did not explain the consequences in a way that relatives could understand. The Clinical Commissioning Group had asked the trust to carry out a review of the investigation.
- Fifty-eight serious incidents (SI's) requiring investigation took place between March 2014 and February 2015, of which 60% were pressure ulcers grade 3. There had been a backlog of serious incident investigations, which were now being addressed. Staff told us there had been reluctance among some staff groups to give statements for an investigation. There was now greater confidence that staff would not be blamed. We saw documentation for four SI's reported for the period of January to May 2015. Two of these incidents had been fully investigated and the learning and action had been shared at the clinical governance meetings. In one incident, we saw

evidence that, since the incident involved other NHS organisations such as London Ambulance Service, the report had identified the need to share the learning to a wider audience. The other two incidents were still being investigated at the time of our inspection.

- Staff we spoke with were able to demonstrate knowledge on the duty of candour and had a clear understanding of their responsibility. One member of staff in the Day Surgical Unit (DSU) was able to give us an example of duty of candour for an incident that had happened on that day. We saw evidence that the trust kept patients informed when a serious incident had happened and updated them on the progress of the investigation.

## Safety thermometer

- Croydon University Hospital participated in the NHS Safety Thermometer scheme, used to collect local data on specific measures related to patient harm and 'harm free' care. Data was collected on a single day each month to indicate performance in key safety areas. This data was collected electronically and a report produced for each area.
- The data we reviewed for a period of January to May 2015 indicated that the surgical wards were providing an average of 97.5% harm free care. The incidents reported were mainly pressure ulcers, although the grade was not specified. This information was clearly displayed on each surgical ward, making it easily accessible for visitors and staff.
- Staff used the Waterlow Pressure Ulcer Prevention Score to assess the patients' risk of developing a pressure ulcer. This assessment was available on the new electronic system and a pressure ulcer care bundle was also used, which was not electronic and stored at patient's bedside. Advice from specialist tissue viability nurses was readily available and staff had access to pressure relieving equipment.
- All patients attending the pre-assessment unit routinely underwent a venous thromboembolism (VTE) assessment, and we saw evidence of this in the records we looked at.

## Cleanliness, infection control and hygiene

- We found the operating theatres to be visibly clean during our inspection. Theatres were cleaned at night by a contracted company and this was audited weekly by the theatre matron with the cleaning supervisor. We

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observed the compliance for May 2015 was 98%. Clinical staff in theatre cleaned technical equipment at night and in-between cases and all equipment items seen were clean and labelled as ready to use. Staff told us they carried out internal audits of equipment cleanliness weekly but were not able to provide documentation for these audits. There were separate facilities for removing used instruments from the operating room, ready for collection by the decontamination service.

- We observed that there were dedicated staff for cleaning ward areas and they were supplied with and used nationally recognised colour-coded cleaning equipment. This enabled them to follow best practice with respect to minimising cross-contamination. The surgical wards we visited were clean and all the patients we spoke with were satisfied with the cleanliness. There were cleaning regimes in place and these were clearly displayed on bathroom doors.
- We looked at the equipment used on wards, including commodes and bedpans, and found them to be clean. Labels indicated when they had been cleaned and by whom. There was easy access to personal protective equipment (PPE) in all areas we inspected and staff used PPE during their activities as required. We observed one nurse attending to a patient's nasogastric tube in an isolation room on Queens 2 without wearing an apron.
- We observed staff complying with the infection prevention and control policy; being bare below the elbow and washing their hands. Posters displaying correct hand washing techniques were available over the sink area. On one ward, Queens 3, we observed nutrition charts, which were not laminated, taped to the wall behind three patient's beds. This was not in line with trust policy.
- Hand wash basins and alcohol hand sanitising gel were available at both ward and theatre entrances and alcohol gel was mounted at each patient bedside. Weekly hand hygiene audits were carried out by the infection control link nurses on each ward and the audit results showed an overall compliance of 93% for all surgical areas in February 2015.
- Theatres carried out a scrub audit monthly and we saw evidence from the most recent audit showing nurses and operating department practitioner (ODP) achieved

a score of 100% but this was 86% for surgical staff. The audit concluded that the low adherence to guidelines by surgical team potentially exposed patients to higher risks of microbial transmissions.

- There were a small number of single rooms, with attached toileting and showering facilities, on each surgical ward for patient requiring isolation. Precautions and signage on the doors of these rooms was clear.
- Infection prevention and control was part of the trust mandatory training. Some consultants we spoke with expressed concerns that elective orthopaedic cases were nursed on the mixed surgical speciality wards, which did not reflect recommendations for delivery of surgical services by the Royal College of Surgeons.
- We noted that the hospital's infection rates were below the national average for Methicillin-resistant Staphylococcus Aureus (MRSA), Clostridium difficile and Methicillin-sensitive Staphylococcus Aureus, (MSSA) between April 2014 and March 2015. All patients were screened for MRSA pre-operatively for elective cases and on admissions for emergency cases. There was a system for regular screening of all patients and we saw evidence of MRSA screening in the records we reviewed.
- The Infection Prevention and Control Team undertook surgical site infection surveillance of selected procedures, which was coordinated by the Centre for Infections at Public Health England. The trust informed us that although they were registered for this audit, they were currently not contributing data. The data available for reduction of long bone fracture for the period of January 2013 to June 2014 indicated that the trust was in line with the national average. For repair of neck of femur fractures, the trust was in line with national average for the period of January 2013 to September 2014.

## Environment and equipment

- Staff in the Day Surgery Unit (DSU) told us of issues relating to lack of equipment. The DSU did not have an X-ray machine and one had to be borrowed from main theatres almost daily. There had been an increase in the number of procedures requiring image intensifier X-ray and patients would be put at risks without this being available. Lists were delayed while waiting for the X-ray machine; staff told us that they had completed incident forms when this had happened and we saw evidence of that. There was only one dental drill, but there were times when two theatres performed oral surgery, so a

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second one had to be borrowed from main theatres. The same process applied for the microscope used in dental surgery and we saw an incident report where a patient's operation had been cancelled due to unavailability of microscope. During our inspection we were told by the (EBME) manager that a second microscope had been ordered for day surgery unit.

- The failure to replace equipment and equipment shortages had been a long standing risk to the service. We noted the lack of a capital replacement programme and old medical devices had been on the corporate risk register for over a year. There was a budget for equipment replacement. We were told the board had recognised the need to have a managed equipment service and the business case for this would be presented to the board in the next two months for approval.
- Surgeons told us some equipment had not been replaced in 20 years. Two old image intensifiers frequently failed and there had been an incident of a patient kept anaesthetised waiting for an image intensifier. There were issues with the lights in main theatre not providing adequate lighting and a second mobile light needed to be used for some cases.
- Surgeons we spoke with told us some of the laparoscopic equipment used in main theatres was dated and the image could be lost during a procedure. The trust had recently purchased some new laparoscopic equipment but some procedures were still being undertaken with dated equipment. The anaesthetic machines in the main theatres had only been replaced in the few months leading to our inspection. We saw evidence of two incident reports, dated May 2015, about patient's operation being cancelled due to technical issues with laparoscopic equipment.
- The theatre environment was generally in a poor state of repair. During our inspection, we observed chipped doors, a damaged wall and damaged floor covering, which posed an infection control risk. The toilet in the male changing room was blocked when we visited theatres, and there were flies in the room. We were told this happened frequently and the problem was only ever fixed temporarily. The case to refurbish theatres had been accepted by the board. We were shown the plans outlining the options for refurbishment during our inspection.
- Annual maintenance and revalidation checks of operating theatre ventilation was carried out and we saw evidence of the latest report dated March 2015, which provided sufficient evidence to assure that a safe, clean, compliant environment for surgical procedures was provided within operating theatres in line with relevant regulations (Building Regulations 2000, England and Wales, approved document F1: Means of Ventilation and Heating and ventilation systems: Health Technical Memorandum. The report commented on some remedial action required notably on the state of repair of theatre doors.
- The trust had an equipment library, which enabled staff to have access to equipment used to support patient's care and treatment. Staff told us they could always access equipment, even out of hours. All equipment we saw had labels indicating that they had been serviced in the last year. The Electrical and Biomedical engineering (EBME) manager showed us records of all equipment serviced and maintained by his department. The equipment schedule was noted to be up to date.
- All the surgical wards had adequate manual handling equipment and physiotherapists we spoke to mentioned that additional specialist manual handling equipment, such as standing hoist, had been purchased by the trust recently.
- We saw resuscitation equipment readily available in all clinical area, with security tabs present on each. Systems were in place to check equipment daily to ensure it was ready for use. We saw from records that staff complied with these systems. Oxygen and suction equipment were also checked daily. In the recovery area, we observed that some suction filters required changing and this was pointed out to the nurse in charge, who carried out the change. We found two surgical instrumentation sets that were out of date by almost six months. Staff immediately removed these sets when we pointed this out to them.

## Medicines management

- Medicines were stored safely and appropriately on wards and theatres, including items which needed to be stored in refrigerated conditions. Temperature checks had been carried out on drug fridges and recorded daily except for one ward, Fairfield 1, where we saw inconsistencies in the recording of drug fridge temperature. Since January 2015, we observed that the temperature was not recorded for up to 12 days a



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month and in one case 6 days in a row. This meant that staff could not guarantee that the medicines in that fridge were still safe to use. We informed the ward manager, who was unable to explain the lapse in temperature recording.

- There was a named pharmacist allocated to each ward, who also attended the multidisciplinary meetings. Staff told us they received support from the pharmacist and generally take home medications were processed to allow a morning discharge if the prescription was received by pharmacy team by 3pm the day before. Pharmacy audits took place regularly and we saw that no concerns were raised in the last audit for the surgical wards or theatres.
- We saw medicines were given to patients by nursing staff in accordance with the prescription, and that safety checks were carried out during the administration process. Staff had access to up-to-date guidance on medicines and received advice from the pharmacist, who reviewed each prescription chart on the electronic prescribing system.
- Medication errors were reported on the electronic incident reporting system. Staff told us they received feedback on medication errors and staff directly involved received additional support and training.

## Records

- The trust had implemented an electronic patient record system. Staff said they were well supported during its implementation and were now generally managing the changes in practice required, in particular contemporaneous record keeping.
- The records we reviewed showed that all entries were completed, and relevant risks assessment carried out at admission and reviewed regularly. The electronic systems triggered care plans for nursing staff to complete depending on the reason for admission. Nursing staff were also able to select other care plans based on patient needs. We saw clear evidence that patients were routinely screened for MRSA and results were available on the electronic system.
- Old medical records had been archived, but staff were able to request these notes prior to or on admission for patients who had received care at the hospital prior to the introduction of the electronic records.

- Records could only be accessed via individual smart cards and we saw evidence that staff always logged out of the computers after use, which meant that the records were not accessible to unauthorised persons.

## Safeguarding

- Most staff we spoke to were able to explain their understanding of safeguarding and the principles behind safeguarding adults and children. They were clear about the escalation process and were able to access the safeguarding team for advice and guidance. This understanding was better for more senior staff we spoke to and some junior staff said they would ask senior staff for advice.
- All clinical staff were required to complete level 1 adult safeguarding via e-learning and attend face to face training for level 2. The trust's target was 90% compliance with adult and children safeguarding training but data provided to us indicated that this target was not being achieved across the surgical wards and theatres.
- In the critical care and surgery directorate 66% of staff had completed adult safeguarding training and 77% for safeguarding children. For general surgery medical staff, the completion rate was lower at 47% for adult safeguarding and 40% for safeguarding children.
- Ward staff training for adult safeguarding ranged from 76% on Queens 1 and Queens 2, up to 90% on Fairfield 1. For children's safeguarding, the training rates ranged from 64% on Purley 3 to 86% on Queens1.

## Mandatory training

- Staff told us that the mandatory training was booked by the ward managers for the surgical wards and the practice development nurse for theatres. Most staff we spoke to were aware of the training they had completed and were able to identify the sessions that were outstanding. Staff could access their learning record online to keep a check on when their training was due to expire.
- The target set by the trust for mandatory training completion was 90%. Across surgery this figure was not achieved for all modules, with some figures as low as 46% for Information Governance training, 52% for fire safety training and 57% for resuscitation training.
- The training rates for medical staff in surgery were consistently low across all modules, with some key areas such as infection prevention and control and resuscitation at 27% each.

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## Assessing and responding to risk

- Nursing staff described the use of an early warning scoring/track and trigger system, called ViEWS, to monitor patients' condition on the surgical wards. They used a handheld device to record observation at the patient's bedside, which then calculated a score and prompted staff to take the necessary action depending on the score. The ViEWS system was also compatible with the electronic patient record system so this information was transferred to the patient records and was accessible from any computer. This was particularly helpful for the outreach and medical team, who could monitor the patient progress remotely.
- The scoring system enabled staff to identify concerns before they became serious and there was a clear escalation plan in place. Staff contacted the medical team and also referred to the critical care outreach team when this was required. We saw the early warning system in use in the records we reviewed.
- Staff were able to identify the necessary steps to take in the event of a clinical emergency and emergency equipment was readily available in all clinical areas.
- On Queens 3, where patients with a fractured neck of femur were admitted, we saw evidence of physiotherapy assessments with respect to patient mobility, displayed in each patient bed area. This ensured that staff were aware of mobility risks.

## Use of the 'five steps to safer surgery' procedures

- Theatre staff completed safety checks before, during and after surgery as required by the 'five steps to safer surgery' – the NHS Patient Safety First campaign adaptation of the World Health Organization (WHO) surgical safety checklist.
- The theatre and anaesthetic staff we spoke with told us the pre-list brief had been standard practice at the trust for more than five years. The brief and the five steps of the World Health Organisation (WHO) surgical safety checklist were recorded electronically. Theatre staff told us there was a debrief as part of sign out at the end of each procedure and if there were any issues such as equipment, these were noted.
- Theatre staff told us that audits of the WHO-surgical safety checklist was carried out, with one case reviewed per day and we saw evidence of these audits showing compliance at 95% and above for the last six months.

## Nursing and theatre staffing

- On the days of our announced inspection, we found that staffing levels across the surgical wards and theatres was adequate. Staffing figures were displayed on each ward. These indicated the optimum levels and the actual levels for the day and night shifts.
- The vacancy rate on the surgical wards ranged from 4.9% on Purley 3 to 19.33% on Queens 2. The matron for surgery told us that recruitment had taken place and new staff were due to join the surgical wards in the next few months.
- The surgical wards used an acuity tool, of which we saw evidence, to determine safe staffing levels and this was escalated to matrons in order to increase staffing on particular shifts when required.
- Staff we spoke with told us that staffing levels had improved and the trust had recently undertaken a recruitment drive overseas to further increase the number of permanent nursing staff. Staff told us that skill mix was generally good, although there were some shifts when a gap for a qualified nurse was filled by a healthcare assistant.
- Senior nurses we spoke with felt that an additional healthcare assistant (HCA) was needed at night. On Purley 3, the ward manager had identified some savings in her ward budget and this money was being used to recruit an additional HCA.
- We saw evidence that all agency staff underwent a structured induction to the trust and to the wards they were allocated. Senior nurses told us that the same agency and bank staff were used where possible, which helped with continuity of care for patients. Agency staff were given a smart card to access the electronic patient records, but were often unfamiliar with the system.
- Staffing in theatres was adequate, although there was a heavy reliance on agency staff, with up to six agency staff per shift. Vacancies in theatres had been exacerbated by high turnover of staff, which was 33% for the last financial year. We were informed on our inspection that from the overseas recruitment, seven nurses had just started in theatres and an additional five nurses were due to start soon.
- Recovery was staffed by one nurse at night and staff told us that this was an issue, if there was more than one patient in recovery at night as the nurse also had to escort patient to the ward.
- The day surgery unit had a stable staff group at the time of our inspection, although the turnover for the period



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of March 2014 to April 2015 was 30%. There had not been enough staff to deal with the high number of patients on Wednesdays, and we were told the risk to patients because staff were so busy had been raised at utilisation meetings. The staffing on Wednesday had recently been increased following recommendation from an external consultancy firm, who were carrying out an observation of patient flow in day surgery.

- Daily meetings in theatres and DSU were used to identify problems with staffing levels or skill mix, with respect to the day's activity, and for the following day.
- On the surgical wards, nursing handover was carried out at the patient bedside and each member of staff had access to a handover sheet, containing the history and MDT management plan for each patient.

## Surgical and medical staffing

- The trust had a lower number of consultants than the England average and the trauma and orthopaedic and general surgical rota were currently 1:8 for on calls. The orthopaedic staffing was also highlighted as an issue in a review by Health Education South London. The clinical director for the surgical division informed us during our inspection that the trust was in the process of recruiting additional consultants.
- The trauma and orthopaedic service operated a daily on call rota, and this has led to complaints, with patients being passed from one consultant to another. The service was in the process of changing to a consultant of the week system, which was already in place for general surgery.
- Consultants we spoke with told us of gaps in medical staffing, notably at the level of doctor in training, which resulted in frequent use of locum medical staff to cover night shifts. There were also gaps at middle grade level in trauma and orthopaedics.
- We were told by staff that General surgery and orthopaedics had 11 senior doctors, some of whom were training grades, and nine junior doctors in training, respectively. The trust told us there were 20 senior doctors and 18 junior doctors but we received no evidence to corroborate this.
- There was a consultant presence seven days a week and a consultant on call at all times. One consultant and one registrar were on call for general surgery and for trauma and orthopaedic respectively. One junior doctor in training was on call for each specialty at night, covering the wards and A&E referrals.

- There were gaps in the anaesthetic rotas, with locums used to fill these. A recruitment programme, for consultant anaesthetists and middle grade doctors had attracted a response and there were expectations that gaps would be filled.
- Anaesthetic cover was available via a consultant on call and an on-site registrar 24 hours a day.
- We observed medical handover at 8.30pm, which was attended by a medical consultant to advise doctors in training who were coming on duty. The meeting highlighted and discussed any patients who were unwell. There was an additional Friday afternoon handover for all surgical patients who are acutely unwell, attended by a consultant surgeon from each team and doctors in training, to review the plan for these patients. A junior doctor in training told us this meeting provided him with the information he needed to prioritise patient care over the weekend.

## Major incident awareness and training

- There was a protocol in place for managing in-patient theatre emergency bookings.
- The hospital had a major internal incident plan, which had been used once earlier in 2015 when there had been unprecedented demand on the hospital. There was a process for cancelling elective work to prioritise emergency surgery at these times.

## Are surgery services effective?

Good



## Summary

National audits indicated that surgical services generally adhered to best practice standards as well as or better than the England average. When they performed worse than the national average they took action to improve. Mortality statistics and information on readmissions to hospital of patients having planned surgery demonstrated that outcomes were within, or exceeded, expectations. However, readmissions following emergency trauma and orthopaedic surgery were worse than expected.

There was a limited range of evidence with respect to local audits for measuring adherence to guidelines, and the service was not using a dashboard at the time of our inspection to monitor its performance.

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Patients who had pain received adequate pain relief. The nutritional needs of patients were assessed and responded to. However, there was a lack of formal agreement with respect pre-operative starving guidelines.

There were no formal arrangement to access anaesthetic review and opinion of patients fitness for surgery at pre-assessment. There was no trauma service provision on a Sunday.

There were good examples of multidisciplinary working, but communication between consultant surgeon teams and ward staff was affected by the number of surgeons with patients on a ward.

The induction programme prepared new staff well for working at the hospital. Staff gave examples of training and development as a result of their appraisal. The simulation centre gave staff the opportunity to practice responding to an emergency.

Patients consent was sought before treatment and care was provided. Staff used to appropriate where patients lacked capacity.

## Evidenced-based care and treatment

- The clinical governance leads for surgery and for anaesthetics were responsible for overseeing the process of reviewing National Institute for Health and Care Excellence (NICE) guidelines and other best practice guidance from professional associations. We were told that surgical specialty and anaesthetic departments discussed guidelines at clinical governance meetings and we saw an example of an agenda for the anaesthetist department's meeting, which included an item for guidelines. Nevertheless, we were not clear how the division monitored adherence to best practice, as information about the divisional audit programme was not evidenced in the documentation provided.
- Local audits of adherence with best practice provided were limited to those for observations charts, commodes, antibiotic prescribing and the sluice environment.
- We found that staff adhered to evidenced based care and treatment in the following areas: Patients attended a nurse led pre-assessment to assess fitness for surgery. The recommended routine tests were carried out in line with NICE guidelines.
- Further assessment on admission for surgery included a pregnancy test, as recommended in national guidance. If the test was not recorded, theatre staff flagged this as part of the checks undertaken when a patient went to theatre. Venous thromboembolism (VTE) risk assessments were routinely undertaken.
- The trust met the expectation of providing an immediate life-saving operation when this was needed by having an operating theatre, and one back up theatre available at all times, with a theatre team, an anaesthetist and consultant surgeon available out of hours. A consultant general surgeon worked the minimum recommended rota of 1 in 8, which allowed for prospective cover. The rota did not meet the minimum recommendation of 1:10 for consultant surgeon cover although the trust told us in factual accuracy that two locum appointments had been made to meet the 1:10 recommendation. This was expected to be in place on the recruitment of two further orthopaedic surgeons by the autumn.
- There was a clear pathway for patients with fractured NOF, in line with nationally agreed standards, with medical care overseen by two orthogeriatrician's. Data from the National Hip Fracture Audit published in 2014 indicated that the trust performed better than average on four measures and worse than average on two measures. For example, 67% of patients were reviewed pre-operatively by a geriatrician, much better than the national figure of 52%. Falls assessments and bone health medication assessments were undertaken for nearly all patients. The percentage of patients having an operation within two days was similar to the national figure of 73%. The trust performed significantly worse than the national average for access to orthopaedic care within four hours (11% compared to 48%) and for pressure ulcers. We understood this was likely to be because of the demand for beds in the hospital, which exceeded capacity, and the lack of pressure relieving mattress in the Emergency Department.
- We observed one patient with a hip fracture who was not being nursed on a pressure relieving mattress. They were waiting for an MRI scan and had been in the hospital for over 36 hours. Nevertheless, we saw that action had been taken in response to the higher than average incidence of pressure ulcers. There were protocols for ward staff to follow for patients with fractures: obtaining pressure relieving mattress, and putting in place a turning chart. Senior ward staff were

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responsible for checking adherence to the protocols. The manager of the ward which cared for patients with fractured hips had started attending trauma meeting several days a week and going to other surgical ward to review patients. There was a pressure ulcer taskforce, which was gathering information about pressure ulcers acquired in the community as well as in hospital, and promoting best practice in pressure care.

- The trust data submitted to the National Bowel Audit published in 2014 was complete in nearly all cases (117, of which 72 had major surgery). The audit reports indicated that the trust performed better than the English average in adhering to best practice measures. All patients were discussed at a multi-disciplinary team meeting, nearly all had a CT scan reported and nearly 90% of patients were seen by a specialist nurse.
- Other surgical specialities, such as colorectal and vascular, did not all have a formal protocols for enhanced care pathways, but specialist nurses described the assessment and care of patients, which complied with best practice expectations. The nurses gathered data about patient pathways. Direct access to community health teams enhanced care following discharge.
- The theatre team adhered to NICE guidelines on the prevention of surgical site infections. The British Association of Day Surgery guidance was currently being reviewed as part of an assessment of the way the day surgery unit was run.
- There were processes in place for the recognition and response to the acutely-ill patient, in line with national guidelines. This included processes for recognising the deteriorating patient on the wards and for nursing staff to obtain appropriate medical and consultant review of patients.
- The National Emergency Laparotomy Audit published in 2014 indicated that the trust followed best practice, such as the availability of an operating theatre, the presence of a senior anaesthetist and surgeon when indicated, and a defined pathway for patients.
- The colorectal service had set up a research unit, funded by charity, which contributed to evidence-based practice.

## Nutrition and hydration

- There was no protocol in place to ensure patients did not become unnecessarily dehydrated before surgery. Patients coming for the morning surgery list were told

they were not able to drink after 6am, although national guidance specifies that patients should be able to drink small amounts of clear fluids up to two hours before surgery. The nurses on the admissions told us anaesthetists did not have a standard approach, with some encouraging patients to be offered sips of water, but others objecting to this.

- Patients at higher risks of dehydration, such as older people and people with diabetes, were given intravenous fluids on the ward prior to surgery.
- Patients were given sandwiches and drinks post-operatively in the day surgery unit. We observed the orderly on the unit and a volunteer taking sandwiches to patients and making sure that patients had enough to drink after their procedure.
- We observed patients being offered drinks on the wards and everyone we spoke with said they had the drinks they needed. Most inpatients we spoke with were complimentary about the cooked meals, but one person did not like the food. We saw that special dietary needs were catered for and there were choices of meals for patients from a variety of religious and cultural backgrounds.
- The dietetic department provided advice and support to cancer and other surgical patients when this was required. The team worked in the hospital and in the community and continued to monitor a patient when they left the hospital if needed.

## Pain relief

- There was an acute pain team of a consultant anaesthetist and a specialist nurse who developed guidance on pain relief and educated doctors in training and ward nurses in managing patients' pain. There were arrangements for an anaesthetist to cover when the nurse was on leave.
- The specialist pain nurse reviewed patients post-operatively. Pain relief included Patient-controlled analgesia (PCA) and local infiltration of analgesia (LIA). Nurses on Purley 3 ward were trained to manage patients with epidurals. Ward staff valued the pain nurse's advice, and told us they would like additional resource to assist them in ensuring patients were receiving appropriate pain relief.
- The pain nurse reported improvements in consistent recording of the early warning score, including pain scores on the new electronic patient record system. The

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nurse was able to follow any patient, review pain scores and check if post operative plans have been implemented. She also used the data to audit pain relief.

- Patients were regularly asked by ward staff whether their pain was being effectively managed. Three patients of the six we spoke with on Purley 3 Ward reported delays in getting pain relief at night. No other patients on the surgical wards mentioned this was a concern.

## Outcomes

- The trust contributed to relevant national audits. The completeness of the data submitted was as good as, or better, than the England average for the audits we reviewed. There had been improvements over the last two year in adherence to standards such as those specified in the hip fracture audit and we saw evidence of action taken when the trust performance was worse than expected. Nevertheless, we were not provided with evidence of adherence to best practice standards from local audits, except for those relating to infection prevention and control and antibiotic prescribing in spite of requests for these. Furthermore, surgical services were not using a dashboard at the time of our inspection to review their performance.
- The Standardised Hospital Mortality Indicator, which compares the expected rate of death in a hospital with the actual rate of death, was within the expected range.
- The relative risk of readmission to Croydon University Hospital following an operation was better than the England average for elective (planned) surgery, but worse than the England average for some non-elective (emergency) surgery. Data for the period June 2013 to May 2014 indicated that the relative risk of readmission for elective surgery for urology was 78 and for general surgery 77 (compared to an expected figure of 100). The relative risk was also better than expected for non-elective general surgery (90) but worse for vascular surgery (111) and much worse for trauma and orthopaedics (168).
- The national figures for patients with a fractured hip showed that the length of stay and the 30 day mortality rate was in line with the England average.
- Information submitted to the national Safety Thermometer programme indicated that that pressure

ulcers were now rarely acquired on the surgical wards. Ninety-six percent of patients received a VTE assessment before surgery in 2015, which was above the national average.

## Competent staff

- There was a week's induction for newly appointed permanent staff and for doctors in training, which included mandatory training, the use of the electronic patient record keeping system, and orientation to the area in which they were working. New nursing, theatre and support staff completed a competency booklet. Overseas staff working for the first time in the NHS received an extended induction and more extensive competency checks. New staff we spoke with said the induction prepared them well for working at the hospital and they felt welcomed and appreciated.
- Consultant surgeons and anaesthetists felt that they were not able to support doctors in training sufficiently because there were no adjustments to the elective lists during induction weeks. The doctors in training we spoke with did not report concerns about their induction and were positive about the level of support they received during their rotation in surgical specialities.
- The nurses we spoke with who were on the preceptorship programme, and being supported during their initial year after qualifying, said they were well supported. One nurse told us they had met with their manager to identify their learning needs: she told us she had completed IV fluids training and was booked to attend training in cannulation. There was a preceptorship pack, which included the list of competencies to be completed under supervision. We noted, however, that nurses taking a coordinating role did not have non-clinical days for undertaking appraisals of the ward staff for whom they were responsible, or for supervising staff. When there were a number of newly qualified nurses on a ward, it was challenging for them to provide the support they felt was needed. In addition, student nurses told us mentors were not always able to give them the time to support them. Senior managers and ward managers told us they were looking at ways to relieve more experienced nurses of some clinical duties, but at the time of our inspection this was not in place.
- The state-of-the-art simulation centre was well-used by surgery services, in particular for doctors in training. An

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anaesthetist trained in simulation worked closely with the manager of the centre to practice responses to emergencies in theatres and to discuss how these might be improved.

- Appraisal rates for theatre, support and nursing staff varied, with some wards and main theatres recording fewer than 75% having an appraisal in the period April 2014 to February 2015. Day surgery unit had recorded that nearly all theatre, nursing and support staff had completed their appraisal. Senior managers informed us that for the year April 2014 to March 2015 the rate was 75% overall, and they were taking steps to improve this in the coming year. The staff we spoke with said they were encouraged to take up training opportunities, and gave examples of training, such as a recent palliative care day. Ward managers were identifying staff with leadership qualities and giving them more responsibility to prepare them for a role as manager. A healthcare support worker told us she was studying a foundation degree in nursing practice, supported by trust.
- Theatre staff rotated to different roles to maintain their skills, and a practice facilitator supported the line managers to identify training needs. We looked at the medical devices training register and saw that all theatre staff were up to date.
- Ward staff cared for patients who had undergone different types of surgery, in addition to medical 'outliers', for whom no bed was available on a medical ward. Ward staff told us they felt confident caring for different patients. For example, a nurse on a ward where the majority of patients were general surgical was able to describe her competence in providing care for patients with fractures. Staff had training in different specialities, often provided by therapists or specialist nurses, sometimes in conjunction with a consultant surgeon. Surgical nurses had attended a colorectal study day run by a consultant and specialist nurses earlier in the year. A ward manager recently attended a three day training course on gynaecology and was planning to set up a study day for ward nurses with input from gynaecology consultants.
- There were 'clinical champions' for infection prevention and control on the wards, who attended additional training and shared their knowledge with ward staff. There were no longer clinical champions for other areas, such as pain or diabetes. Nurse specialists who attended a focus group felt that ward nurses were not as

up to date as they were in the past and those who had undertaken additional training were not always being used to pass on their knowledge to other ward staff. There were two diabetes specialist nurses covering the hospital, where one in five patients had diabetes. Specialist nurses told us doctors in training contacted them, instead of discussing care with ward nurses, which placed additional pressure on a limited resource. A doctor in training told us he approached nurse specialists as their first port of call.

- There had been a high rate of turnover among theatre staff and we were told there had been problems in retaining good staff because of the lack of opportunity for progression. There had been only one grade of operation department practitioners (ODPs) and the lowest grade of healthcare support worker for theatres. The establishment had been changed to include higher grade ODPs, but not for higher grade support workers.

## Multidisciplinary working

- Theatre, anaesthetic, surgical and medical staff reported good joint working in main theatres and in day surgery theatres.
- Nursing staff described close working relationship within the ward team and with tissue viability nurses, occupational therapists and physiotherapists to enhance the care of patients. Dietitians, and nurses specialising in pain, incontinence, stoma care, diabetes, dementia and learning disability were available to contribute to effective care. We observed good interaction by all members of the multidisciplinary team in planning on-going care and discharge for patients admitted with a fractured neck of femur during a weekly meeting. Doctors in training told us medical specialties were responsive to requests for advice or patient review when surgical patient had medical needs.
- There were daily trauma meetings on weekdays attended by consultant surgeons, doctors in training and an orthogeriatrician, which was attended by a ward manager on some days. Therapists were not present. Staff working with urology, colorectal, breast and urogynaecology teams said that nurse specialists were available to ensure that good practice was followed in the care and treatment of patients.
- Notwithstanding the examples of good multidisciplinary working, we observed, and staff told us about, examples of breakdown in communication having an impact on the effectiveness of services.



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- There was no formal arrangement to access anaesthetic review of patients at pre-assessment and pre-assessment nurses went to the anaesthetists' office to ask for an opinion. We saw the notes of patient whose surgery was due the following day, which indicated the anaesthetist covering the list had just cancelled the procedure because the need for an electrocardiogram (ECG) was indicated. An anaesthetist had not reviewed the patient at pre-assessment, although this had been requested by a nurse.
- We received reports of high dependency beds being unavailable to surgical patients because of lack of communication between surgeons and the ICU about the availability of beds. We were not provided with data that confirmed or disproved this assertion.
- The day surgery unit was very busy on one of the days of our inspection, and patients were being sent from main theatres to the unit for discharge. Staff told us they were not kept informed about the numbers they were likely to receive. Consultant surgeons reported responsive radiology and scanning services. However, we found there was no agreed process about radiological investigations required by the day surgery unit. This resulted in delays and in day surgery unit staff spending time transferring patients and therefore being unavailable on the busy unit.

## Seven-day service

- Pharmacy and radiology were available on weekdays and then on call out of hours, with limited access. We noted that a day surgery unit patient had been discharged after the pharmacy closed with analgesia from stocks held at the unit, but without other medication prescribed. They were asked to return the following day for their medication.
- There was no trauma service available on a Sunday for patients who had a fractured neck of femur.

## Access to information

- The implementation of the electronic patient record system over the previous 18 months meant that staff had access to current patient information, including the patient's history, without reference to paper records. Doctors in training entered notes on the system during the consultant ward round and other members of the multidisciplinary team made contemporaneous notes of their observations and assessments. There was an electronic screen in the office with an overview of patients on the ward and their care plan, which was

colour coded to highlight when action was required. Discharge letters were sent electronically to the patient's GP, although there had been problems with these initially.

- The additional module for theatres had recently been added to the electronic patient record system. This enabled theatre staff to automatically send for a patient when they were ready, and the patient path through theatres and recovery was displayed on an electronic board. Sometimes the failure of staff in the hospital to update patient records resulted in delays in treatment. We noted an incident report of a cancelled operation when the day surgery unit refused to take patient from the surgical assessment unit (SAU) because the system showed the patient as an outpatient. A patient we spoke with said information was not passed from ED to the SAU and this had caused delays.
- We observed that the system was not accessible on most computers on the ward for a period of two hours during our inspection, and ward staff told us the system was frequently 'down'. Each ward had a computer that was in operation at all times, but this was used to print drug charts, and was not used by staff for viewing notes or updating risk assessments as all staff would want to use this computer when the rest of the system was down. We were told there had been an hour's delay in administration of medicines because of the time it took to print the drug charts. The trust told us during factual accuracy that the system was down for two hours during our inspection due to a national choose and book system implementation that was not within the trust's control. However staff were unaware that this was the reason for the issues.
- Consultant ward rounds often took place without a nurse present so there was no verbal exchange of information about the patient's condition or the plan for the patient. One of the wards had an average of eight consultants with patients at any one time during ward rounds, and we were told this was higher on some wards. Managers tried to allocate a nurse to each consultant for the ward round, but this was not always possible. In addition, we were told there were a variety of approaches to communicating information by the surgical team, with some teams ensuring that information was passed on verbally as well as in the electronic notes, and other teams leaving without



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speaking to ward staff. When there was limited access to the patients' electronic record, as there was during our inspection, ward staff did not know about investigations to be ordered or other aspects of the patient's plan.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients told us staff explained treatment and care and sought their consent before proceeding. They said they had been given information about the benefits and risks of their surgery before they signed the consent from.
- There was discrete mandatory training for all staff in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with understood their role in applying the MCA and DoLS. Opportunities to discuss individual cases reinforced understanding, while staff who were not confident in their understanding said they knew who to contact if they wanted advice. There was a team available in applying the process when this was required. The specialist nurse for learning disability confirmed that, although further work was needed to improve knowledge of the MCA among some medical and surgical staff, there had been noticeable improvements over the last year. She gave an example of a member of medical staff distinguishing between a decision that a patient was competent to make and a different decision that they were not. The first procedure took place with the patient's consent and a best decision meeting was held for the second decision. She said some departments, such as pre-assessment and radiology were effective in recognising when patients had capacity to make a decision and when to refer for further assessment of capacity. We observed a patient who was receiving one to one care because of their level of confusion and saw the completed application for DoLS.
- There was no monitoring of the use of MCA and DoLS in the service at the time of our inspection, so we did not have information about how often these were used.

experience of the trust commented on "how much better it is now." Comments included: "staff are gentle, kind and caring", "staff seem very on the ball and listen to me" and "the ward is exemplary." We observed staff being friendly towards patients, and treating them and visitors with understanding and patience. There were some concerns expressed about poor communication.

Treatment was provided in a respectful and dignified manner. Patients told us that they were usually involved in decisions about their care, and were kept up to date with their progress. Emotional support was provided by staff in their interactions with patients and by clinical nurse specialists, who visited the wards regularly.

## Compassionate care

- Patients told us that they were treated with dignity and respect by all members of the care team. We observed patients being asked how they wanted to be addressed, staff knocking on doors before entering, and curtains being pulled around beds before treatment or private conversations took place.
- All the patients who had used the hospital in the past told us how the care had improved since their last admission. A patient said, "I'm gobsmacked at how much better it is than before."
- We also reviewed the comments we had received from people contacting the CQC before and shortly after the inspection. There were positive comments about improvements to the attitude of staff, but a small number of relatives complained that the staff on the wards (nursing and medical) did not appear to listen to their concerns.
- On the surgical wards, we saw that patients had their call bell within reach and bells were answered promptly. One patient told us that a nurse or health care assistant (HCA) was always present in the bay and accessible to patients.
- We saw evidence of a patient living with dementia having one to one care from a HCA. The patient was distressed as she was looking for her daughter and the staff member spoke to the patient in a calm and caring manner, explaining where she was and that her daughter would visit later that day.

## Are surgery services caring?

Good



## Summary

Nearly all the patients we spoke with were positive about their treatment and care, and those who had previous

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- May 2015 results for the Friend and Family Test on the surgical wards indicated that more than 94% of patients would recommend the trust. The response rate for the trust was slightly higher than the England average and for the surgical wards ranged from 36% to 65%.
- The locality the trust was in performed poorly in the cancer patient experience survey results for inpatient stays. They were in the top 20% of trusts for three areas, but were in the bottom 20% of trusts for 19 areas. The main concerns raised by patients were about poor communication between staff and patients.
- A patient we spoke with on Fairfield 1 told us "I'm very impressed with the attitude and care. Staff concern is primarily with the patient and patient's needs."
- We observed a member of staff assisting patients with their menu choice and time was taken to go through each option and the patient was not rushed at any point.
- We observed an interaction between a patient and a phlebotomist, where the patient was treated in a respectful and caring manner and was asked which arm he wished the blood to be taken from.
- On Purley 3, one patient told us that "staff try very hard and are friendly, but there is a lot of demands on them and this caused communication problems at times." On the same ward, a patient felt that there was not enough staff at night.

## Understanding and involvement of patients and those close to them

- Patients we spoke told us that their treatment had been explained to them fully when they had their appointment in outpatients. They said that nurses had taken the time to go through everything when they came for pre-assessment.
- We attended a multidisciplinary meeting and we saw evidence of staff discussing the patient's choice when planning their discharge and therapist liaising with patient's relative and involving them in planning the care package the patient would receive after discharge.
- We also noted that there was a family meeting planned to discuss on-going care for a patient who lacked capacity.
- Results of the National Cancer Patient Experience Survey 2014 for the locality the hospital was in reported patients did not always feel fully involved in decisions about their care and treatment.

## Emotional support

- Staff confirmed there was access to clinical nurse specialists, including the specialist pain nurse, and breast and stoma care nurses, as well as the colorectal and palliative care nurse.
- On one ward, Queens 2, the ward manager ran a 'visitors clinic' daily, where for one hour he made himself available for any relatives to come and speak to him about any concerns they might have or if they required additional information or support.
- We were not made aware of any specific counselling or support services available to patients with regards to clinical care.

## Are surgery services responsive?

Requires improvement

## Summary

Two thirds of surgical activity was day-case surgery. However, the day surgical services were not always able to cope with the high level of activity. Single sex accommodation was not always achievable on the day surgical unit.

A Surgical Assessment Unit (SAU) had been set up at the beginning of 2015 in one of the surgical wards to facilitate the flow of surgical patients. This was sometimes achieved, but at the time of our inspection the unit was not following the operational policy for the unit and the unit was being used by medical patients.

Surgical patients were sometimes admitted to the day surgical unit and were then cancelled as there were no theatre operation slots available.

Operations were sometimes cancelled because of lack of technical equipment availability.

Privacy and confidentiality was not always afforded in the SAU because of the level of activity.

Theatres were underutilised and scheduling of operations was not planned to take account of demands on the day surgery unit (DSU) or on ICU.

The length of time from referral to treatment had been reduced and was now generally in line with, or better than,

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the national average. Discharge planning had improved since our last inspection, but there were still delays in transfers of patients to the community, in particular for those patients requiring a step-down bed.

Patients with learning disabilities were receiving a responsive and effective service. Patient's needs were taken into account in the planning and delivery of care.

There had been improvements to the handling of complaints, but some people were kept waiting for a long time before receiving a satisfactory response.

## Service planning and delivery to meet the needs of local people

- Croydon Health Services NHS Trust worked closely with commissioners and other NHS trusts in South West (SW) London to optimise care pathways for patients. The trust was part of the SW London cancer network, with close contacts with the regional centres at other hospitals. Joint replacement surgery was performed by surgeons from the trust and other trust at the SW London Elective Orthopaedic Centre (EOC).
- There were strong links within Croydon's health and social care economy. GPs were consulted about the setup of the Surgical Assessment Unit (SAU) and about developing direct access to some surgical procedures. Community health services were part of the trust and had direct access to electronic patient records. This facilitated the deployment of therapists to provide support to surgical patients discharged from hospital, although there was sometimes a wait for therapy.
- There was a shortage of 'intermediate care beds' for older patients who no longer needed inpatient care, particularly for those surgical patients who needed two people to transfer them. This was recognised by the trust and by the Clinical Commissioning Group, but at the time of our inspection there was no agreed plan to commission beds that would provide effective rehabilitation.
- The trend of increased day surgery cases in recent years was reflected at the hospital, with nearly two-thirds of the annual 23,000 surgical procedures undertaken as day cases. However, on busy days the day surgery unit facilities were not adequate to deal with the increased activity. The bay for male patients was not always maintained as single sex on Wednesdays because of the number of procedures for women patients. Staff always informed the patients and obtained their consent and

this was also documented in the patient records. Steps were taken to maximise patients' privacy, such as keeping curtains half drawn and not positioning male and female patients directly opposite each other. There was only one assessment room on the unit at the time of our inspection, although we were told that the estates department had agreed to convert a storeroom into an additional assessment room. At the time of our inspection doctors and surgeons looked for other spaces in the DSU for confidential discussions, when the assessment room was in use, such as a bay on the ward or an office. Occasionally medical or surgical staff spoke to patients in the lounge: a patient we spoke with during our inspection told us they had overheard such a conversation.

- The area used for assessing surgical patients (pre-assessment) and as an admissions area for patients the day of surgery was spacious and comfortable with separate sitting areas for females and males in addition to a mixed lounge. There were enough rooms for anaesthetists and surgeons to carry out final pre-operative checks in privacy. We noted that the area was hot on the warmest days of our visit and staff reported that patients complained of the heat. Staff had reported the lack of adequate ventilation, but had received no information about action to address this.
- We were informed of agreement to improve and expand the facilities for the dental/ maxillofacial unit. The unit had raised funds to buy a chair for bariatric patients.

## Meeting people's individual needs

- The acute liaison nurse for patients with a learning disability had worked with trust staff to improve patient experience and the effectiveness of treatment. Staff, including porters and domestic staff, had improved understanding of the needs of patients with a learning disability. The patient and their family or carers were asked to complete 'health care passport', which detailed the person's preferences, method of communication, likes and dislikes and medical needs. These were kept at the end of the bed and referred to by all staff providing care and treatment. The liaison nurse had also written a guide for staff to prompt them to consider aspects of care, such as the patient's capacity to consent and whether they would benefit from the use of a side room.
- Patients with learning disabilities were put first on the theatre list to avoid long waits and we were told there were dedicated lists for patients with learning

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disabilities. We observed the care and kindness with which the cardiac catheter laboratory team supported a patient with learning disabilities to receive treatment. We were also told of the year-long planning, led by the liaison nurse, for a patient with a fear of hospitals, to which all staff involved in the diagnosis, treatment and care had contributed. The surgery took place during our inspection.

- Staff attended dementia awareness training and we observed kind and attentive interaction between ward staff and patients living with dementia. A symbol of a butterfly identified patients living with dementia, and they were automatically allocated a red tray at mealtimes, to make sure they received support with eating.
- There was no direct admission for patients with needs, such as dementia and learning disability, who were often moved several times after their arrival at the Urgent Care Centre, causing distress.
- GPs and hospital staff booked the interpreter service in advance, for example for pre-operative assessment.
- We observed that staff coming on duty were alerted to the needs of patients at handover, such as the need to be supervised when moving around the ward. Patients told us that ward staff regularly checked to see that they had everything they needed, and there were regular rounds by the ward manager and matron.
- We noted that there was no television, radio or telephone at patients' bedsides and there were no communal rooms. Several patients we spoke with, in particular those who had stayed on the ward for more than a week, commented on this and said they became bored.

## Access and flow

- The trust had worked hard to reduce the referral to treatment time (RTT), and was performing in line with, or better than, the national average for waiting times from referral to diagnosis or treatment. Most surgical specialties were meeting the referral to treatment (RTT) waiting time target (within 18 weeks) for admitted and non-admitted pathways. The urgent referral performance target was being met in March 2015 (people seen by a cancer specialist within two weeks from the time when an urgent GP referral was made). The percentage of patients waiting more than six weeks for diagnostic was in line with the national average. The

newly appointed associate director of operations for the division was meeting regularly with operations managers and the access team to address any breaches of waiting time targets.

- The surgical assessment unit (SAU) opened in December 2014 on one of the surgical wards had allocated two treatment rooms and an ambulatory area to treat patients with conditions such as abdominal pain, abscesses and hernia complications. The aim was reduce pressure on the ED by sending patients directly to the SAU following triage at the Urgent Care Centre or in the ED, and to facilitate access to timely surgery. The plan for the service was to be open 24 hours a day, seven days a week, but at the time of our unannounced inspection in the evening the service had closed at 6.30pm. An additional two health care assistants had been recruited to the ward, but there was no dedicated medical, nursing or support staff for the unit. At the time of our inspection the unit was not ring-fenced for surgical patients and there were beds in the area being used for medical patients. A consultant told us this was to avoid a breach of the four hour target for ED and did not benefit the patient, who was likely to be moved a second time to another ward.
- On the day of our unannounced inspection, we saw evidence that the SAU had facilitated the prompt treatment of patients. The three patients who had been to the SAU had been surgical patients: two had received surgery and one had been moved to a surgical ward. However, the small numbers of patients meant that the SAU area was underused, while there was frequently a shortage of inpatient surgical beds. We were told that patients who were booked for surgery and had been nil by mouth all day sometimes had to go home and return the following day because there was no slot on the theatre list. One patient we spoke with on our announced inspection had returned to the SAU for three days in a row for a pain relieving procedure and had still not had surgery. Patients attending the unit did not always receive prompt or effective review. One patient told us they had been mistaken for another patient by a member of medical staff, although this mistake had been rectified. Another patient said that several members of staff had asked them the same questions, and they were unclear who was responsible for their treatment.
- We observed staff managing the flow of patients through the admissions area before they went to theatre

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for surgery. Most surgical specialties now ran a morning and afternoon list so patients were invited in two batches, but there were some all-day lists and patients requested to attend early in the morning might not be seen until the afternoon. Some patients expressed concern that they were waiting longer than people who had arrived after them. Staff reassured them and answered queries. They sometimes telephoned theatre to ask for information about timings.

- One nurse was allocated to assess patients sent directly from outpatients for pre-assessment, which enabled the patient to come only once to the hospital prior to surgery (a one-stop clinic). Some specialties, such as ENT and dental offered all patients a one-stop clinic, with the pre-assessment nurses working flexibly so that patients were assessed preceding or following an outpatient appointment. Volunteers showed patients the way. There had been work with Croydon GPs to create direct access from GPs for hernia and some urology procedures. However, staff in the admissions area told us that GPs did not always assess patients for surgery adequately, and we saw an incident of a cancellation when the patient arrived on the day of the procedure without pre-assessment.
- Daily theatre utilisation meetings were attended by managers, and leads from day surgery, pre-assessment and theatres to discuss the previous day's lists and any issues arising. There was a weekly scheduling meeting chaired by the theatre manager. Lists were planned six weeks in advance.
- The information we received from the trust for the first quarter of 2015 indicated there utilisation of theatres was 63%. We looked at the DSU schedule and saw some gaps in the theatre schedule. On other days all theatres were in use and patients were also sent to DSU from main theatres, resulting in pressures on staff, who reported they were unable to provide a responsive service to patients. One staff member commented that the schedule "was run to consultants' whims, not for patients". New surgeons with additional lists were due to start shortly, which would put additional pressure on the DSU.
- We asked for data on cancellations and received some information about the 17 cancellations in November and December 2014 only. The most usual reason for cancellation (six cases) was the surgeon being unavailable and there were two cancellations because lists overran. There were four cancellations because no HDU bed was available and one because a ward bed was unavailable. There were three cases of equipment being unavailable.
- Lack of an effective equipment replacement programme and on-going unavailability and dated equipment issues in main theatres and the day surgery unit meant that some operations were being cancelled on the day. Staff made those decisions when they felt unable to provide safe care due to equipment problems.
- During our inspection we observed, or were informed of, reasons for delays to surgery. Some of these continued to occur because the underlying causes for these delays were not tackled. We were told a list started late on the morning of our inspection due to lack of drill for a dental procedure. We observed a consultant arriving late for an afternoon list at the day surgery unit from St George's. Several consultants operated at the hospital, but they were not set up on the IT system and could not print out their list or prepare discharge letters. Consultant surgeons commented on the number of medical outliers on surgical wards, which affected theatre utilisation because there was no bed available for surgical patients. Theatre staff told us elective cases sometimes started without an allocated bed, which resulted in patients waiting in recovery for transfer to the ward. Furthermore, the planning of surgery did not appear to take account of demands on the ICU. Major surgery was scheduled on Mondays and Tuesdays when there was a particular shortage of high dependency and critical care (HD/CC) beds because of admissions over the weekend.
- National data on delayed transfer of care for April 2013 to Nov 2014 indicated that nearly half the delays at Croydon University Hospital were a result of failure to complete an assessment (25% compared to a national average of 19%) and waiting for NHS non-acute care (24% compared to 21%). Delayed discharge was identified in our last inspection in September 2013. There had been action to address this and discharges late at night were now avoided.
- Ward staff, therapists and social workers had daily discussions at 9am about the readiness of patients for discharge. There were also weekly multidisciplinary meetings attended by a discharge coordinator and medical staff. We observed a meeting chaired by a consultant orthogeriatrician to discuss patients' progress and discharge plans. The meeting was



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well-organised, with good interaction between staff and a holistic view of the patients' care, which was recorded directly onto the electronic patient record system. There was evidence of engagement with patient and their family in decision making and discharge planning. There was a weekly meeting to discuss all delayed transfer of care by the discharge planning team, which was attended by representatives from the surgical wards.

- Staff had attended a discharge planning day to share good practice, and were implementing suggestions. Discharge planning started early in the patients' stay, and patients ready for discharge were identified the previous day. The phlebotomy service had started to take bloods earlier in the day, which reduced delays. Hospital staff were able to make a direct referral to community services, such as district nursing to provide care and treatment on discharge. The community matron came to discussions on the wards on Saturday and Sunday to facilitate discharges. Nevertheless we did not see evidence of continuous communication between hospital and community staff and there was not routine attendance by community services staff at multi-disciplinary discharge discussion.
- The processing of medicines to take away at discharge (TTA) had improved but there was room for further progress with forward planning by doctors so that prescriptions arrived at pharmacy by 3pm the day before discharge. There continued to be delays in the discharge process because of problems with transport, and the difficulties in transferring patients to a suitable bed in the community.
- A discharge pathway for patients with a learning disability had been put in place, which specified a review within seven days of admission by a member of the learning disability community nursing team. The patient's social worker, who was often from outside the area, and the provider of the home where they lived, were involved in ensuring there were adequate services in place for patients when they returned home. The pathway specified there should be no discharges on Fridays as this had often led to readmissions over the weekend in the past.

## Learning from complaints and concerns

- Clinical staff were aware of the complaints reporting and investigation process, and there was information about complaining in the areas we inspected. There had been work to improve the quality and timeliness of responses

to complaints at the trust and the directorate had been supported in dealing with complaints. The directorate had met the target of 80% of complaints to be responded within 25 days. We looked at three letters sent to us by the trust and two letters sent to us by patients or relatives in response to complaints about surgical services. The letters were signed by the chief executive and four of these provided an explanation about the circumstances surrounding the complaint, an apology when this was appropriate, and a description of action taken to prevent a recurrence. One of the patients who contacted us accepted the explanation provided, but experienced lengthy delays to rectify the problem that had been caused by her treatment. She spoke with the chief executive at trust public meeting, and received the treatment shortly afterwards. Another complainant had not received further correspondence from the trust following her husband's death. She had been told there was an investigation about the circumstances surrounding the death, but had not been kept informed of progress with this.

## Are surgery services well-led?

Inadequate



## Summary

The new leadership of the directorate had inherited a weak governance structure and as a result changes were not yet fully developed. A strategy for the surgical directorate had not been developed.

Risks related to service provision had not always been identified. Risks that had been included on the risk register were not always responded to in a timely manner.

The new leadership team were working to overcome previous difficulties and there remained a culture of distrust. There was an absence of standardised practice in relation to incident reporting and risk management.

There was commitment to providing patients with effective and safe services in many areas, but these were often functioning in isolation from other services and professions.



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There was low staff morale and a sense of frustration about the frequency of changes and lack of sustainment. Staff didn't always feel listened to where they had contributions to make about improvements or concerns.

## Vision and strategy for this service

- There had been recent changes to the organisational structure of Croydon Health Services NHS Trust. Surgery services was now part of the Integrated Surgery, Cancer and Clinical Support Directorate, which also included intensive care, outpatients, diagnostics and pharmacy. The clinical director had been recently appointed and was working with the associate directors of operations (ADO) and nursing (ADN) to understand and improve services. There would be five business units in the division which would each have a clinical lead, matron and operational lead.
  - There was no current strategy for surgery. The directors were aware of the challenges facing them as they engaged staff in developing a strategy for the service. They were in the process of running four workshops on demand and capacity to staff, and there were plans for away days to discuss services and to break down some of the barriers between different services, teams and professions. The associate directors had made a commitment to listen to staff. We heard from staff that they were being encouraged to report any incidents that affected the running of the service, and the ADO told us she was reviewing these. The ADO and ADN were holding open door sessions, and staff were aware of these. A senior member of anaesthetic staff confirmed that they now received responses to emails and telephone calls.
- understood performance in surgery services because we were not provided with, a dashboard or any other report that summarised activity. With the exception of referral to treatment times, which were closely monitored, and the theatre dashboard, which we were told was unreliable, we saw little evidence of the use of data to monitor performance.
  - We were told that there were monthly clinical governance meetings for each specialty and for anaesthetics, and these fed into the quality board meetings. We asked to see minutes of these meetings, but did not receive them, and we did not see evidence of items from these meetings being discussed at board meetings. There did not appear to be a process to integrate mortality and morbidity discussion, which we were told took place regularly at the monthly meeting, with incident reporting.
  - We were sent the minutes of the March 2015 clinical governance meeting attended by eight consultant surgeons (not including trauma and orthopaedics). There was a discussion about referral to treatment times, and theatre utilisation. Consultants expressed a lack of trust in the data on utilisation and thought more work should be done with coders to make sure the coding used in the Patient Tracking List (PTL), which was used to measure referral to treatment time, was accurate.
  - Risks which related to service delivery such as the surgical assessment unit, surgical equipment items and patient cancellations had not been included on the risk register. The risks identified on the register had been regularly updated, but items had remained on the risk register for months and sometimes years without being addressed. Mitigation of risk was reliant on steps taken by clinical staff, without appropriate checks of their effectiveness.
  - The new leadership of the directorate told us of the expectation that in future there would be ownership by consultants of the data used in the performance dashboard, which would result in a greater willingness to accept challenges to improve efficiency. It was too soon to assess whether the reports the quality board needed to understand risk and performance would accurately reflect activity.

## Governance, risk management and quality measurement

- We found evidence of the absence of a robust clinical governance structure. We saw minutes of meetings of the quality and performance board for the previous directorate, critical care and surgery, which maintained an overview of the risk register, serious incidents and complaints. The board meetings were attended by nursing and operational managers and by trust clinical governance and complaints staff, and had no surgery or medical consultant attendance. The minutes of these meetings did not demonstrate there was an understanding of risk that was shared with staff in the directorate. We were not clear how the board

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## Leadership of service

- The new senior management team were working to restore confidence in the leadership of the directorate. The staff we spoke with hoped for stability and a focus on patient care and 'getting the basics right'.
- Some parts of the service, such as the surgical wards and DSU, now had a stable workforce. Main theatres, in contrast, had seen a high turnover of staff and four managers in two years. Medical, surgical and theatre staff reported that it was difficult to introduce improvements without continuity of management. It was hoped that this would change with a new permanent theatre manager, and the recruitment of permanent theatre staff.
- We found examples of local leadership on the wards and in the day surgery unit. Ward managers provided guidance to staff and the matron prominent in her presence and the support she offered. There were regular ward meeting where staff received feedback from incidents and were given the opportunity to suggest new ideas. We spoke with a member of domestic staff, who attended the ward meetings, and said she felt part of the team, and would raise any issue of concern.
- We observed effective communication between members of the team on the day surgery unit, and staff told us teamwork enabled the smooth running of the unit at busy periods. The volunteer who worked on the unit one day a week praised the friendliness of the staff and said he was treated as part of the team. There was effective teamwork in the pre-assessment and admissions area.

## Public and staff engagement

- We were told of local initiatives to improve motivate staff and to put 'listening into action'. One of the wards had a ward newsletter, which discussed learning from incidents and the 'focus for the month' to improve services. It also reported the staff member of the month, who was nominated by patients and staff. A consultant anaesthetist started a safety newsletter that was available on the intranet. The day surgery unit had listened to staff and patients and introduced changes, such as improved information for patients about what they should expect when they came for day surgery. The admissions area had been given funds to improve the seating and other facilities after submitting a proposal to the trust.

## Culture

- Staff commented on the gap between the front line and decision-making that had characterised the way services had operated in the past. Staff in pre-assessment, theatre and the day surgery unit felt they had not been able to contribute to improvements and that when they raised concerns these were not listened to. Three consultancy firms had been paid to look at surgical pathways over the last two years. We were told that some recommendations had been implemented, only to be changed by the subsequent consultancy. They had consulted staff regarding a decision to introduce a 'twilight shift' in theatres but the initial decision resulted in staff leaving and the decision had recently been reversed by senior management. Many members of staff expressed a willingness to respond to overtures by the new leadership to work together to improve services.
- There was low morale among some consultant surgeons and distrust of medical leadership of the trust. We received concerning reports of consultants being blamed when they raised concerns, which had resulted in a culture of fear. However, recent changes in clinical leadership at trust and directorate level were welcomed by the consultants with whom we spoke. At the time of our inspection, it was too soon to gauge how the consultant group would respond to the expectation of greater accountability and standardisation.







## Innovation, improvement and sustainability

- The main focus of the new leadership group for the directorate was to put in place the structure that would enable them to understand the performance of their services and to improve the processes to manage and address risk.
- There were also plans to develop services. Surgery has delivered on financial targets each year and now wanted new investment to develop and increase activity. There were opportunities to bring patients back to the hospital from other hospitals in SW London who had capacity problems. Recent appointments, such as a foot and ankle surgeon and a hand surgeon were expected to bring additional patients. The new directorate leadership were aware of the importance of good data and improved planning and scheduling in order to

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achieve this. It was not possible at the time of our inspection to assess whether these changes would result in sustainable growth and improvements in the clinical governance structures.

# Critical care

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

## Information about the service

Croydon University Hospital has one intensive care unit (ICU) of eight beds and one high dependency unit (HDU) of seven beds. It is part of the South London critical care network, which includes several other NHS trusts across the south of England. The ICU mostly admits emergency patients but as it is a category four district general hospital, has to transfer patients to tertiary centres for specialist needs such as liver transplant or trauma. Otherwise it admits all conditions including respiratory, cardiac, sepsis, and pneumonia. The trust has an outreach service located in the critical care area but governed under a different department. There is also a resuscitation team.

Over the course of two and a half days announced and one evening unannounced, we inspected the critical care unit and spoke with members of the resuscitation and outreach teams. All together, we spoke with 25 members of staff including doctors, nurses, allied health professionals (such as pharmacists and therapists), administrative and ancillary staff, service and divisional leads for the service. We also spoke with five patients, their families and relatives. We checked 10 pieces of equipment and reviewed five patient records. We observed care, and checked trust records such as policies, procedures and audits. We used comments from the listening event where members of the public gave their experiences of the trust, and comments from staff focus groups we conducted.

## Summary of findings

The critical care service required improvement in a number of areas but was moving in a positive direction. There were a few issues, particularly with medicines management, the environment of the unit, staffing skill mix, both nursing and medical, and discharges. Performance monitoring also needed to improve.

However, patient feedback and observations of care were positive. The unit mostly learned from incidents, national guidelines were mostly met, and infection control was improving despite being challenged by the environment. Governance arrangements were clear and the new leadership team were valued and approachable. Appropriate relatives facilities and support for people in vulnerable circumstances were in place. Patient outcomes were mostly around the national average and the outreach team were having a positive impact on these in the rest of the hospital.

# Critical care

## Are critical care services safe?

Requires improvement



Although there were many elements of the critical care unit provided safely, it was not holistic across the whole unit. Concerns regarding medicines had not been followed up until we found them, despite incident reports and audits showing there was a concern. There were an above average amount of infections although these were reducing and were partially due to the environment. The environment did not comply with national standards although this was being managed. Safeguarding training was well below the trust target although staff had an awareness of who to report to. Although nurse staffing levels were appropriate, the use of agency staff at night was too high. Medical staffing skill mix did not fully meet national guidance. Mortality and morbidity meetings were not recorded.

However, incident reporting was well understood and learning was in place. The unit was improving its rate of patients coming to harm. Cleanliness and adherence to infection control procedures was appropriate. Equipment checks were up to date and well supplied. Patient records were complete and up to date. Mandatory training rates were near or above the trust target in most areas. An outreach team was always on site, although they were sometimes stretched. Therapy staffing levels were below establishment but could still meet patients' needs. Business continuity and major incident plans were appropriate.

### Incidents

- The trust reported that there were no never events or serious incidents in the last 18 months in critical care. A never event is a 'a particular type of serious incident that meets all the following criteria - 1. it is wholly preventable where guidance of safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. 2. Has a potential to cause serious patient harm or death. However serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event. 3. There is evidence that the category of the Never Event has occurred in the past for example through reports to the National Reporting and Learning System (NRLS) and a risk of recurrence remains. 4. Occurrence of the Never Event is easily recognisable and clearly defined - this requirement helps minimise disputes around classification and ensures focus on learning and improving patient safety.'
- A report from the critical care service showed there had been three serious incidents since January 2015. Immediate action had been taken including training on sepsis, but the actions focused on the surgery departments input into the patient's care. Two investigations still required finalising, although one was awaiting a coroner's report. Any serious incidents that were investigated were reviewed by a serious incident panel. We requested the root cause analysis reports into these incidents but did not receive them.
- In the last 12 months, the critical care service reported 201 incidents, over a quarter of which were pressure ulcers, mostly grade two which was the second least serious type. There were also 15 regarding health and safety, 13 regarding medicine issues, 11 regarding admissions, discharge, transfer and access matters, and 10 about bed management. There were also 10 involving security, and a number of other areas that had five and under incidents. Similar trends had occurred in the last two reporting months of March and April 2015.
- All the staff we spoke with were aware of how to report an incident and said they had received feedback, both individually and in meetings in critical care. Staff were able to give us a range of examples of learning from incidents that they had implemented such as changes to policies and procedures. However there was an acknowledgement by staff and in the unit meetings that they may not be reporting near misses or delayed discharges enough.
- A monthly report on incidents was produced by the matron, which we were told was reviewed with staff at meetings. None of the meeting minutes we reviewed showed that incidents were discussed. The report gave an overview of what incidents were reported and any immediate actions taken. Actions included reminding staff about procedures, checking of medicine cupboards and reviews of stock levels. However, we found learning from medicine cupboard checks had not been followed through.
- The appropriate staff were trained or in training to investigate incidents and were using approved root cause analysis methods and the NHS England format.

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Any serious incidents were investigated more independently by a lead in A&E or the acute medical unit and there was a representative for Health and Safety to look at any non-medical incidents. However, one person had not had refresher training for root cause analysis for six years.

- In the March 2015 critical care meeting there was discussion regarding evidencing quarterly mortality and morbidity meetings. However, staff told us these were still not being recorded when we inspected, although meetings happened monthly.
- Duty of Candour training was given at induction, in policy form and was recorded as part of the formal electronic reporting system when an incident occurred. Staff were also aware of their responsibilities.

## Safety thermometer

- Safety thermometer results were displayed in the corridor entering the unit and showed there had been a decline in patients coming to harm over the last few months. No patients had come to harm (such as acquired pressure ulcers, urinary tract infections or falls) since February 2015, although two had been admitted with grade two pressure ulcers. We found 100% of patients were assessed for venous thromboembolisms (VTEs). There had been no acquired grade three pressure ulcers in over a year. Any acquired pressure ulcers had a small incident investigation.
- Staff were able to describe the contributory factors to patients acquiring pressure ulcers. In most cases this was linked to the treatment they were on. The unit had brought in new beds that had improved things as there was a falling pressure ulcer rate since they had been introduced as shown by their safety thermometer statistics.
- There was a tissue viability nurse team that staff were positive about, but also reported that the tissue viability team were understaffed, due to covering both the hospital and community services.
- Patients skin was checked frequently by staff and where pressure ulcers were noted staff checked that they had been incident reported, and that the patient had a referral to tissue viability. They also made sure that a pressure mattress was in place and noted what the type and place of the pressure ulcer was. The checks for the last month showed no pressure ulcers had deteriorated and all prevention and mitigation measures were in place.

- Under the safety thermometer reporting, which is done one day a month each month, there had been four pressure ulcers, no falls, and two urinary tract infections (UTIs) in last 12 months, which were spread over the year.
- Audits were undertaken weekly to ensure patients had compression stockings on if they were a VTE risk. The audit showed only five patients had not been given stockings when required since January 2015.

## Cleanliness, infection control and hygiene

- When we checked the critical care unit, we found it was clean. Machines called 'Deprox' were used to de-fumigate the side rooms after each patient stay and the unit used a technique called adenosine triphosphate (ATP) for checking if the environment or equipment was clean. ATP involved swabbing areas and checking how many organisms were present. If the rating was over 100, the surface was deep cleaned. Dusting took place twice a day. Deep cleans were undertaken every time a patient was transferred or discharged. An independent cleaning check was conducted monthly. Cleaning checks were undertaken every few days and since 1 June, these had shown no issues.
- Linen and scrubs were stored on trollies in the corridor. These were found to be neat and tidy.
- Some notices displayed in the corridor were paper and not laminated which meant they could not be cleaned.
- Staff adhered to infection control precautions throughout our inspection, such as cleaning hands when entering and exiting the unit and bed spaces, and wearing personal protective equipment when caring for patients.
- Side rooms had signs displaying that there was a presence of infection and their doors were closed.
- Hand gels were appropriately placed and only one was empty on one day of our inspection. The last hand hygiene audit showed compliance at 100% on 17 June 2015.
- Staff were aware of the protocol in case of a patient being admitted with Ebola, which included ensuring they received a negative pressure side room. We saw that there was a dedicated page to such an event on the intranet, which provided guidance to staff.
- When a bronchoscope was used from theatres, this was decontaminated by theatres before it was used again and a local unit wipe and flush was also conducted.



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However, the notes for the use of the scope were not kept with the patient notes, only in a log book. This meant the use of the scope could not be traced to particular patients.

- There were dedicated infection and prevention control champions for the unit who attended meetings with the infection control team and conducted some of the infection control and cleanliness audits.
- Equipment was visibly clean and had clean stickers to show they had been cleaned within the last 24 hours.
- The critical care unit was just worse than average for acquired Meticillin-resistant Staphylococcus Aureus (MRSA), and there had been no blood related MRSA since 2011. Patients admitted with MRSA was improving and was better than average. The latest report by the intensive care society and research centre (ICNARC) showed Colostrum Difficile (C Diff) on admission was better than average but acquired C Diff was just worse than average. Acquired sepsis was better than average.
- Infection prevention and control training compliance was at 90% for staff on the unit.
- The infection control report for critical care in March 2015 showed ventilation-associated pneumonia (VAP) care bundle audits were at or very near 100% compliance (with a lowest of compliance rate of 95% in last six months). Central Vascular Catheter (CVC) audits were also at or near 100%, which help prevent central line catheter blood stream infections (CRBSiS). Spot checks of these also showed 100% compliance.
- The last CQC report in November 2013 showed and data continued to show that the unit had and continued to have a large amount of patients acquiring glycopeptide resistant enterococci (GRE). Monthly acquiring rates were varying between zero and nine patients, averaging around three although this was a reduction on previous years. Prevention measures had been put in place including trying to isolate colonised and infected patients with GRE. This was difficult due to the lack of availability of side rooms and clinical requirements of the patients on the unit. This matter was therefore on the ICU risk register and mitigating actions were in place. These included barrier nursing with gloves and aprons, enhanced environmental and near patient cleaning, enhanced hand hygiene including audits. There was also restrictions on the use of glycopeptide antibiotics such as Vancomycin and Teicoplanin. Admission and weekly screening for GRE on the unit was

taking place, and there was greater emphasis on informing receiving ward/healthcare settings of all GRE positive patients when transferred. Lastly a focus on environmental cleanliness using ATP monitoring.

- All the waste bins we checked were closed and not overflowing. However, the large sharps bin where the smaller sharps bins were placed once they were full was unlocked and placed behind a curtain in a public space. The lack of a safety cover for the sharps bin was on the risk register and mitigation was in place such as having sharps bins in bed spaces and ensure staff were health and safety vigilant.

## Environment and equipment

- Our last report from November 2013 showed the critical care unit had two side rooms for infectious patients and this had not changed. However, one of these was not a positive or negative pressure room and the other was still being investigated whether it was a negative pressure room as they were unsure if the airflow was contained. Negative and positive air pressure rooms are to either prevent patients from catching an infection when they are immunosuppressed or to stop a patient's own infection from spreading.
- Our last report also stated that the environment was too small and cramped. This had not changed since our last inspection and meant the service was not following intensive care society standards regarding space between beds which should be 2.5 metres wide. Otherwise, other than a slightly broken side rail in a corridor, we found no immediate part of the environment unsafe during our inspection. A recent environmental risk assessment and health and safety audit equally found clutter, space and storage as a problem. The risk register identified the space as a concern and mitigation was in place such as use of the 'portacabin' for storage and managing bed flow.
- All the equipment we checked was within its use by date, including resuscitation trolleys. Portable appliance testing (PATs), fire extinguisher checks and other equipment daily checks and servicing had been carried out. We requested the capital replacement programme for equipment to ensure equipment was replaced at the end of its useable life but we did not receive this.
- Staff told us they had no issues in getting equipment. The unit had two types of ventilator but staff were trained in using both of these. There was only one

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bronchoscope that staff told us needed replacing but they were able to use a spare from theatres if necessary. This issue had been identified by the unit but no plan was yet in place.

- There was no dedicated handyman or housekeeper for the critical care unit. Therefore nurses were completing the daily equipment checks and had to rely on the equipment companies or trust wide staff to service the equipment although nurse leads had been allocated.
- A fire inspection was conducted monthly and the only issue shown were the clutter in the storage room which still existed due to the amount of equipment stored but it was in an orderly manner. A previous fire inspection showed a light had been flickering but this had been repaired.
- Control of substances hazardous to health (COSHH) assessments had been undertaken, but a health and safety audit found staff had not been trained regarding COSHH.
- Emergency tracheostomy equipment was available on the unit.

## Medicines

- Most of the medicines we checked were managed appropriately including their storage and administration. Keys were held with an appropriate member of staff. IV fluids and controlled medicines were stored and documented correctly. Allergies were clearly recorded on patient notes.
- We saw a number of out of date medicines in the units, some over five months out of date including adrenaline. Another medicine had no date. In addition, medicines were stored in the fridge that were recommended to be kept at room temperature. Staff were unable to tell us if being stored at a colder temperature would have an effect on their efficacy. A medicine audit in March 2015 had highlighted medicines not being disposed of. Staff responded immediately to this by reporting these as an incident and creating drug fridge checking forms. We were told the next newsletter would highlight medicines management.
- Those patients that could were able to self-medicate and their medicines were appropriately stored and they were supervised as necessary.
- Drugs charts were complete and checked appropriately.

- Microbiology conducted rounds twice a week on the unit and called the consultant on duty daily to receive an update on patients. Staff commented that they were easy to contact.

## Records

- All the patient records we checked were up to date and complete including drug charts, care plans, observation charts, nursing assessments, fluid balance charts and decisions to admit. Observation chart audits showed 100% compliance since January 2015. Most staff told us they were still getting used to the new Cerner Millennium (electronic) patient records system, as it had only been implemented in critical care in May 2015. They told us it was working well far and they felt eventually, it would improve the efficiency of nurses work as there would be less time completing records. The critical care system was bespoke, which was why it was one of the last units to transition to it. There was also an electronic patient records champion for the unit in case of any problems.
- Staff were still using a system called 'Wardwatcher' to submit ICNARC data from the EPR as it had not been fully ensured that the data would be complete directly from the EPR.. This meant staff were interpreting and cleansing data three times before it reached ICNARC. The last ICNARC report showed a number of areas where data was incomplete.
- The EPR could only be accessed with a staff card and we observed staff not leaving their cards in the computers when they walked away. This meant that records were securely stored and unauthorised access was prevented.
- Information governance training for staff on the unit was at 78% compliance.
- It was raised during a March 2015 critical care meeting that discharge summaries were not detailed enough but we found no issues when we reviewed the records.

## Safeguarding

- Staff were aware of how to report a safeguarding concern and knew who the safeguarding leads were for the unit and for the trust. They were able to provide recent examples of when a safeguarding concern had been raised and showed that appropriate investigations and procedures had been undertaken following these concerns such as when there was disagreement over a patient's resuscitation status.

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- Safeguarding adults training for the unit was 91% for level one, 66% for level two and 26% for level three of those eligible. For safeguarding children compliance was 81% for level one, 77% for level two and 17% for level three of those eligible when the target was 90%. This was despite concerns raised by commissioners that safeguarding training compliance was not at an acceptable level.

## Mandatory training

- Mandatory training rates for critical care staff as of April 2015 were 81% for equality and diversity, 86% for fire safety, 81% for health, safety and welfare, 86% for moving and handling, 79% for conflict resolution, 84% for resuscitation and 96% for intensive life support against a 90% target.
- Staff told us mandatory training was their responsibility and clinical staff were chased to ensure they were up to date as otherwise they would lose their pay increment. Staff reported there was sometimes difficulty getting resuscitation training and it could be difficult logging into the e-learning system. However, administrative staff did not have any financial incentive to complete training, and told us they were not chased, although it was shown in red on their training sheet if they were overdue.

## Assessing and responding to patient risk

- There was a 24 hour, seven days a week nurse led outreach service that responded to deteriorating patients around the hospital.
- Outreach were also responsible for caring for those patients with continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BPAP). They followed up patients within 24 hours after discharge from critical care. They felt these responsibilities with the current staffing levels meant they were overworked at times.
- The outreach service reported no concerns with escalation of patients from the track and trigger/early warning score system, and actually reported that they were over referred to by ward staff. Therefore training was in place for ward staff such as AIMS to empower nurses to manage deteriorating patients better themselves. These courses were run two to three times a month. If there were any concerns with staff delaying in alerting when a patient deteriorated, the outreach

team did on ward training to improve this. However, the critical care unit identified that patients were not being seen by outreach prior to admission although they felt this might be a data quality issue.

- Patient notes we saw showed outreach reviewed a patient very quickly after being alerted. However, outreach said that alerts went through switchboard and patient names were not highlighted; only the ward, so outreach sometimes had to find the patients.
- An audit on the use of and training delivered by the outreach service showed that there had been a reduction in cardiac arrests and critical care admissions in nine out of the past 12 months, when compared to the previous year.
- All the patient notes we reviewed showed patients were admitted within four hours of the decision to admit although we received reports from staff of some patients waiting around two hours in resuscitation.

## Nursing staffing

- The critical care unit was below its whole time equivalent (WTE) by around 15 nursing staff (21%), which were mostly band sixes and this was on the risk register. However, the service was over recruiting band five nurses of at least six months experience to cover the vacancies. This included three new starters the week we inspected so they would be supernumerary for at least four weeks. They were also reviewing the use of physician assistants. Despite this, the service was meeting the intensive care society standards of 1:1 care for level three patients and 1:2 care for level two patients. On the day we inspected, they had 12 nurses for eight patients including the matron and band seven lead nurse. During the day, there was always a band seven shift lead and a band six shift led at night. Staff reported that recruitment was slow but nursing levels had improved.
- There was a high use of agency staff, particularly at night where up to six out of 12 nurses were agency and an overall agency usage rate of 14.7%, which had constantly been over 10% each month. The high amount of agency staff at night is contrary to the intensive care society standards, where only up to 20% of staff should be agency each shift. This had been reported by CQC in our last report and was on the unit's risk register. However, a high number of the agency staff the unit used were regular and there was an appropriate induction for agency staff with a checklist that required

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completing to ensure they were competent before they started working on the unit, which we saw was completed. This included ensuring they were trained with the ventilators, any dialysis on the unit and electronic patient records as well as fire safety, and resuscitation. Intravenous therapy (IV) medicines were not allowed to be given by agency staff, unless the practice development nurse had signed them off for this.

- Handovers took place twice a day. These were conducted both as a team and then nurse to nurse at bed side. They covered both the treatment plan, tests, clinical history, medicines and observations of each patient, but also the social side including next of kin and if they were for resuscitation. A previous quality round had found handovers noisy due to the amount of staff attending them. These were then changed so the whole shift taking over was at the handover whilst each nurse from the previous shift handed their patient to the team individually.
- There was a dedicated SIM and resuscitation team, which included clinical fellows that were 50% clinical and 50% dedicated to SIM or the resuscitation team. They were mobile so would train on the wards as well as in courses.
- There were two nurses on shift each day and one at night for the outreach service, which was sometimes shadowed by medical students. However, some of the staff were unaware what their establishment was and they were due to lose two members of staff in the next few months.

## Medical staffing

- The unit was always staffed with an advanced airway trained consultant during the day, and an on-call consultant at night with a varying amount of junior doctors, from three to seven on shift that were all dedicated solely to the unit. However, there was a lack of continuity as it was not the same consultant on-call from the day shift but each worked in a four or three days in a row rota, as there were two intensivist vacancies. The trust told us critical care used no locums but there were two vacant consultant posts out of seven, so two of the permanent consultants at the trust were covering these posts as locums. There was wide agreement both in the trust and externally that recruitment was difficult. This was on the risk register.

- A team of senior house officers (SHO), clinical fellows and registrars covered the night shift rota but only one of these covered the unit at night. Although an SHO in year two of their training is considered too junior to cover an ITU at night according to the intensive care society standards, they were not left on their own for their first six weeks and had airway management skills. There was also a registrar anaesthetist available to bleep who also covered outreach, resuscitation and theatres. Doctors felt this was a safe arrangement and told us a consultant would arrive within 30 minutes if they were called in out of hours. In addition, junior doctors were on the unit for 12 months rather than six, which helped with continuity. The lack of experienced junior doctors was on the risk register.
- The patients named clinician was the critical care consultant rather than their medical or surgical doctor. A medical physician was on duty once a week to review complex patients. Doctors felt there was a good working relationship between critical care doctors and both surgeons and medical doctors.
- Although therapy staffing was below establishment, there was an appropriate amount of therapy staff for the unit. Two physiotherapists attended the unit daily and were able to provide the appropriate amount of rehabilitation, despite not being purely dedicated to the unit. There was a physiotherapist on-call at night. A pharmacist was dedicated to the unit. There was also input by occupational therapists, speech and language therapists and dietitian's either on referral or via an informal request.
- Handovers took place twice a day, with the handover at night between consultants conducted on the phone
- Sickness rates for the unit were 0% for clinical staff, 0% for administrative staff and 6.1% for nurses. We received some concerns that staff were required to make up their sick leave and had to use annual leave for training but found no other evidence that this was the case.
- Staff turnover on the unit was 0% for clinical staff, 0% for administrative staff and 5.5% for nursing staff.

## Major incident awareness and training

- There was an up to date emergency preparedness and business continuity policy for the trust with specific critical care plans. This included the responsibilities for critical care staff in different major incidents. Local major incident action cards were in place and fire

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evacuation drills had been undertaken and learned from. Dedicated leads were in place in case of an evacuation with a detailed evacuation plan with action cards and flow charts.

- If the EPR went down, there was a separately networked computer where patient notes were available in read only format and could be printed out for completion.

## Are critical care services effective?

Good



The critical care unit was working effectively in most areas. National guidance was mostly followed and kept up to date. Pain relief was well managed, although not always scored by an adequate method. Nutrition and hydration was well managed. There was effective use of new equipment to improve patient outcomes. Patient outcomes were around the average in most areas. Most staff had their competence assured. There was effective multidisciplinary working across the different specialities. Information was shared, accessible and appropriately recorded and transferred. There was appropriate understanding and use of the Mental Capacity Act 2005 and deprivation of liberty safeguards.

However, not enough nursing staff were appropriately critical care trained, some audits had below average scores and there were not always actions to improve although a number of audits had only recently been completed or published.

### Evidence-based care and treatment

- All patients received daily physiotherapy as required by the National Institute for Health and Care Excellence (NICE) guidance and intensive care society standards. Patients were screened within 24 hours of admission by a physiotherapist to identify their rehabilitation needs.
- Patients with tracheostomies had no sign above their bed stating what size and type of tubing they had, which had been recommended by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and staff were unaware of this guidance.
- The critical care unit had a dedicated intranet page with up to date policies and procedures, such as; surviving sepsis, fluid intake, citrate dialysis, post cardiac arrest care and ALung. The electronic patient records system also alerted staff if new guidance had been

published. There were links on both the intranet and the electronic patient records system to the national guidance each policy referred to. Staff told us any updates on national guidance were given by consultants to junior staff as part of teaching sessions every two weeks.

- Some paper policies at the nurses' station were out of date such as the organ donation policy, which was due for review in March 2014. However staff were aware that these needed to be updated and the updates needed were not fundamental.
- We requested audits on how the unit was meeting national guidance but did not receive these.

### Pain relief

- A hospital based acute pain service was available on referral and staff told us they were very responsive although they were not needed often.
- There was no use of a tool to ascertain if patients were in pain while they were sedated although pain scores were recorded.
- All the patients we spoke with told us their pain was well managed.

### Equipment

- We found the new beds that had been brought in in early 2015 had a positive impact on patients' care. Patients told us they were more comfortable. Nurses told us this had helped reduce pressure ulcers. Physiotherapists told us although the beds were not as low as they would like, the reclining element of them meant they could do some of the chest therapy in the bed rather than requiring the patient to move into a chair.

### Nutrition and hydration

- A dietitian was available via referral for the service and all the nutrition assessments and fluid balance charts we viewed were complete and up to date with documented dietitian reviews. Nutrition and fluid plans were followed with fluid balances totalled and acted upon appropriately.
- All the nasogastric feeds we checked were in date.
- Volunteers were available and supported patients to eat.

### Patient outcomes

- The ICNARC indicators for the unit were mostly around the national average but were only available for October to December 2014 as they had only joined ICNARC in



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summer 2014. Action plans had yet to be developed.

Most ICNARC indicators are shown as above or below average as individual figures are not always published in their reports.

- Cardiopulmonary resuscitation rates were worse than the national average but had been improving in nine of the last 12 months according to recent audits.
- Ventilated admissions had a worse than the national average mortality and length of stay but better than the national average sepsis. Severe sepsis admissions had a better than national average mortality, and around average length of stay.
- Pneumonia admissions had around the national average mortality but better than the national average length of stay.
- Elective surgical admissions had around the national average mortality but better than the national average length of stay and around the national average sepsis.
- Emergency surgical admissions had a better than national average mortality, worse than the national average length of stay and slightly better than the national average sepsis.
- Trauma admissions had a better than the national average mortality, but slightly worse than the national average length of stay.
- The unit was slightly worse than the national average for early deaths and slightly better than national average for late deaths.
- Early and late readmissions were around the national average and these rates had improved.
- Post unit deaths were better than the national average and had improved. Over 50% of patients had a decrease in their independence. None of the staff we spoke with were able to answer why there was such a decrease in independence compared to similar units.
- Mortality was 1.01 according to ICNARC and 1.10 according to Acute Physiology and Chronic Health Evaluation (APACHE II), which are around the national average (20th of 32 similar units on ICNARC, 25th of 29 on APACHE II).
- Overall length of stay was above the national average at 16.18 bed days but we were told this was due to three patients who were particularly long stayers.
- Prior to submitting to ICNARC, the service was analysing bed occupancy, length of stay, and admissions. These showed bed occupancy had gone up, length of stay had broadly stayed the same and respiratory admissions were increasing.
- The trust reviewed its in-hospital cardiac arrests for April 2014 to March 2015 for outside of the emergency department and intensive care. These showed a large reduction in nine months out of 12 compared to 2013/14. Trends were found linking harm events such as raised troponin and creatinine and signs of acute kidney injury with cardiac arrests. An action was put in place to review when to contact the outreach team as most cardiac arrests were occurring below the escalation score threshold for contacting them, although almost half had a slight increase in score. There was also an action to add a cardiac arrest scoring system to review the track and trigger score with troponin rises, acute kidney injury and other possible signs of imminent cardiac arrest. These actions were due to be implemented in 2015/16.
- Audits showed 12 patients had not had their visual phlebitis score documented in the last five months. However, between 11 and 17 June, all had been checked.
- The organ donation audit showed the unit was better than the national average for all the indicators such as referrals, consent and approach when death was by brain stem but worse than the national average when death was circulatory. We were told this was due to two missed opportunities so actions had been put in place on the electronic patient records system to flag potential donors.
- The physiotherapy department were using the Chelsea critical care assessment tool (Cpax) to assess their outcomes from rehabilitation but we were not sent their results.
- Quality rounds were conducted twice monthly although the executive expected them to be done weekly. We found some of the issues highlighted had been actioned such as quality of handovers and patient record completion.
- Central venous catheter (CVC) audits were conducted but showed that the observer, assistant or operator were not always recorded.



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## Competent staff

- In April 2015, the trust sent us data that showed that appraisals for staff in critical care were at 100% for clinical (non nursing) staff, there was no data for administrative staff, and 56% for nurses. However, all the other data we reviewed such as the local training matrixes suggested it was at 90% for nurses that had been at the trust over 12 months and staff we spoke with told us they had appraisals and one to one meetings with their line management and discussion included their professional development. Some staff had masters degrees approved and national vocational qualifications (NVQs) approved and supported by the trust. Others had requested specific courses such as ICNARC, which were being looked at.
- Senior staff estimated between 60 and 65% of nurses were critical care trained. However data we were shown from the trust recorded 22 out of 59 were recorded as trained, which is below the national guideline of 50% and rotas were not formally arranged to ensure a certain percentage of staff on shift were trained. Staff told us there were never any issues in getting band five nurses onto the critical care training course.
- The outreach team worked bank critical care shifts to ensure they stayed competent. Nurses were also assessed for their competency in treatment lines, documentation, ventilators, monitors, filters, dopplers, tracheostomies, blood transfusions, and intravenous medicines.
- Some of the band six and seven nurses had developed from band five at the trust. They were also mentors and these mentors were given four to six weeks supernumerary to perform this role.
- There were a number of simulation courses including paediatric retrieval, dealing with obstetric emergencies and junior doctor training for dealing with acute emergencies. All the feedback compiled on these courses were positive.
- All critical care consultants were advanced life support trained.
- New starters told us they felt well supported by seniors including the educational input they required.
- Therapists had yearly training to update their skills which included rehabilitation of the critically ill.

- We were unable to speak to the practice development nurse but there was one permanently dedicated to the unit who was supernumerary. However, there were no clinical educators. The band seven shift leading nurse was not always supernumerary.

## Multidisciplinary working

- There was evidence of internal and external multidisciplinary working across the critical care unit. Consultant ward rounds were always joined by junior doctors, a physiotherapist, pharmacist and nurses. Staff commented that there was genuine cross staff group working. Occupational and physiotherapists said they were screened each other's patients so there was no double working.
- Although the critical care consultant was the named clinician for patients in the unit, there was still input from surgical and medical doctors although this was sometimes variable.
- The critical care network the service was part of had recently reformed and was starting to undertake external partnership working. In addition, staff were encouraged to attend the London critical care conference and had been involved in presenting items at conferences previously.
- There was a positive working relationship with the specialist nurses for organ donation with an improved referral rate and awareness by staff of organ donation.

## Seven-day services

- The unit was 85% compliant with seven day services, against the London Quality Standards such as intensivist on site presence, review of patients within 12 hours of admission and use of early warning scores for eight hours prior to discharge.
- X-rays were able to be conducted on the ward and access to other scans were available but the procedure for doing so was not clear.
- An outreach nurse was available out of hours and mostly covered the acute medical unit (AMU) and A&E due to the higher likelihood that patients would deteriorate there.
- There was no change to the shift patterns of physiotherapists or consultants at weekends with a dedicated consultant and two physiotherapists during the day with one of each on-call at night.

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## Access to information

- When patients were transferred between wards and the critical care unit, this was clearly documented and structured with a summary of their critical care stay, plan for on-going treatment and an assessment of their on-going needs.
- There was no written discharge summary by physiotherapists but their input was documented on the electronic patient records system including their rehabilitation and weaning plans and they often followed the patient to the ward.

## Consent and Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed and checked patients that had their liberty deprived through use of mittens or other physical restraints. All these patients had an application for a deprivation of liberty safeguards (DoLS) completed and approved as well as a mental capacity assessment.
- If consent was required, such as undertaking a dietary assessment, this was appropriately obtained and recorded.
- Mental Capacity Act 2005 training had only become mandatory within the last few months but all staff on the unit had attended a study day on the topic.
- In March 2015, the critical care meeting discussed how to implement DoLS as there was currently variety across the critical care network as to whether those patients under medicine sedation should be applied for. They were due to meet with the local clinical commissioning group (CCG) to get guidance and paperwork on this. This view was confirmed by staff and the safeguarding lead had approved the current procedure of not declaring those under medicine sedation, as otherwise most patients in ITU would require a DoLS application. This is current agreed practice in most critical care units.

## Are critical care services caring?

Good



The critical care unit provided a caring, kind and compassionate service, which involved patients and their relatives in their care. All the feedback from patients and their relatives was positive. Feedback forms were also positive about the care provided although this was on a low response rate. Observations of care showed patients'

privacy and dignity was maintained and patients and their families were involved in their care. Conversations involving difficult and emotional decisions were appropriately conducted.

## Compassionate care

- All the observations of care we saw were kind and compassionate with appropriate calming and attentive communication. Staff maintained patients' privacy and dignity by fully closing curtains around them. Staff introduced themselves to patients before conducting any care.
- All the patients, families and friends we spoke with were happy with the care and treatment they were provided on the unit. Some patients called the staff "fab" and "fantastic" and that care had greatly improved in recent years, exceeding their expectations. Another family said they "could not have wished for anything better."
- The latest Friend and Family test scores were 100% in May 2015 and 85.7% in April 2015 of patients who said they would recommend being treated at the unit. However, this was based on eight patients in May and seven in April. Similar results and numbers responding were in the six months before this. A quality round found staff were finding it difficult to approach relatives regarding the survey.

## Understanding and involvement of patients and those close to them

- All the patients, families and friends we spoke with told us they were involved in their care. They said staff explained their treatment in a way they could understand. Some patients specifically commented that they felt listened to more than in years previously and staff ensured families were kept informed regularly. Staff also respected patients understanding if they knew more medical terminology. One patient told us a therapist had got them out of bed for therapy but it was done at their own pace.
- We observed staff involving patients, families and friends in their care. Patient diaries were in place for all long term patients.
- Named nurses and consultant information was above each patient's bed.
- The last organ donation audit showed in most cases, that staff approached relatives regarding organ donation appropriately.

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## Emotional support

- Part of staff discussions at handovers were the social circumstances of a patient, including their next of kin, and this included a discussion if a patient had a poor prognosis and ensuring the family were informed delicately in the relatives room.
- Chaplaincy details were advertised in the relatives' booklet and patients had the option of attending follow up clinics after their stay in hospital.

## Are critical care services responsive?

Requires improvement



The critical care unit was not always responsive to patients' needs, although this was partly due to factors outside of its control. The unit had a high amount of delayed and out of hours discharges, although this was due to capacity and demand on the medical wards and flow was being managed as best as possible. Unplanned readmissions were high. Bed occupancy was high although there were both short and long term plans to address this and elective surgery was relatively unaffected. The environment did not meet patients' needs although this was also due to be addressed in the long term.

Patients were reviewed by a doctor when required. Facilities for relatives were appropriate. Patients in vulnerable circumstances had appropriate support and plans. There was an awareness of the complaints process, although we received relatively little information to ensure this process was followed through correctly.

## Service planning and delivery to meet the needs of local people

- The latest ICNARC showed most patient admissions were unplanned (emergency), though there were a small amount of planned (elective) admissions. Staff estimated around 98% of admissions were emergencies with one elective a week. Most admissions came via patients attending the A&E, or after care in theatres or on a ward. Most patients required level two care (Patients requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care) but nearly 50% required level three care (Patients requiring advanced respiratory support alone or basic respiratory support

together with support of at least two organ systems. This level includes all complex patients requiring support for multi-organ failure). Patients organ support requirements were mostly advanced respiratory, cardiac, renal and gastric with small amount of neurological and a high amount of basic cardiac and respiratory support. Most patients only required one organ supported but some patients required up to five organs supported. These confirmed the unit had a large mix of patient conditions and were not able to fully plan in advance as emergency admissions could be sporadic day to day. On one day of the inspection they had no admissions, while on another they had five.

- A number of posters and leaflets were displayed in both the relatives room and the corridor, which gave patients information on the unit such as visiting times, performance (also known as 'Know how we are doing'), and how the unit worked. We were told there had been photos of staff members displayed but these had been taken down due to some issues that had arisen with some visitors where staff had been approached outside of the hospital.
- There was a well facilitated relatives' room. It included two separate areas so relatives could be told news without affecting other visitors. It also had tea and coffee facilities, a shower and pull out beds for people to stay. Staff reported they had never needed additional beds for relatives but there were some available in paediatrics if it ever became necessary.
- There was only one set of toilets on the unit for staff which were mixed sex and only three computers were available in the administration office when four or more staff could be stationed there at a time. Otherwise, staff were happy with the facilities they had including a shower, lockers, staff room and changing room, although we observed that the staff room was not always large enough to fit everyone who was on a break.
- Although the ward was mostly safe, it was not responsive to the needs of patients. Because the beds were too close together, it was particularly difficult to arrange all the equipment around them so that it did not get in the way of staff treating patients, especially if they were on dialysis. This made rehabilitation particularly difficult at times if it needed to be done out of the bed.
- There was an overall lack of storage space which meant some equipment was being kept in an old bed space. The main storage area was a portacabin. Although this

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was tidy and ordered, it was very full and meant stepping over items to get to the back of the space. A plan had been developed to arrange a new portacabin to increase the amount of storage space.

- Visiting hours were displayed as 1.00pm to 8.00pm. However patients told us the units were flexible if they visitors needed to come earlier. We also saw families in the unit later than 8.00pm.
- The critical care unit conducted follow up clinics which were run by a doctor and physiotherapist, of which 40 patients had attended last year.
- Patients told us the food and drink had improved and there was always water available within reach but their quality was still variable. However, there was no patient fridge if they wanted to bring in their own food and drink.

## Meeting people's individual needs

- The trust serviced a population where over 100 languages were spoken locally due to the locality of the Border Agencies offices in Croydon town centre. Translators were available on referral via the site practitioner both in person and on the telephone.
- A learning disability nurse was available on referral. Ppatients that had learning disabilities had the appropriate care and plans in place such as hospital passports as well as a review by the learning disability nurse, and a star next to their bed to flag their additional needs. However, staff told us patients with learning disabilities were not always flagged on the electronic patient records system before they were admitted which meant staff were not always immediately aware of the support needs of a patient.
- Patients who lived with dementia had a separate care plan including 'This is me' and had a delirium screening. Lights were dimmed at night to aid patients to sleep and particularly those that were delirious.
- There was a homeless health team and we saw an example of where they had reviewed a patient who would require support once they were discharged.

## Access and flow

- The bed occupancy in level three beds were between 97% and 153%. The level two beds occupancy was between 92% and 122% from September 2014 and February 2015 which was worse than the national average. Executives told us they had 10 patients a day requiring HDU beds in December 2014, which was the highest overall acuity of patients they ever had. Beds

occupied had mostly been between seven and 14 according to ICNARC. During our visit, only eight beds were occupied on two days, and 10 on another day. We were told patients were sometimes cared for in the recovery area in operating or the resuscitation area in A&E when there were no ITU or HDU beds but one was normally made available within four hours. In light of this and the issues with the space, there were plans to add an additional bay from a neighbouring ward to increase capacity in the short term and add additional beds in the long term as part of a renovation and extension plan.

- There were appropriate bed meetings three times a day, at 10.30am, 2.30 and 4.30pm. Patients were admitted within four hours of the decision to admit on all the records we viewed.
- Non clinical transfers out were much worse than the national average but staff felt this had improved. Clinical transfers out were high due to some patients requiring tertiary services such as extracorporeal membrane oxygenation (ECMO) for liver conditions or brain injuries. If a patient had to be transferred, they were normally accompanied by a member of the outreach team. According to the latest ICNARC report, transfers in were better than the national average. Non clinical transfers in were better than the national average but had been worse than average.
- Unplanned readmissions within 48 hours were worse than the national average but there were no exact figures for this.
- The unit was slightly worse than average for early discharges and out of hours (OOH) discharges with 26 patients discharged after 10pm in 2014/15. The service was around the national average for delayed discharges but just worse than average for four hour delayed discharges. Most delays were less than a day but affected nearly 40% of the unit's survivors. 109 patients were delayed more than a day in 2014/15 and a total of discharges were delayed a total 239 bed days. The percentage of patients delayed by one to two days was 15%. Staff told us it was often difficult to transfer a patient down to a medical ward, particularly for tracheostomy patients, respiratory, neurology or stroke. This was because of limited capacity on medical wards and the wards that took tracheostomy patients had a high recent turnover of staff. This meant staff that had been trained to care for those patients were not as available as they had been. We observed two patients

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who were due for step down to a medical ward but there were no beds to do so with one waiting five days at the time of our inspection. A Commissioning for Quality and Innovation (CQUINN) target for 2015/16 was in place to reduce the amount of delayed discharges. Most discharges were delayed and nearly 50% of patients were fully ready to be discharged of those delayed.

- Almost all patients were recorded as being discharged at level two. Staff told us actually a high number of level one patients were discharged but they may have been recorded as level two as that would have been their status at the start of the day counted but have improved to level one by the time they were discharged. The unit did not tell us about any measures they took to prevent mixed sex breaches when a patient became level one.
- There had been four cancelled elective surgeries due to a lack of critical care beds in November and December 2014.
- Patients told us and records showed that patients were seen at least twice a day by a doctor and a ward round by the consultant was conducted daily. Electronic patient records showed patients were seen every 12 hours although it records when the note has been recorded, and not when the patient was seen.

## Learning from complaints and concerns

- There had been one complaint received about the unit since October 2014 but it had not yet replied to. The complaint was regarding level of care, timeliness of intervention and lack of compassion. There had been a recent complaint in May 2015 but this related to care from two years ago and was not due for response at the time of our inspection. There had been 11 complaints in the last 12 months, although some of these were complaints that were reopened. Complaints were mainly regarding attitude of staff, inappropriate treatment, lack of communication and low staffing levels. However, we did not see the responses to these complaints or a record of any actions taken despite requesting this.
- The service received very few complaints but staff were aware of the complaints process and received learning from complaints when needed. Patient and Liaison Service (PALS) leaflets were available in the relatives' room.

- There was a clear complaints investigation process, with the assistant director of nursing receiving and compiling complaints responses.

## Are critical care services well-led?

Requires improvement



Although there are elements of critical care that were not well-led, with a mostly new leadership team, areas of risk and improvement had been identified and workstreams were in place to make the necessary changes in the short and long term. There was a clear vision and strategy for the service, which staff had been involved in. The service had identified its major risks and other risks had been discussed and actioned in various forums although these were not always up to date. Performance was monitored though it was piecemeal and required further development. There was clear governance arrangements with identified leads and the leadership team were visible and approachable. The culture of the service was mostly positive. Staff and the public were engaged in the running and future of the service. Some innovative improvements were being reviewed or considered.

## Vision and strategy for this service

- There was a clear vision and strategy for the service, which most staff were aware of. This included rebuilding the unit after the new emergency department was completed and was at outline business case stage with an expected completion time in around two years. However, this had only recently been restarted due to leadership changes including, a new clinical director in the last few weeks and new assistant director of operations in the last few months. An initial feasibility options study had been undertaken in November 2013 with costs assessed but we did not receive any information with regard to additional work that had happened beyond this.
- There was a workforce strategy to improve staffing levels, which included over recruitment and up skilling of band five nurses to cover band six vacancies.
- One plan was to review how to care for deteriorating patients, including the remit of the outreach team. However, this review was in its early stages.
- Staff told us they felt involved in the trust wide vision.



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## Governance, risk management and quality measurement

- The leadership was aware of the risk of over recruiting band five nurses could lead to a dilution of skill mix, which would make them non-compliant with intensive care society standards.
- The governance arrangement had recently changed so the directorate critical care was under was larger, and included surgery and cancer services.
- Performance dashboards were in place. However, there were currently no specific action plans from the ICNARC results due to the recent time of joining. They had identified their trends from the performance statistics prior to joining ICNARC but these only reviewed length of stay and admission trends, not patient outcomes. There was a performance dashboard that reviewed safety statistics such as pressure ulcers, staffing, and patient feedback.
- Team meetings occurred monthly and discussed governance issues including delayed discharges, impact of the new emergency department build, porters, performance monitoring, and recruitment. Sisters meetings also took place which discussed similar issues plus organ donation, quality rounds, hand hygiene, training, electronic patient records, nursing objectives, and relative engagement. However, none of these meetings had a record of actions being followed up and the agenda was ad-hoc.
- Outreach were not governed under critical care but the 24/7 team, which the outreach staff felt was inappropriate as the skills between the teams were different. However the links with critical care remained including attendance at critical care meetings. Outreach staff told us they felt more supported by critical care than their directorate management. There was some discussion in critical care meetings about outreach coming under critical care but there was no record of a final decision on this.
- There was a 2015/16 critical care action plan for quality experience safety programme (QESP), which focuses on meeting the five key questions for CQC. Workstreams included relative information, how are we doing, staff communication, delayed discharges, electronic patient records, staff training, and ward environment. Each workstream had particular focuses and actions to improve each area. All had a responsible doctor and nurse under each workstream and these were reviewed at each sisters meeting.
- Critical care management meetings occurred monthly although not in January 2015, which included the lead consultants, lead nurses, lead physio (although they rarely attended and had recently gone on paternity leave), outreach nurse, audit staff and the practice development nurse. There was due to be an organ donation discussion as part of meeting but the specialist nurse for organ donation rarely attended. They recently discussed their ICNARC report, from which they recognised they were not an outlier and had good C Diff rate, and were aware there were issues with discharge, although this was competing against the trust plan to improve with four hour wait in A&E target. The meeting reviewed actions from previous meetings but didn't sign them off. For example, in November 2014, storage of citrate fluids was discussed as a problem but it was not mentioned in later minutes. The agenda also fluctuated with some discussions on incidents, complaints, and friends and family test but not every month.
- The unit was involved in south west London critical care network.
- Most of the areas we identified as risks were on the risk register such and appropriate mitigations were in place considering some of the restrictions they had such as recruitment and the environment. This risks included the environment itself and the need for additional beds. However, some of these risks had been on the risk register over two years and some had not been updated in a year. In addition, out of hours and delayed discharged, the lack of recorded mortality and morbidity meetings, safeguarding training, medicines management, and unplanned readmissions were not on the register although most of these had been discussed in other meetings.

## Leadership of service

- Most of the leadership were new in post due to a recent change in directorate structure. The clinical director had been in post four weeks, the assistant director of nursing for 18 months and the assistant director of operations for two months. The unit had a long standing matron leading the unit and each shift had identified band seven or band six shift leads although they were not always supernumerary.
- Staff across the specialities for the unit felt their leadership was visible and supportive. The executive team did a 'Walk Round Wednesday' each week, which



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most staff said they were aware of and had seen an executive team member. Staff knew and saw their divisional leads and felt they were approachable. However, administrative staff felt senior leads were less visible than nurses and clinicians.

## Culture within the service

- Most staff commented there was a positive culture in critical care, including a team working ethic. A social gathering took place yearly. However, others felt the service was still considered less important than others at the trust, which impacted on them when trying to get new equipment as they had requested equipment previously but were told other department requests were more urgent.
- Staff spoke about trust wide rewards being in place for units such as 'STARS'.

## Public and staff engagement







- A newsletter had started to be produced in the last two months, which relatives had been involved in and were circulated to staff and on noticeboards. These discussed friends and family test results, safeguarding, IT, performance, staff stories and any trust information. The newsletter was presented in an explaining and informative format rather than monitoring or dashboards so both staff and visitors were aware of what was happening on the unit.

- Staff were complimentary about Listening in Action (LiA) and told us they had been able to get projects, new ways of working or new equipment approved via raising them in this forum. Examples given were new signage and changes to the layout.
- Staff had been involved in the discussions and planning of the new critical care unit.
- The matron had regular meetings with the nursing staff on the unit and daily shift briefings, which included a discussion on any patient and family feedback as well as any specific notices such as how to complete the electronic patient record and ensuring patients were hydrated during high temperatures.

## Innovation, improvement and sustainability

- The service was currently using citrate dialysis and was continually being reviewed to see if it had a positive outcome for patients using filter line audits to ascertain if there were complications. The cost of this service was low compared to similar units so the unit were also reviewing to ensure they were being correctly paid.
- Although the unit had to make savings, the leadership was confident it would not impact on patient care and efficiencies could be made without reducing staff numbers.
- The unit were due to review investing in ALungs as a cost effective way to not ventilate for chronic obstructive pulmonary disease (COPD) patients.

# Maternity and gynaecology

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

## Information about the service

Croydon Health Services NHS Trust provides an integrated maternity service, out-patient and in-patient gynaecological care. Women can access maternity services via their General Practitioner or self-refer using a form available on the trust website. The service is in one of three directorates within the trust and forms part of the Integrated Women's, Children's and Sexual Health Directorate.

The maternity pathway is provided from a hospital antenatal clinic, Early Pregnancy Unit, Day Assessment Unit, antenatal inpatient ward (Hope), and Triage facility. There is a Delivery Suite with eleven labour rooms and two obstetric operating theatres, a birth centre, postnatal ward (Mary) and a community midwifery service.

Women have a choice of place of birth at home, birth centre or the delivery suite. There are five community midwifery teams, including a specialist midwife working with migrants and refugees. The latter are based at the Homeless Health Team at the Rainbow Health Centre. The majority of antenatal care for women without complications takes place in the community and is provided by midwives and general practitioners in conjunction with hospital based facilities. Postnatal care is provided by community midwives in women's homes and children's centres.

The number of birth during 2014/2015 was 3,833.

The gynaecology out-patient department based at the hospital is combined with the antenatal clinic and there are two wards where gynaecological care is provided. The

Gynaecology in-patient facilities are managed by the Integrated Surgery, Cancer and Clinical Support Directorate. Queens 1 Ward, where women with early pregnancy related conditions such as hyperemesis and miscarriage are cared for, also provides care for orthopaedic patients. Purley 3 ward is a combined breast/ Gynae/general surgical ward where elective surgery gynaecological patients are cared for, including Gynae-oncology. Elective surgery patients are admitted to the admissions area prior to surgery; transfer to the operating theatre and from there to Purley 3 ward. There are gynaecological surgical lists five days a week. Surgical gynaecological procedures are also carried out in the Day Surgery facility.

Gynaecology clinics are held every day in the combined antenatal/gynaecology clinic and there are also some clinics held at Purley Hospital. Clinics include fertility, uro-gynaecology, rapid access,(urgent cancer referrals) and an Intermediate Gynaecology Service (GP referrals). The woman's unit includes the Early Pregnancy (EPU) and Gynaecological Assessment units (GAU). Gynaecological procedures were conducted on a daily basis such as colposcopy and hysteroscopy by medical staff and nurses. Ultrasound facilities are incorporated into the antenatal/ gynaecological clinics and the EPU and GAU. These were provided by ultra-sonographers and those medical/ nursing/midwifery staff who had been trained to scan.

# Maternity and gynaecology

## Summary of findings

We found that many aspects of maternity and gynaecology services at Croydon Health Services NHS trust maternity services were provided to a good standard. There had been continued and sustained improvements to maternity services. Women who had previously given birth at the hospital commented positively on the improvements to maternity service and told us staff were caring, responsive and knowledgeable.

We found an integrated clinical governance system was in use and action was taken when non-compliance with standards was identified. The risk register was active and regularly updated and plans for mitigation put in place pending action to eliminate the risk. Some risks took a lengthy period of time for final resolution. Information about performance and risk was communicated through the governance arrangements to the Trust Board.

There were robust arrangements in place for recording adverse events and near misses, and investigating and learning from these. There was an expectation of openness and honesty. When outcomes were worse than expected, staff met women, and their families when appropriate, to provide a full explanation.

Areas that required further improvement including staff attendance at mandatory training, auditing of documentation related to termination of pregnancies.

Agreed staffing levels were appropriate to meet current demand. However, improvements were needed in the use of the maternity services escalation policy at busy times. New staff were well supported, and there was a comprehensive training programme, with opportunities for development. The directorate had identified that appraisal rates for midwifery staff were low and action had been taken to improve this. Staff we spoke reported there was effective communication in maternity and gynaecology services.

There was easy access to services for women and there were individualised care plans developed for each woman depending on her needs.

There was adherence to good practice guidelines and outcomes for women met expectations.

# Maternity and gynaecology

## Are maternity and gynaecology services safe?

Requires improvement



Safety in maternity and gynaecology services requires improvement. There was a backlog of maintenance for lighting equipment in the obstetric theatres. Problems with some of the lighting had been identified in 2011 and recorded on the risk register but action for final resolution of this had been lengthy.

There had been no audit undertaken of compliance of the HSA1 paperwork for termination of pregnancy, which is required by the Department of Health. Not all women received a risk assessment for venous thromboembolism (VTE) and 20-25% of women had not received the full range of antenatal screening for infectious diseases and other conditions.

Safety related training had not been completed to the required targets, despite being mandatory for staff.

Staff were reporting and receiving feedback on incidents and were compliant with infection prevention and control procedures. The service had good systems for protecting women and children.

The number of midwives had increased and consultant presence on the delivery suite at 98 hours per week, was in line with Royal College of Obstetricians and Gynaecologists recommendations.

### Incidents

- Both maternity and gynaecological services promoted the reporting and learning from incidents. All staff that we interviewed had a clear understanding of the reporting system and their responsibility for report incidents.
- There were 24 serious incidents requiring investigation reported in maternity services, of which 15 were unexpected admission to the Neonatal Intensive Care Unit (NICU) and three were intrauterine deaths. Serious incidents were reviewed weekly to decide about the type of investigation to initiate.
- We saw investigations of serious incidents, such as unplanned admission to NICU. A multi-disciplinary team contributed to the investigation, including a consultant obstetrician and neonatologist when appropriate. There

was a focus on the chronology of events, but clinical care and other factors that affected the outcome were identified, including in one case the level of demand on the labour ward. Actions included supervisors meeting with the clinicians involved in the incident and recommendations for changes to policies. Investigation findings were presented at the obstetric clinical governance meeting.

- When there were poor outcomes for mother or baby, senior staff and supervisors of midwives (SOMs) met women, and their families when appropriate, to provide an explanation and answer questions. These meetings often took place at the woman's home. A SOMs also offered a debrief to midwives involved in an incident soon after the event.
- Actions identified in investigations were recorded on the maternity serious incident action log, and monitored at the monthly maternity risk management meeting. A report on progress with actions was presented at the monthly Maternity Quality Board.

### Cleanliness, infection control and hygiene

- All areas we visited were visibly clean. There was sanitising gel at the entrances to the wards and departments and staff actively encouraged its use. We observed staff regularly washing their hands and using hand gel between women and babies care. The bare below the elbow policy was adhered to, and there was access to personal protective equipment such as gloves and aprons.
- We looked at the birthing pools on delivery suite and the birth centre and found them to be well maintained. Staff we spoke with knew the pool cleaning and evacuation procedures.
- On both maternity and gynaecology areas we saw that cleaned equipment was labelled with tags to indicate that it had been cleaned.
- Feedback from people using the services indicated they were satisfied with the cleanliness of the wards, bathrooms and toilet facilities. Comments made included "the cleaners are always cleaning and the staff wash their hands between patients."
- We were informed that maternity postnatal readmissions, which appeared on the maternity dashboard, had been audited and the readmissions were postnatal women, the majority of whom had undergone caesarean section and were readmitted with a wound infection and were women with raised BMI all

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of whom had delivered at Croydon Healthcare. However staff informed us that the readmission of women was not always of those women who had delivered at Croydon Healthcare but those who had delivered in neighbouring maternity units and lived locally.

- Infection control training was a mandatory subject and we found in information provided to us that 70% of relevant staff had completed the required training update, against a target of 90%.

## Environment and equipment

- The processes of checking equipment and stock were robust. The resuscitaire in each delivery room displayed information about when the machine was last checked and what action if any had been taken.
- There were Cardiotocograph (CTG) machines to allow for electronic monitoring of the fetal heart during pregnancy and labour available throughout the service.
- Daily checks of adult resuscitation equipment in each clinical area were undertaken and recorded. The drawers containing drugs were kept locked to avoid inappropriate access.
- The gynaecology and antenatal clinics within the hospital setting were accessed via the same entrance. The reception area was shared between gynaecology at one end of the reception desk and antenatal at the other. There were segmented waiting areas for clinics and though this was not ideal, the staff ensured that women were kept separated as far as practicable.
- Women attending for review by consultant medical staff where fetal abnormality had been detected were asked to report to the clinic. Midwifery staff were informed of the woman's name and 'hovered' in reception to ensure that they were fast tracked through the clinic into a consulting room.
- There was a backlog of maintenance of the two obstetric theatres and the theatres required refurbishment and rewiring. In obstetric theatre 1 one of the lighting panels and lights required attention. This had been identified on the risk register since 2011, but main overhead surgeons light had failed on two occasions during the first six months of 2015. There were mobile temporary theatre lights in both obstetric theatres to mitigate the impact of this but staff were concerned about the hazards of the cabling for this and

of the delay in having the replacement lights approved.

We were informed one light would be updated this financial year (2015/2016) and the second during the following financial year (2016/2017).

- Obstetric theatre number 2 required a full refurbishment including replacement of lights, rewiring and a new lighting panel.
- Within the triage facility the staff base was shared with a room which contained an examination couch behind a curtain. It was difficult to ensure confidentiality when answering the telephone and providing advice to women over the telephone. The telephone extension for the Day Assessment Unit (DAU) was directed to triage, which staff stated unnecessarily added to the triage workload.
- The Garden Suite had recently been refurbished, funded by the Department of Health, for families experiencing bereavement. This was in a quiet corridor away from other maternity clinical areas.

## Medicines

- Medicines were stored appropriately in all in-patient areas. Medicine administration was recorded and signed for, with two signatures for controlled drugs.
- Medicines training included an update by a pharmacy representative and covered epidural administration.

## Records

- All pregnant women receiving services carried their own hand-held notes. The delivery suite receptionist obtained medical records when required by clinical staff.
- Mandatory training included individual documentation audit and the preceptorship programme included a review of maternity guidelines on maternity records.
- Supervisors of midwives had undertaken a record keeping audit in 2014 using a standardised clinical record-keeping tool. The maternity service introduced the maternity module of the electronic patient record system in April 2015. This created a problem in providing accurate screening data. Information retrieval was difficult so manual retrieval was undertaken.
- There had been no audit undertaken of the compliance of the HSA1 paperwork for termination of pregnancy required by the Department of Health. We reviewed one HSA1 form that had been completed in line with the

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Abortion Act 1967. It was not possible to review a HSA4 form as these were sent electronically to the Department of Health and a copy was not kept with the medical records.

- We reviewed a small number of patient notes related to individuals who were receiving gynaecology care and within the maternity service and found that they had been completed with relevant clinical information, signed and dated in accordance with guidelines.

## Safeguarding

- The mandatory training programme for staff within the maternity service included level 3 safeguarding training with annual updates. There were specialist midwives who provided support and advice to staff when caring for women with safeguarding concerns. Completion of safeguarding adults training was at 96% and 59% for children in the information provided to us.
- All women were risk assessed at booking and community midwives followed up those that did not attend for antenatal care both within the hospital and community environment. Managers and staff demonstrated understanding of the safeguarding process and concerns were identified on the IT system.
- A midwife was employed to provide care to vulnerable women, asylum seekers and refugees. She worked closely with social workers and the Border Agency group as part of the Homeless Health Team through the Rainbow Health Centre.
- A named midwife for safeguarding within the maternity service communicated with the trust lead for safeguarding and provided support to staff in the maternity service.

## Security

- The inpatient maternity unit was secure from the main hospital corridor by security keys and there were security guards at the entrance to the maternity unit. Access to each clinical area within maternity and gynaecology were restricted by use of security keys. Entry to the delivery suite was controlled by a receptionist from 8am to 3pm Monday to Friday. The receptionist had been trained in conflict resolution. Outside these hours entry was controlled by the clinical staff on the delivery suite. We were informed that receptionist cover for the delivery suite would be

available 24/7 when staff were appointed. There was CCTV throughout the maternity service and the security call system displayed an image of the person seeking entry to clinical areas.

## Mandatory training

- There had been recent changes to the arrangements for the responsibility of mandatory training for midwives, maternity support workers and healthcare assistants. A database had been developed to record the attendance at mandatory study days. Each midwife had one week mandatory training per year. The mandatory training programme had been developed in response to issues identified within the service including the special care baby unit. An interview with the clinical placement facilitator (band 8a) stated that the percentage of midwives who had undertaken CTG training for the year 2014/2015 was 75%. The training sessions in February and March 2015 were cancelled due to difficulties with the practice development midwife role. They further stated that they could not say how many midwives had undertaken mandatory training in the past year due to difficulties with recording events and attendances. In the past year 66% of staff had undertaken blood transfusion administration training, 49% perineal suturing training and 50 to 60% skills drills.
- We saw from safety related mandatory training figures provided that the target of 90% had not been achieved in moving and handling (56%), resuscitation (70%) and health and safety (84%).
- The maternity service had a contingency plan for 2015/16 to catch up with regard to outstanding mandatory training.
- In addition to mandatory training all newly appointed and qualified nursing and midwifery staff attended an orientation programme, which incorporated a one week trust induction programme. Staff were supernumerary during their orientation programme.

## Assessing and responding to patient risk

- Women were assessed at booking and continually assessed throughout their pregnancy, with appropriate referrals made to ensure a plan of care was in place.
- Women admitted to the gynaecology ward were assessed by nursing staff and any risks identified were acted upon. For example, risks related to mobility or venous thromboembolism.



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- Prior to April 2015 a number of women attending the maternity department did not receive a risk assessment for venous thromboembolism (VTE). The low levels of assessments identified had been placed on the risk register in July 2014. Initial action had been taken to record and monitor assessments manually and the rate was noted to improve but not to a consistent level across the relevant service areas. We noted on the Clinical Performance and Governance Score card for 2014/15 that the rates remained variable, with scores ranging from 54% on Hope Ward up to 91% for community bookings in April 2015. We were informed that there had been no cases of pulmonary embolism within the maternity service during the past year, but failure to assess women put them at risk. Reports of the Confidential Enquiry into Maternal Deaths and Child Health have found pulmonary embolism the leading cause of maternal death in the UK.
- The National Screening Committee Standards requires that all women booked for antenatal care must be offered screening for a variety of infectious diseases and other conditions. Between 20 and 25% of women had not been receiving the full range of recommended screening tests. This had been placed on the risk register and action taken to mitigate the risk. A specialist midwife monitored screening and maintained a database. She updated community midwifery teams weekly on the women with outstanding tests and they were expected to follow up and report back. The number of outstanding screening tests were reported to senior management and recorded on the maternity dashboard.
- Triage was open at all times and out of hours women with concerns such as reduced fetal movement attended or telephoned for advice.
- Inpatient staff used maternity early warning score (MEWS) and high dependency unit (HDU) charts to monitor women's health and this was included in the annual midwifery mandatory training programme. Women on the gynaecology ward were monitored post-operatively using the trusts' early warning score procedure. Staff alerted the medical team where a deterioration was identified.
- The delivery suite orientation programme for newly appointed staff adult resuscitation, neonatal resuscitation and use of emergency equipment.
- All newly qualified midwives were provided with a Midwifery Preceptorship Document which identified who to contact in the case of obstetric, neonatal and adult cardiac emergencies. There was a supervisor of midwives on-call 24/7, the majority of whom were also midwifery managers. All midwives were aware of how to contact a supervisor of midwives. There had been action to improve compliance with the WHO surgical safety checklist in obstetric procedures, and audits had found this had resulted in improvements. A quality audit was in progress to review staff engagement with the checklist.
- Women having elective caesarean section were assessed prior to admission and the enhanced recovery approach was embedded in the patient pathway.
- Emergency slots were available at the start and end of each antenatal and gynaecological clinic session to ensure women were able to access medical assessment and appropriate care in a timely manner depending on their individual needs.
- The Early Pregnancy Unit (EPU) was open from 9am to 11am Monday to Friday. Outside these hours women would access care through the Emergency Department (ED). Women over 16 week's pregnancy had access to the maternity triage facility 24/7. A Gynaecology Assessment Unit had been established with the EPU, which was available on weekdays to women who self-referred or were referred by their GP.

## Midwifery and nurse staffing

- Recruitment of midwives had been successful and vacancy rates had fallen. Remaining vacancies had been offered to student midwives who qualified in October. The use of agency staff was minimal and those that were used were familiar with the service. Turnover rates for midwives had also reduced, although turnover continued to be higher than the trust target.
- The staffing levels at the time had been assessed to ensure that a midwife to birth ratio was 1:28 and could be maintained against increased activity. Women were provided with 1:1 care when in established labour. The staff we spoke with generally felt that the staffing levels enabled midwives to care for women and their families appropriately. We spoke to twelve women within the maternity unit and they all stated that there were sufficient staff to deal with their requirements. We observed staff answering call bells in a reasonable time.

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- Nevertheless, we found evidence, for example from the audit of induction of labour, and the audit of caesarean sections, that care and treatment was sometimes affected when the unit was busy. Some staff reported pressures on the service at times of high demand, in particular on the antenatal ward. We noted that the maternity service had set a goal to increase the number of births and this was reflected in an orange or red rating when the numbers were lower than this. We were not clear that the current staffing levels had been assessed on the basis of this level of demand.
- Staffing levels on the gynaecology wards were displayed and included expected staffing numbers by role and actual numbers for each part of the day and night shift.

## Medical Staffing

- There was dedicated consultant presence on the delivery suite 98 hours per week. This was in line with Royal College of Obstetricians and Gynaecologists recommendations and evidenced on the maternity dashboard. There was a consultant available on-call out of hours and at weekends.
- There were four handovers per day 8am, 1pm, 8pm and 10pm. These included multidisciplinary handovers, board rounds, bedside and telephone. Medical staff reported that there was good multidisciplinary working.
- The recently opened Gynaecology Assessment Unit was currently staffed with locums, but permanent staff had been appointed.
- Junior medical staff reported that consultant medical staff were very supportive. There was consultant presence 8am-10pm during the day and at night a doctor in training covered Gynaecology, ED and Triage. The ED was a long distance from the maternity unit.

## Medical and theatre staffing

- Consultants were available via on-call rotas from home out of hours. The obstetric theatres were managed by the maternity service. They had anaesthetic support. On the three days when there were elective caesarean sections there were two consultant anaesthetists on duty. There were gaps in the obstetric rota and some sessions were covered by internal locums. There was a recruitment programme, with the expectation that gaps would be filled.
- Staff we spoke to said there were insufficient nurses to staff the two bedded recovery area appropriately, especially if the delivery suite was busy.

- A team leader had responsibility for the obstetric theatres with support from theatre. We interviewed the team leader for the obstetric theatre and she advised us that there were nurses covering the obstetric theatre three nights per week. There was no cover for annual leave and outside these hours midwives had to scrub. In addition to this she stated that she had been attempting to set up training for the midwives to learn to scrub and they were so busy they could not be spared to undertake the training. Midwives were therefore assisting with emergency caesarean sections out of hours. Scrubbing for caesarean sections was not included in the midwifery mandatory training. The College of Operating Department Practitioners, The Royal College of Midwives and Association for Perioperative Practice in A Consensus Statement (2009) stated that “the midwife should not be expected to provide instrument/scrub assistance or act as the assistant to the obstetrician.” It was recommended that this was achieved by 2012.

## Major incident awareness and training

- There was a trust wide protocol for responding to major incidents, the policy was known by staff who confirmed they would be directed to the action they would be required to take.
- All newly appointed staff were informed of the action to take in the event of a security issue or fire.

## Are maternity and gynaecology services effective?

Good



Women's care and treatment in the maternity and gynaecology service was planned and delivered in line with current evidence based guidance and standards. Outcomes for women using the maternity service were within the expected range.

We found that women using the maternity and gynaecology services received pain relief as required and arrangements were in place to ensure women and their babies received adequate nutrition and hydration.

Multidisciplinary team working was good and training opportunities for professional development was actively encouraged.

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## Evidence-based care and treatment

- Staff had access to guidance, policies and procedures via the trust intranet. The care of women using the maternity services was in line with the Royal College of Obstetricians and Gynaecologists guidelines (including Safer Childbirth: minimum standards for the organisation and delivery of care in labour). These standards set out guidance in respect to the organisation and include safe staffing levels, staff roles and education, training and professional development, and the facilities and equipment to support the service.
- We found from our discussions and from observations that care was being provided in line with the National Institute of Health and Care Excellence (NICE) Quality Standard 22. This quality standard covers the antenatal care of all pregnant women up to 42 weeks of pregnancy, in all settings that provide routine antenatal care, including primary, community and hospital-based care.
- We found sufficient evidence to demonstrate that women were being cared for in accordance with NICE Quality Standard 190 Intrapartum care. This included having a choice as to where to have their baby, care throughout their labour, monitoring during labour and care of the new born baby.
- We saw that a 'fresh eyes' approach was used to peer review electronic recordings of the baby's heart rate. This involved a second person assessing the baby's heart rate against certain criteria to confirm that the baby was coping with labour.
- We saw from our observations of activity and from reviewing care records that the care of women who planned for or needed a caesarean section was managed in accordance with NICE Quality Standard 32.
- There was evidence to indicate that NICE Quality Standard 37 guidance was being adhered to in respect to postnatal care. This included the care and support that every woman, their baby and, as appropriate, their partner and family should expect to receive during the postnatal period. On the postnatal ward staff supported women with breast feeding and caring for their baby prior to discharge.
- We found from our discussions and from observations that care was being provided in line with the NICE Clinical Guideline (CG110) Pregnancy and complex social factors: A model for service provision of pregnant

women with complex social factors. This guideline covers the care of vulnerable women including teenagers, substance misuse, asylum seekers and those subject to domestic abuse.

- We saw the minutes of the monthly meetings of the maternity Practice Review and Guidelines Committee, chaired by the audit midwife, which identified guidelines that required review or development. We noted that there was sometimes no consultant or medical attendance at these meetings.
- We saw examples of audits initiated to assess the effectiveness of action (for example VTE risk assessments) and to monitor compliance with best practice (for example induction of labour). There were monthly Obstetric Clinical Governance Meetings at which audit results had been presented and investigation of serious incidents were shared. However, the monitoring of compliance with guidelines had not been audited annually as identified in the trust requirements.

## Pain relief

- Our review of medical records found from discussion with women that options were offered for pain relief during labour and caesarean sections. One woman stated that she had not considered a birth pool for relief of pain during labour and had tried it at the suggestion of the midwife caring for her. She had found this a most beneficial method of pain relief during labour. An anaesthetist was available at all times for the provision of an epidural for pain relief during labour.
- The publication "Having your baby with Croydon Health Services" detailed workshops available to parents during pregnancy where they were informed about the pain relief options available to them.
- Women indicated that pain relief was provided when required in all clinical areas. Women on the postnatal ward said that they were provided with pain relief as and when required.
- Women experiencing pregnancy loss were provided with a range of available options for pain relief including Opiate analgesia via a patient controlled analgesia (PCA) system or epidural.

## Nutrition and hydration

- The maternity service had level 2 United Nations International Children's Emergency Fund, (UNICEF) accredited baby friendly status and was working

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towards level 3 accreditation. This aims to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways which will support optimum health and development. Stage 2 accreditation is achieved when a service demonstrates that all staff have been educated according to the role.

- An infant feeding midwife was responsible for the oversight of infant feeding. The trust promoted breastfeeding and the important health benefits now known to exist for both the mother and the baby. Their policy aimed to ensure that health benefits of breastfeeding and the potential health risks of artificial feeding were discussed with all women to assist them to make an informed choice about how they would feed their baby. Breastfeeding was 87% following delivery, better than the England average. This fell to 79% on discharge.
- Breastfeeding support was reported to be good by mothers in the birth centre and postnatal ward. Meals would be kept for women if they were breastfeeding during meal times.

## Patient outcomes

- Maternity services performed within expected ranges for maternal readmissions, puerperal infections and other outcome measures monitored by the CQC outlier programme.
- We reviewed a copy of the maternity clinical governance and performance dashboard from April 2014 up to June 2015. This contained evidence of monitoring of patient outcomes, staffing, skills mix and risk management.
- Perineal tears were monitored on the maternity dashboard on a monthly basis. The obstetric specialist advisor confirmed that the rates were within normal limits and that the trust were a centre of excellence for support to women locally and nationally for follow-up care. Perineal tears were monitored by type of birth, such as instrumental delivery, spontaneous vaginal delivery on the labour ward, spontaneous vaginal delivery on the birth centre, home birth and born before arrival. We saw figures for the period 2014/15 that indicated the percentage of tears ranged between 2.3% for spontaneous vaginal delivery and 9.9% for instrument deliveries.
- Neonatal morbidity was reported on the maternity dashboard by stillbirths (intrapartum & intrauterine death). We saw from information that there had been 17 intrauterine deaths between the period of April 2014 and February 2015.
- All term admissions to SCBU and unexpected term admissions to SCBU were monitored. We saw from information within the performance dashboard for 2014/15 that results were 190 and 163 respectively.
- Maternal morbidity was monitored and information provided indicated there were two post partum hysterectomies for the period 2014/15, 96 postnatal readmissions 42 days after delivery and 12 readmissions with confirmed infections.
- When non-compliance with standards was identified, audits were undertaken, action plans put in place, and the standard re-audited.
- The caesarean section rate was 26.8%, similar to the national average.
- Maternity services had identified that reductions in the caesarean section rate were possible and had set a goal to do this on the maternity dashboard. An audit of the caesarean section rate had been undertaken in November 2014. This indicated that the cause was multifactorial and indicated a degree of influence by the level of activity on the unit, the arrival of new staff and the involvement of consultants in the decision making. One-third of emergency caesarean sections were performed at night when the consultant was usually off site. The trust had identified that it was partially compliant against current practice. The newly appointed Clinical Director (June 2015) advised us that a 'Task Force' would be established to address the issue of the caesarean section rate with a review of caesarean sections on a daily or weekly basis.
- The maternity services in South West London participate in the monitoring of clinical outcomes in conjunction with the South West London Network who maintained a dashboard comparing the four maternity services at Croydon, Epsom & St. Helier, Kingston and St. Georges during the antenatal, intrapartum, postnatal periods and for neonates, birth activity, staffing and maternal satisfaction and safety.
- At the time of our inspection the gynaecology services did not have a performance dashboard in use. We were told that one was planned.

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## Competent staff

- Newly appointed and qualified staff attended an orientation programme, which incorporated a one week trust induction programme. Staff were supernumerary during their orientation programme. Information was provided to staff regarding the contact numbers for obstetric emergencies.
- Staff stated that they were actively encouraged to take up development opportunities. Midwifery staff stated that there had been a marked improvement in the development opportunities since the appointment of the midwifery management team over the past three years.
- There were nurses with specialist skills within the Early Pregnancy/Gynaecology Assessment unit for colposcopy and hysteroscopy.
- Staff told us that the medical staff initiated unplanned emergency skills drills sessions on the delivery suite for obstetric emergencies.
- The rate for completion of performance development reviews was 65% for the directorate and 63% for maternity services.
- Newly qualified midwives had a year-long preceptorship programme, which identified learning objectives to ensure competency in areas such as drug administration, recovery from anaesthetic, perineal suturing and obstetric emergencies. Mandatory training for midwives covered issues such as pregnancy loss, care of diabetic women, infectious diseases, anaesthetic update including epidural, mental health, safeguarding, high dependency care and obstetric emergencies.
- Obstetric theatres were run by suitably skilled and competent staff. Midwifery staff who scrubbed at nights and weekends were taught by theatre staff to scrub for surgical procedures. We saw evidence of scrubbing for receiving baby in theatre. Care of women recovering from general anaesthesia, epidural or spinal anaesthesia was included in the midwifery preceptorship programme.
- The last Local Supervising Authority report of their annual audit to monitor the standards of supervision of midwifery practice was dated June 2014. The report found that the domain considering team working, leadership and development was met and identified that the supervisors of midwives were involving service users in a group to develop the enhanced recovery

programme for women undergoing caesarean section. The function of statutory supervision of midwives to ensure that safe and high quality midwifery care is provided to women.

- The Nursing and Midwifery Council (NMC) sets the rules and standards for the statutory supervision of midwives. Supervisors of Midwives (SOMs) were a source of professional advice on all midwifery matters and were accountable to the local supervising authority midwifery officer (LSAMO) for all supervisory activities.

## Multidisciplinary working

- The supervisors of midwives were actively involved in steering a research project to pilot an Australian multidisciplinary training model for midwives and health visitors working with vulnerable families throughout pregnancy and their child's early years.
- The staff we spoke to identified good multidisciplinary working in relation to developing individual plans of care for women. For example women with diabetes or other medical conditions.
- There were multidisciplinary pathways developed for the care of women with suspected fetal abnormalities. The midwifery, nursing, sonography, chaplaincy and medical staff developed a plan of care for women to ensure confidentiality and sensitive care for the women her partner and family. Women under 16 weeks of pregnancy were cared for by nursing and medical staff in the EPU and gynaecology in-patient wards and the Day Surgery unit. Women over 16 weeks of pregnancy were cared for within the maternity unit.
- All the staff we spoke to stated that there were good working relationships between professions and that the focus of the care provided was always on the woman/patient to ensure the experience was safe and patient centred.

## Seven day services

- The maternity service was accessible 24/7 via the triage facility.
- There was out of hours consultant cover available via an on-call system.
- Staff and women stated that support services such as ultrasonography and pharmacy were available when they required them.



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## Access to information

- Women had direct access to the Early Pregnancy unit and GPs are able to make direct referrals to the Gynae' Assessment unit.
- The integrated maternity service demonstrated the seamless transfer from the hospital to the community midwifery service where information was available to continue the plan of care for both the woman and her baby.
- We were told by nurses on the Queen's 1 Ward that information was not available to women following pregnancy loss regarding the disposal of the pregnancy remains although women were asked to sign a form indicating their wishes. However, we saw a detailed check list was to be completed and included in women's records. This indicated where information and discussion had taken place about funeral arrangements where the baby was born before the 24th week of pregnancy.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff and women described the process for gaining consent to undergo a caesarean section – both elective and emergency.
- We looked at a sample of notes for a medical termination of pregnancy and saw that the consent forms had been appropriately signed - (HSA1). The evidence-based clinical guidelines for staff for related procedures clearly documented what consent was required.
- Midwives told us they had access to specialists when they had concerns regarding safeguarding issues of a mother or baby.

## Are maternity and gynaecology services caring?

Good



Women who attended Croydon Healthcare received good care. Staff treated women with dignity and kindness and they felt well looked after as a result. Women who had given birth at the hospital before commented on the improvements to the service.

Women we spoke with told us that staff were caring and that information had been explained to them about their treatment.

## Compassionate care

- The trust received similar scores for the Friends and Family Test as the England average although questions, with better than average results on birth and postnatal community provision. The CQCs Survey of Women's experiences of Maternity Services found the trust was performing about the same as other trusts.
- The women and partners we spoke with all reported that they received good quality care and kindness from all members of staff. We observed integrated patient centred care and saw staff responding compassionately when women required assistance.
- Staff reported that an increase in staff numbers had enabled them to give better quality care. Women we spoke to were pleased with the level of care they were receiving and commented that the staff were approachable and helpful.
- Several women that we spoke to on the ante and postnatal ward who had given birth at the hospital before commented that the service had improved since their previous pregnancy.

## Understanding and involvement of patients and those close to them

- The women we spoke with all reported that communication was good throughout their pregnancy and that their partners had been actively involved in their care. We observed situations where potential grandparents were also involved by the staff.
- Women on the postnatal ward were pleased that their partners were able to stay with them overnight.

## Emotional support

- Women reported that the medical staff discussed findings from screening results during the antenatal period and ensured that women were emotionally supported by the midwives and specialist nurses within the EPU.
- We were advised by midwives that women had access to de-briefing from midwives following labour experience if requested.
- A bereavement midwife was responsible for speaking with women and their families who had been bereaved during or following childbirth or had a termination due to medical reasons. She also provided support to the



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midwives in caring for women who had experienced pregnancy loss. She participated in the midwifery mandatory training programme on issues of pregnancy loss. The bereavement midwife maintained a database of women who had a loss after 16 weeks of pregnancy and ensured support and advice was provided where wanted and necessary. The consultant medical staff and the bereavement midwife provided counselling to women who have experienced pregnancy loss.

- There was a multidisciplinary emotional support network available to women in the maternity service who had experienced loss, which included the chaplaincy team and reflected the appropriate faiths for individual women and their families.
- The support to women prior to 16 weeks who experienced pregnancy loss was not structured within the gynaecology ward. It was suggested by the medical staff that all women would be better cared for emotionally within the maternity unit. Although the clinical safety of women was described as good on the gynaecology ward, a lack of empathy was felt to be attributed to the fact there were no dedicated gynaecology trained nurses on the ward. We were advised that the trust had approved a post of senior nurse to cover gynaecology.

## Are maternity and gynaecology services responsive?

Good



The flow through the maternity unit enabled women to access the service at each stage of their pregnancy with ease.

The gynaecology services were responsive to the needs of women requiring elective and emergency services.

There were arrangements in place to support people with physical and learning disabilities. Translation services could be arranged as required.

The individual needs of women at each stage of their pregnancy were fully considered by staff and acted on.

The 'Making a comment, suggestion or complaint about the NHS services we provide' leaflet was understood by staff. Women were supported to raise concerns and have these acted upon as soon as possible.

## Service planning and delivery to meet the needs of local people

- The maternity service was able to meet demand and had an understanding of the needs of the local population.
- We were advised that the gynaecological service was able to meet the demands of the local population and it was planned to have a gynaecology dashboard developed to assist with providing an overview.
- There were a number of specialist nurses/midwives available to support women with specific requirements: colposcopy, hysteroscopy, diabetes, mental health, screening coordinators, infectious diseases, infant feeding, safeguarding, bereavements and perineal specialists.

## Access and flow

- There was clear access to the maternity and gynaecology services for the women of Croydon and for GPs referring women.
- The midwives in the antenatal clinic checked referrals on a daily basis to ensure the service responded in a timely manner. This was monitored on the maternity dashboard.
- Triage was open at all times, with telephone advice available out of hours. Women who suspected they were in labour were assessed by a midwife prior to transfer elsewhere unless the birth was imminent in which case they were admitted directly to the delivery suite or birth centre. The triage became quite congested when busy and confidentiality was an issue because the telephone was answered by midwives in a room with an examination couch.
- The Maternity Day Unit had recently opened from 8am to 6pm on weekdays for booked appointments for conditions such as raised blood pressure, obstetric cholestasis, reduced fetal movements and premature rupture of membranes. Referrals were taken from antenatal clinic, community midwives, GPs and women were able to self-refer.
- The maternity Day Assessment Unit had recently moved from the triage area to a designated area on the nearby antenatal ward. This was a self-contained clinical space, which afforded more physical space and privacy for safe and effective provision of services.
- Bed Occupancy rate had been higher than the England average in five of the last six quarters but always below 70%. There was an escalation policy in place when the

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maternity unit encountered problems meeting demand. However, we were told that midwifery staff were uncertain of the action to take out of hours, and often contacted the supervisor of midwives on duty instead of the duty manager. An action point from an investigation of an incident identified the need to review the maternity escalation policy and to consider an on call rota to of maternity services managers. The maternity unit had not closed between Sep 2013 and Feb 2015.

- Midwives were concerned that when the delivery suite was busy priority of maintaining the birth centre service was compromised. They were hopeful this would not occur so often now that recruitment of midwives had improved.

## Meeting people's individual needs

- Each woman had an individualised plan of care clearly detailed in their notes. Where women had complex needs, such as diabetes and learning disabilities, specialist care was available. Both the birth centre and delivery suite had facilities for women with disabilities. There was a dedicated team caring for teenagers and young parents to meet their specific needs. There was specialist support for women with a previous caesarean section and there was a VBAC (Vaginal Birth After Caesarean) programme.
- Language Line was used within the maternity and gynaecology services and staff and women reported that this worked relatively well.
- There were monthly early pregnancy open evenings where couples could find out more about pregnancy and giving birth. Support to stop smoking was available. Weekend workshops were run that covered the stages of labour, active birth and birth positions. This included what to expect when couples take their baby home from hospital and advice regarding breastfeeding.
- Gynaecology clinics were run Monday to Friday and there was a one stop clinic where women receive diagnosis and treatment of common gynaecological conditions.
- Women had choice with respect to their diet and cultural or therapeutic needs were met.

## Learning from complaints and concerns

- The trust provides a leaflet for patients 'Making a comment, suggestion or complaint about the NHS services we provide' which details the Patient Advice and Liaison service (PALS) service. Staff within the

maternity service stated that they would also respond, where possible, immediately to concerns raised by women in an attempt to resolve the issue without the need for formal complaint.

- Some of the people we spoke to were not clear about how they would go about making a complaint but stated that they were sure the staff would inform them if they asked.
- There were process for responding to complaints, which included regular review at risk management meetings and feeding learning back to staff.

## Are maternity and gynaecology services well-led?

Good



Maternity service staff and women giving birth at the hospital commented positively on the improvements to the service in the last three years. Midwives were enthusiastic about the ethos of women-centred care, openness and transparency. Staff we spoke with in maternity and gynaecology services reported their areas to be well-led, with open communication channels and a good level of support.

We found a joined up approach to clinical governance in the Integrated Women's, Children's and Sexual Health Directorate. Action was taken when non-compliance with standards was identified. Nevertheless, action was not always fully effective.

## Vision and strategy for this service

- The managers of the Integrated Women's, Children's and Sexual Health Directorate described the trust strategy and the proposed future location for women's services on the hospital site.
- An annual business plan was in place, which identified the main objectives and focus of the service. Additionally, the maternity and gynaecology services were part of the trusts overarching operational plan and overall strategy; however, the staff we spoke with were not aware of this or about the direction of focus.
- The maternity service at Croydon were very active within the South West London Network Board and included operational plans within the network, which included amongst the aims to: increase births outside of hospital and within midwifery led birthing units;

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increase continuity of care, reduce postnatal re-admissions, and shared learning from serious incidents. The strategy also includes compliance against the London Quality Standards for Maternity.

- The stated objectives of the maternity service were documented in the midwifery preceptorship programme as: deliver high quality integrated patient centred care which improves outcomes, patient safety and patient experience; work with partners to improve the health and wellbeing of the people of Croydon; develop the workforce to establish a way of working that builds a culture that is committed to an open transparent evidence based approach; deliver best practice performance standards against the national operating framework; deliver well managed quality services which are value for money for the taxpayer.
- The interface between statutory supervision of midwives and the service's aims was evident. The number of supervisors of midwives had increased and their role developed to support midwives and encourage a positive working culture; engage with women using the service, and promote evidenced-based practice.

## Governance, risk management and quality measurement

- There was an integrated clinical governance structure in the directorate, with clear reporting lines to trust-wide committees, and the board. We saw from notes of service, directorate and trust-wide meetings that there were processes in place to review activity, monitor risks and encourage adherence to best practice. We noted in maternity services, that attendance at these meetings was multidisciplinary. There was evidence of engagement at meetings and discussion of actions required where relevant.
- A maternity dashboard, which rated clinical outcomes red, amber and green (RAG) was updated monthly and reviewed at the Maternity Quality Board. There was a directorate risk register, which was an active document and regularly reviewed at the monthly maternity and gynaecology risk management meeting. Reports from the various forums were presented to the monthly Directorate Quality board and quarterly to the Trust Risk Assurance and Policy Group.

## Leadership of service

- The Clinical Director for the Integrated Women's, Children's and Sexual Health Directorate was appointed

from 1st June 2015. This had left the post of Head of Service for obstetrics and gynaecology vacant. We were informed that this post had been advertised internally and would hopefully be appointed to shortly.

- Staff commented on the improvements to women's services in the last three years. Women currently using the maternity service stated that the care had improved significantly since their last experience at the hospital. This was also reflected in the national survey of women's experiences of maternity services. Without exception, midwifery staff reported that education and training was more openly available.

## Public and staff engagement

- Nursing and midwifery staff reported positively on the level of engagement with their immediate line managers, midwifery management team and medical staff. They reported their areas to be well-led, with open communication channels and a good level of support.

## Culture within the service

- The staff we spoke with described good multidisciplinary working relationships, committed to providing women-centred care. The culture was described by staff as open, with safety a key focus and candour and honesty actively encouraged.
- Staff stated they felt supported and valued - particularly the midwives. They stated that they were actively encouraged to participate in on-going training and education. Newly qualified midwives were applying to stay at the trust to gain clinical experience with the support of a structured preceptorship programme.

## Innovative practice







- Medical staff were proud of the perineal care service provided to women at the trust and referred to its international profile.
- Staff were particularly proud of the urogynaecology and pelvic floor reconstruction unit at Croydon Healthcare, which they described as a centre of excellence. The service was provided by two of the consultant medical staff, research fellows and a specialist perineal care midwife. They had an international profile in relation to research, provided courses to the obstetric community and had won many awards.
- Midwives were working as part of the 'Croydon Best Start' initiative, building relationships so that families with babies and young children could get the services they needed at the right time. The aim of this was

# Maternity and gynaecology

to promote the healthy child and school readiness programme so that effectiveness of services were improved and positive benefits were achieved for babies and their families. 'Best Start' included parents with children from conception to school age, health visitors, early learning practitioners, children's centres and the community, working alongside midwives, GPs and some specialist services.

- The maternity service was currently developing and piloting a programme of antenatal courses designed to support women with limited English. An experienced ESOL trainer was involved in the programme.

# Services for children and young people

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

## Information about the service

The paediatric service includes treatment and care facilities for children and young people. There are two wards, Rupert Bear Ward, which has 16 beds and the Dolphin day unit, 12 beds. In addition there is a special care baby unit, which has facilities to look after 24 babies.

We attended three handovers and spoke with a range of staff involved in children's and young people's services. This included; four consultants and one paediatric anaesthetist, four junior medical staff, one paediatric pharmacist, one chaplain, seven senior nurses, two matrons, and five staff nurses. We also spoke with; one hospital school teacher, one play specialist, one senior midwife, two Patient Advocacy and Liaison officers, five student nurses and one practice education facilitator, one ward kitchen hostess and one ward clerk. We spoke with 13 parents and two children and reviewed information provided to us prior to and during the visit. This included four patient records.

## Summary of findings

Children's services at Croydon University Hospital provided effective, caring and responsive support to premature babies, sick children and their families.

Many aspects of care were safe but one area that did require improvement was staff attendance at mandatory training. Staff were required to complete safety related subjects but targets were not always met, particularly within the paediatric medical staff. The service had systems to respond to any deteriorating child.

There were some discrepancies in staffing levels of doctors and nurses due to vacancies, which were managed to ensure patient safety was not compromised.

There was an open and transparent approach to reporting and learning from incidents. Infection prevention and control measures were in place to minimise risks to those who used the service.

Effectiveness of services were geared to reducing emergency readmission rates and delivering the best treatment and care outcomes for children and young people, in accordance with best practice.

A multidisciplinary team approach to patient care prevailed, and our observations and feedback from people using the services demonstrated that care was delivered in a kind, compassionate, respectful and friendly manner.

# Services for children and young people

Responsiveness of the service was achieved through close working arrangements with community-based services, which ensured that children could expect to be cared for at home via community nursing services. The service was well-led and staff spoke positively about providing high quality care that was aligned to the trust-wide vision of ensuring that patients received safe, clean and personal care.

Whilst the overall care environment and ambience of the Rupert Bear Ward and Special Care Baby Unit were tired and in need of refurbishment especially with regard to parent accommodation, the trust had acknowledged this was an area of concern and had developed action plans to improve facilities for babies and sick children.

## Are services for children and young people safe?

Requires improvement



Improvements were needed to ensure that the service was provided safely. This was because staff did not always complete the required mandatory safety related training.

Children's services had good incident reporting systems that staff described in detail. Staff were aware of their responsibilities to report incidents and lessons were learnt from subsequent investigation of these.

Safety checks were carried out at each stage of the patient journey, from ward through the operating environment. The clinical areas were visibly clean, although some parts were in need of refurbishment.

The Rupert Bear Ward was scheduled for rebuilding and relocation, which would greatly improve the environment.

There were systems in use to ensure that patients were protected from the risk of harm associated with hospital-acquired infections. Equipment was suitably clean and readily available to support the delivery of safe care.

Medicines were managed safely and patients received the prescribed medicines as indicated. Records were completed to indicate the treatment and care provided to each patient. However, the electronic patient record had not been designed to facilitate the inclusion of all child related observations and staff were using both paper and electronic records, which made it less practical.

Nursing and medical staffing vacancies were managed to ensure the safety of patients. However, weekend consultant staffing arrangements sometimes meant children were not seen by a consultant within 24 hours of arrival.

Staff could recognise and respond to the needs of vulnerable patients.

Safe procedures were in place to monitor patient conditions and to respond appropriately where there was a deterioration. Transfer arrangements were in place where treatment and care needs required higher level of clinical interventions.



# Services for children and young people

## Incidents

- We spoke with a range of medical, allied health professionals, a school teacher and play specialist and nursing staff. They were able to describe the incident reporting system, and were able to explain their roles and responsibilities with regards to the reporting of incidents. Furthermore, staff members were able to explain, and provided examples of how lessons learnt had been generated from incidents and accidents.
- Information provided to us in advance of or inspection indicated that there had not been any never events in children's and young peoples services. A never event is a 'serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers' (Serious Incident Framework, NHS England, March 2013).
- A total of 66 incidents were reported via the trust's incident reporting system between 1 January 2014 and 31 March 2015. These were attributed to the children's services across the trust including the community, the emergency department, and the special care baby unit, children's outpatients, the Dolphin day unit and Rupert Bear Ward. Two of those incidents were categorised as "serious incidents" (SI). A SI is a serious incident requiring investigation. We saw information within the trust incident reporting pack, which demonstrated that where SI's occurred these were investigated and reported to the commission and other external agencies.
- We reviewed each of the 66 incidents that had been reported and there was evidence that senior members of the team had reviewed each incident. Each incident had detailed information regarding any immediate action taken as well as any action taken as a result of any subsequent investigation. We spoke with the doctor involved with one of the incidents and it was evident that all procedures had been followed.
- We were given examples of learning from an incident after we interviewed the ward manager of the special care baby unit. The incident had resulted in changes to the security arrangements. We noted that the additional security measures introduced subsequent to this event and a new abduction policy included the employment of additional security staff and vigilant monitoring of security cameras via CCTV and heightened door protocols to prevent tailgating.
- There had been no recorded instances of pressure ulcers, falls or catheter related urinary tract infections in children's or young people's services.
- Staff attended weekly morbidity and mortality meetings where serious incidents had been escalated where indicated. The action plans were monitored at monthly meetings and all neonatal serious incidents were discussed at regional neonatal network meetings. The neonatal unit held weekly perinatal and high risk meetings. We attended one such meeting where we observed high levels of discussion pertinent to individual children.
- The duty of candour requires staff to be open and transparent with people about the care and treatment they receive. We observed wall mounted posters within children's services, which explicitly explained the duty of candour for visitors to the wards. Namely that any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. This procedure was confirmed by members of the PALS team. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have, occurred and the staff working throughout children's services who we interviewed told us that they had a good understanding of their roles and responsibilities in relation to the duty of candour.

## Cleanliness, infection control and hygiene

- Staff working within children's and young people's services had a good understanding of their roles and responsibilities in relation to cleaning and infection control practices.
- We made observational checks of the cleanliness of the environment on the special care baby unit, (SCBU), the Dolphin day unit and Rupert Bear Ward and all were compliant with national standards, including 100% hand hygiene compliance dated February 2015. We noted that all the hygiene protocols pertinent to the clinical areas we visited were in date and fully compliant.

# Services for children and young people

- Hand hygiene audits were conducted each week. The results of these were communicated to central infection control in the trust as part of the on-going collection of hand hygiene data. This data showed that hand hygiene compliance was 100%. We observed staff members carrying out regular hand hygiene practices and wearing personal protective equipment such as gloves. The clinical areas all had prominent laminated hand hygiene posters evident on walls and parents told us that they had been taught hand hygiene by the nursing staff.
- Although the clinical environment of the SCBU dated back to the 1970's and that of Rupert Bear Ward in some parts to the 19th century, the units were visibly clean. Parents we spoke to told us that the areas were constantly being cleaned and that they regularly observed staff members maintaining hygiene standards.
- Cleaning schedules were in place and there were clearly defined roles for cleaning and decontaminating equipment. Cleaning schedules were documented and audited for compliance on all children's areas. We inspected the cleaning schedule on Dolphin Ward for example and noted that it was 100% up to date.
- The nursing staff of the theatre recovery area had procedures for deep cleaning, which had been carried out weekly. During our inspection of the recovery area we observed that the area was visibly clean and we inspected the cleaning schedule and noted that adherence to the schedule was fully compliant.
- We inspected the sluice areas of the Dolphin Ward and Rupert Bear Ward and inspected four commodes, which were clean and had 'I am clean' tags attached.
- Children's and young people's services reported zero cases of *Clostridium difficile* positives for March 2015 and three cases of *Meticillin-Susceptible Staphylococcus aureus* (MSSA) Bacteraemia for March 2015. All babies admitted to the special care baby unit were screened for *Meticillin Resistant Staphylococcus Aureus* (MRSA). There were no specific isolation facilities in special care as all babies were nursed in incubators.
- Infection prevention and control training was a mandatory subject and figures provided to us indicated a completion rate of 93%-96% in children's acute services.

## Environment and equipment

- Dolphin Ward, which was the day care unit, consisted of large modern bays with direct access to the operating theatres and a specific child recovery suite. The recovery suite being adjacent to the day unit facilitated easy transfer of patients back to their bed area.
- Rupert Bear Ward was the inpatient unit which was found to be clean and bright but dated. The ward was made up of four bedded bays with side rooms. We noted collapsible curtain rails in the bays of Rupert Bear Ward and there were no ligature points in the children's wet room.
- Clinical equipment throughout children's services was found to be in date and fully maintained. The SCBU and Rupert Bear Ward had sufficient equipment to provide safe care to premature babies and sick children.
- We made observations of the paediatric recovery bay attached to the operating theatre and part of the Dolphin day care unit. The recovery equipment including that used for resuscitation was up-to-date and fit for purpose. Equipment had been checked daily by the registered children's nurses who staffed recovery.
- The Electro-Biomedical Engineering Department, (EBME) was responsible for the maintenance, repair and management of medical equipment within the trust. Staff we spoke to were aware of whom to contact or alert if they identified broken equipment or environmental issues that needed attention.
- Resuscitation equipment was inspected in part of children's services and the trolleys were clean, secure, updated and had been checked and logged on a daily basis. Breast feeding pumps were plentiful and free breast pump hire was available for mothers.
- Security measures were good and all clinical areas were accessed by key pad entry.

## Medicines

- Medicines and controlled drugs were secured safely and appropriately accounted for in the records we inspected. The resuscitation drugs were securely stored and checked daily.
- We inspected and checked the daily drug fridge temperature log and found that regular checks had been undertaken and recorded to ensure that medicines were stored at the correct temperature.

# Services for children and young people

- The paediatric pharmacist we interviewed told us that they attended the paediatric wards every day to discuss any issues with the senior medical and nursing staff. The pharmacist assistant undertook medicines stock top up twice weekly, and this was confirmed by the nurses we interviewed.
- We were told by the paediatric pharmacist that all drug alerts were put on notice boards and emailed centrally to all care staff. This was corroborated by the nursing staff we interviewed during the inspection.
- The pharmacist informed us that the neonatal unit followed strict guidelines for making up drugs and the instructions for doing so were available via the trust intranet, which we examined and found to be the case.
- We saw minutes of the Medicines Management Committee, which indicated that paediatric related issues were discussed. For example, the minutes of the January 2015 meeting indicated that action was taken with regard to guidance around treatment for children with Bronchiolitis.
- Safe and secure handling of medicines audits had been undertaken on Rupert Bear Ward. We reviewed the report resulting from an audit visit, which took place in March 2015. Actions to address the identified concerns were clearly indicated, with a responsible individual and timescale. We saw that the findings had also been added to the incident report system.
- The pharmacist joined the ward rounds midmorning to assist the care team in making medicine related decisions about treatment.
- We checked medication records of four sets of notes and found that they had all been appropriately completed with all relevant information including dosage and route of administration.
- We observed children being administered pain relief medication and noted that children were appropriately identified following Nursing and Midwifery Council guidelines for the administration of medication.

## Records

- Records within children's services were partially maintained through the recently introduced trust's medical IT system. Electronic patient records (EPR) had been implemented in September 2013. This had unified and integrated the clinical, medical and administrative system, and was designed to ensure that all patient

information was stored centrally and was available to clinical staff. The system was primarily designed for adult patients and some aspects such as child and infant clinical observations could not be recorded electronically. Therefore children's services were relying on a combination of hand written and electronic data recording. No date had been set to modify the system to accommodate full sets of child data. The staff of children's services had been lobbying for changes to the new EPR to accommodate child related physiological data but no date has been given as to when this will become operational.

- We inspected four sets of patient records both written and electronic and we noted that the care plans were individually holistically focused. The record inspection confirmed that risk assessments had been completed and physical and emotional needs had been documented. One child we spoke with had a moderate learning disability and nursing staff had fully documented this within the record with appropriate interventions prescribed. Parents were actively involved in care planning especially those with children with long term conditions.
- We saw that the trust staff were using a copy of the Surgical Safety Checklist recommended by the World Health Organisation (WHO) and the National Patient Safety Agency (NPSA). The staff were using a copy of this checklist for each person to ensure that staff were consistent in the checks they performed. All checks performed were completed clearly and contained all the elements included on the WHO checklist.

## Safeguarding

- All staff members we spoke to across children's and young people's services demonstrated a clear awareness of the referral process they were to follow should a safeguarding concern arise.
- The trust had a safeguarding strategy in place, which followed the key principles as set out in 'Working Together to Safeguard children (2015)'. This states that "It is the responsibility of employers to recognise that in order for staff to fulfil their duties in relation to safeguarding and promoting the welfare of children and young people, they will have different training needs which are dependent on their degree of contact with children, young people, adults

# Services for children and young people

- We saw that the trust had a safeguarding brochure, which outlined the availability and purpose of child safeguarding and protection training. Safeguarding training was mandatory and was arranged through the workforce development team. Croydon Safeguarding Children Board (CSCB) multi-agency training was also accessible to staff, with a priority to staff working directly with children and families.
- All nursing staff, play specialist and the school teachers were level 3 safe guarding updated, and this was confirmed after inspecting the mandatory updating records held by the sister. Our inspection of the safeguarding figures provided to us indicated that on Rupert Bear Ward there was 100% compliance with adult safeguarding training and 81% for children's training, with a target of 90%. On the SCBU training attendance was at 98% and 82% respectively. There was no data for staff working on the Dolphin Ward.
- Attendance at Safeguarding updates was monitored by the practice development sister on the neonatal unit and by the senior nurses of Dolphin Ward and Rupert Bear Ward. Any non-compliance for whatever reason was recorded and subsequent dates offered. Confirmation of attendance was monitored through the annual appraisal system. We ascertained that health care support workers including the play specialist had been updated.
- The medical staff we interviewed told us that safeguarding updating was part of their annual appraisal system. Doctors we interviewed all confirmed their level three safeguarding updates had been completed. However, the data provided to us for safeguarding training of paediatric medical staff indicated the 90% target had not been achieved for adults, at 78%, but had almost been met for children's, at 89%.
- The trust had a safeguarding policy, a designated consultant safeguard lead and a designated safeguarding nurse. Staff were fully aware of the process of engaging with the safeguarding policy and all we interviewed were able to describe the mechanisms for doing so.
- Throughout children's services CCTV was used to ensure people were safe.

## Mandatory training

- All the medical trainees we spoke to told us that they participated in major incident planning and simulation exercises. They used the hospital simulation centre once per week to practice aspects of care such as resuscitation. The consultant paediatricians we spoke to were able to corroborate this.
- All mandatory training was organised at the beginning of every year by the sisters of each of the children's services areas. Mandatory training included for example, moving and handling and resuscitation, which were completed every 12 months. Completion of training ranged between 77% for information governance on Rupert Bear Ward up to 96% for safety related subjects such as health and safety, fire and moving and handling. The target for such training was set at 90%.
- Mandatory training rates for paediatric medical staff were much less well achieved. For example, resuscitation had only been completed by 22% of medical staff, infection prevention and control (56%), and fire safety was also at 56% completion.

## Assessing and responding to patient risk

- Sick children were monitored for signs of deterioration through the use of a paediatric early warning score system (PEWS) to ensure their safety and well-being. The use of this paediatric early warning scoring system enabled staff to monitor a number of indicators that identified if a child's clinical condition was deteriorating and when a higher level of care was required. Staff we spoke to in theatre recovery and other parts of children's services were aware of the appropriate action to be taken if patients scored higher than expected, and patients who required close monitoring and action were identified and cared for appropriately in all areas of children's services.
- There was a process in place for referring children who were deteriorating via the South Thames Retrieval Service (STRS), and the Children's Acute Transport Service (CATS), which specialises in the inter-hospital transfer of critically ill children in South London. Children requiring intensive care management prior to retrieval were cared for by the anaesthetic team and transferred to the operating where they were held until the CATS team arrived.

# Services for children and young people

- Neonatal care for preterm and sick babies was organised into local areas around the country. Hospitals, and other NHS services for babies and their families, worked together in these areas, and are known as Neonatal Operational Delivery Network. A live patient management system was used by doctors and nurses to share knowledge and skills. We inspected the perinatal data base network and found it to be fully compatible with other similar services throughout England.
- Similarly there was a process for using the neonatal transport service, which was a dedicated service providing a specialist transfer team to retrieve sick infants requiring transport between the neonatal units within London. The SCBU was a Level II unit with capacity for four intensive cots, five high dependency cots and 15 special care cots.

## Nursing staffing

- There were 65.74 whole time equivalent (WTE) children's nurses employed within acute children's services and all members of the trained nursing team including the nurses working within recovery had attended the Paediatric Immediate Life Support (PILS) course. The paediatricians' had advanced paediatric life support training.
- Staff we interviewed told us that they did not use formal acuity tools to correlate patient dependency with staffing levels. Staffing levels were adjusted as required on a daily basis using bank nurses and when necessary agency nurses.
- Children were cared for by a contingent of fully trained and registered children's nurses on Dolphin Ward, paediatric recovery and Rupert Bear Ward.
- Infants on the special care baby unit were cared for by registered nurses who had undertaken post qualifying courses in neonatal care. We were informed however, that nurse staffing levels on special care was sub-optimum, but risk managed by NHS Professionals bank staff. The staff we interviewed told us that all bank nurses employed had been provided with induction and that many were actually current of former staff working additional shifts. We were informed by the sister of Dolphin Ward that there were 1.85 whole time equivalent (WTE) trained nurse vacancies. We were informed that these vacancies were being covered by bank staff and that agency staff were not used on Dolphin Ward.
- We inspected the nursing rosters and the general paediatric areas and the SCBU to assess if they met the Royal College of Nursing (RCN) guidelines, "Defining staffing levels for children and young people's services" (Registered nurses to sick children/infants requiring special care). The guidelines suggest staffing ratios of 1:4 and we examined the off duty rosters to confirm that these standards were being upheld. We examined the data on staffing levels for Rupert Bear Ward for both day and night for the months December 2015 through to May 2015 and this showed that variation ranged from 97% to 100% compliance, with one episode of 93% in April 2015
- We were told by the matron of children's services that two band six paediatric nurses were on long term sick leave from Rupert Bear Ward. The matron told us that agency nurses were used for three to four shifts per week.
- We found from information reviewed that a band 6 paediatric nurse was present for each shift on the wards that made up children's services, which was meeting RCN guidelines.
- The numbers of staff planned and actually on duty were displayed at the ward entrance in line with guidance contained in the Department of Health Document 'Hard Truths', which states that processes should be in place so that staffing establishments are met on a shift-by-shift basis.
- Play provision for sick children at the time of our visit was inadequate as children's services employed one play specialist to cover both Dolphin and Rupert Bear Ward. The play specialist was working on a phased return to work and we were informed by the matron that an advertisement for a further appointment of one WTE play specialist was to be posted in the near future. The risk was being managed through the use of three volunteer play helpers who had been screened by the hospital volunteer department for suitability to work with children.



# Services for children and young people

- Student nurses we spoke with told us that they felt well supported by their mentors and confirmed that the Nursing and Midwifery Council (NMC) rule, which stipulated that they must work with their mentor for 40% of the time spent on placement was fully met.
- We were told by the sister of Dolphin Ward that there were always two trained children's nurses allocated to the paediatric recovery. The recovery nurses we interviewed told us that they also recovered anaesthetised children who were sent to theatre from Rupert Bear Ward. The nurses we interviewed from Rupert Bear Ward confirmed this arrangement and we interviewed a young boy and his mother we had been transferred from Rupert Bear Ward prior to going to theatre and subsequent care in recovery.
- We attended nursing handovers in the special care baby unit and Rupert Bear Ward during which each infant and child was fully discussed. The nursing handovers were not multidisciplinary and primarily concentrated on the nursing management of each child and the plan of care for that day. Additionally we attended one medical handover, which was also a teaching handover for more junior medical staff. We were told that other ward rounds were multidisciplinary and would for example include the schoolteachers.

## Medical staffing

- The medical skill mix was made up of a larger percentage of registrars compared with the England average, meaning that there were less consultants at this location. Out of the total workforce of 43 whole time equivalent (WTE) children's service related medical staff, 21% were at consultant level, 10% at middle career level, that is at least three years at senior house officer or a higher grade. The registrar group made up 62% of the medical staff and junior, those in foundation years one and two, 7%.
- Children's services at Croydon employed four neonatal consultants, who delivered care to new-borns requiring special care during the day, but also covered neonatal and general paediatrics at nights and weekends.
- The consultants we interviewed told us that all consultants offered on call cover for both special care and general paediatrics. The consultants told us that they had aspirations to split the rota into a paediatric and neonatal roster but informed us that this was not currently possible because of the limited number of employed consultants.
- The consultant establishment for general paediatrics was five with one vacancy currently filled by a locum. The vacant post was focused on neurology/epilepsy, but was said to be proving difficult to recruit to because all consultants needed to possess neonatal skills to cover on call.
- Children's services were not fully compliant with the Royal College of Paediatrics and Child Health (RCPCH) Facing the Future criteria specifically with regard to patients being seen by a consultant within 24 hours of admission. This was sometimes a problem at weekends, as there was only one consultant on duty. Two consultants on duty each weekend would be necessary to fully meet the criteria. The consultants we spoke with assured us that the potential risk was well managed with the current rostering of consultants at weekends and that this was not a cause for concern.
- All acute paediatric areas in the UK were audited in 2013 by the RCPCH, but the results were anonymous. This data showed that over three quarters (77%) of children saw a paediatrician on middle or consultant grade rotas within four hours of admission, with just under a quarter who did not, and 88% of children or young people admitted to a paediatric department with an acute medical problem were seen by a consultant paediatrician (or equivalent) within the first 24 hours. Children's services at Croydon therefore lie in the lower quartile. Despite this the doctors we spoke to were confident that care delivery to children was safe.
- Doctors we spoke to told us that junior medical cover was satisfactory, with separate neonatal rotas 24/7 at both junior and middle grade. The doctors acknowledge that there were some gaps in the middle grade rotas because of maternity and sick leave, which were filled by locums, usually Croydon staff undertaking extra shifts or former trainees who were very keen to come back and work at the hospital. We were told that consultants rarely had to act down as registrars.



# Services for children and young people

- Doctors told us that medical cover was good with enough middle grades available at all times. Trainees told us that the consultants were fully involved in care delivery and would always come in for very sick babies.
- The RCPCH standard that at least one medical handover in every 24 hours is led by a paediatric consultant (or equivalent) was being met at Croydon and the paediatric medical handover we attended as part of the inspection was detailed and informative. The handover was attended by four consultants and eight trainees, plus a community nurse and the matron. The handover was preceded by a comprehensive teaching presentation from one of the trainees. A computerised handover sheet projected on to a media screen for all to see and this helped facilitate an accurate handover. All admissions and in-patients were presented by senior house officer, promoting high level discussion between the consultants pertinent to each child's management. We noted that there was appropriate awareness of safeguarding issues throughout the handover.

## Major incident awareness and training

- The trust had an overarching business continuity plan, which we viewed. This contained detailed information based on a three level approach; Gold, Silver and Bronze, which included responsiveness for the provision of paediatric functions. Staff we spoke with were familiar with major incident plans, including fire, winter and summer preparedness.
- Nurses and doctors we spoke to were highly aware of the major incident plans especially with regard to a potential Ebola Outbreak given the proximity of the hospital to the Home Office and Gatwick airport. Ebola preparedness had been communicated to staff via the intranet with frequent updates.

## Are services for children and young people effective?

Good



The trust utilised a range of policies and guidelines, which were based on national guidance. Auditing of compliance with national guidelines took place; where there was

identified poor compliance action plans were developed to address the shortfalls. There was good evidence of multi-disciplinary working and access to services to support the delivery of care.

Systems were in place to ensure that the clinical, psychosocial and general health needs of children could be met; this was delivered through a comprehensive assessment process, which was family centred. Children and young people had their pain assessed and managed appropriately.

Nutritional needs of children and young people were addressed. There was lack of provision of refrigerators for mothers to store expressed breast milk in some areas.

Staff looking after children and young people were suitably skilled and experienced. They had access to information to support their practice.

Consent for treatment and care was sought in accordance with professional guidance.

## Evidence-based care and treatment

- Staff we spoke with told us that evidence based practice (EBP) guidelines and protocols were available via the trust intranet and the trainee doctors we interviewed told us that the EBP and protocols and guidelines were easy to access. During the inspection we checked a sample of the protocols and confirmed that they were contemporary and up to date.
- The recovery nurses we interviewed told us that they followed protocols and for example, that they used the Great Ormond Street Hospital protocol for Magnetic Resonance Imaging (MRI).
- The service had participated in a full range of service delivery audits such as a Health and safety audit, which was conducted on Rupert Bear Ward in April 2014 scoring 100%. An audit of Croydon GP referrals to children's services was conducted in November 2014 and showed that GP's wanted a telephone advice line, an email advice system and a rapid assessment clinic, all of which were being considered at the time of our visit.
- The diabetes team, which provided care to 110 young people across Croydon aged 11 to 19 at any one time was audited in 2014 and configured as an external review of services for children with diabetes at Croydon Health Services. The audit showed that the trust

# Services for children and young people

provided excellent care. The review by the NHS England National Peer Review Team looked at the services the paediatric diabetes team was providing to young people and their families in the community as well as specifically looking at the support that was delivered within hospital. The review gave the service a 100% score for services in hospital and an 87.1% score across the service more widely and rated it as one of the best performing in South London. The service was described in the report as a 'cohesive team' that is 'patient focused'.

## Pain relief

- Children's services used a pain assessment scale, known as 'FLACC' Face, Legs, Activity, Cry, and Consolability. This was especially used in the recovery suite and subsequently post operatively within Dolphin Ward. Staff on Rupert Bear Ward used either a Wong smiley faces iconic Likert scale or FLACC to monitor pain. Parents we interviewed confirmed that staff frequently assessed their Child's level of pain and offered analgesia as appropriate and checked at intervals to ascertain the effectiveness of the medication.
- On Dolphin Ward we noted the staff used the hospital pain management protocol, and the protocol for the management of children recovering from post-operative tonsillectomy.
- Parents and children we spoke with told us that they receive the appropriate level of pain relief.
- The nursing staff we interviewed on Dolphin Ward told us that there was a good multidisciplinary team (MDT) approach to the management of child pain with good links to the Anaesthetic department. Trainee doctors told us that they had access to the hospital pain team and other pain management strategies form the Shared Care Oncology Outreach Team.
- We observed a consultant anaesthetist advising recovery nurses on the pain management of a post-operative child in recovery.
- Pain assessment scales were evident throughout children's services, with the special care baby unit having a sucrose protocol for neonatal discomfort.
- The play specialist and volunteer play workers and other care staff had access to a full range of diversionary play materials. "Starlight distraction boxes" containing diversionary toys were available on Dolphin Ward and Rupert Bear Ward.
- Topically applied local anaesthetic was applied routinely prior to cannulation and was used in conjunction with diversionary play.

## Nutrition and hydration

- The special care baby unit had level 2 United Nations International Children's Emergency Fund, (UNICEF) accredited baby friendly status and was seeking level 3 accreditation later in 2015. The UNICEF accreditation is designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways which will support optimum health and development. Stage 2 accreditation is achieved when a service demonstrates that all staff have been educated according to their role. The standards state that all health care staff must be trained to support a mother to express her breast milk for her baby. Breast feeding facilities on the special care unit were in place and staff members' were noted to be positive in helping and supporting breast feeding mothers.
- Breast milk storage on the special care baby unit met the Royal College of Nursing (RCN) Breastfeeding in children's wards and departments guidance for good practice. This entailed providing mothers who needed to express breast milk with a dedicated facility that was appropriately furnished with well-maintained and sterilised equipment for the safe expression and storage of breast milk. Fridges used to store expressed breast milk should be labelled as such and posters or advice leaflets on safe storage instructions provided. Fridges where expressed breast milk was stored needed to be appropriately secured to prevent unwarranted access. Although this standard was met within special care, this was not the case with Rupert Bear Ward, where no special refrigeration was available. There had been a dedicated fridge and staff told us this had broken down and had not been replaced. We were told by nursing staff that should the need arise that breast milk would be stored in the ward domestic refrigerator. We noted that temperature checks were made of the domestic fridge, ensuring that if it were to be used, it would be safe.
- The Children's ward menus were imaginatively designed, with a full choice of nourishing food and

# Services for children and young people

snacks being available. A range of ethnically diverse meals were accessible such as Halal meals. We observed these being prepared in the adjacent ward kitchen.

- We observed the ward nutrition hostess as they prepared the menu choices in the secure kitchen adjacent to Rupert Bear Ward. This was undertaken with full health and safety considerations including the use of microwave food thermometers.
- Mothers we spoke to told us that the food for children was good and that they were very happy with the specially designed and safe hot drinks dispenser on the ward for parents.

## Patient outcomes

- There were emergency readmissions after primary emergency admission at the service among patients in the under one age group between October 2013 and September 2014. However no treatment speciality reported six or more readmissions. There had not been any emergency readmissions for elective surgery cases.
- The trust rate of multiple emergency admissions for children aged one-17 years of age showed a higher than average readmission rate for Asthma and Epilepsy, compared to the England average. Multiple admission rates for children and young people aged one to 17 with Asthma was 18.7%, against an England average of 16.7% between July 2013 and June 2014. For patients with Epilepsy the multiple admission rates for individuals in age range of one year to 17 was 36.7% compared with 29.1% for the England average in the same period.
- Bed occupancy rates for paediatrics was reported to be 68% for April 2015 and 66% in May 2015.
- About 110 young people with Diabetes across Croydon aged eight to 19 received care from the children's services. The paediatric service provision for children with diabetes had expanded with a recently appointed consultant. A review carried out by the NHS England National Peer Review Team of this service in 2013 awarded it 100% for services in hospital and an 87.1% score across the service more widely.

## Competent staff

- The directorate report for children's services demonstrated that 100% of the medical staff had commenced the online appraisal service as part of the revalidation process. Children's services had an 81.6% appraisal compliance rate.
- Parents of children with sickle cell disease told us that the clinical nurse specialist for sickle cell disease was excellent.
- All staff working in paediatric wards had undertaken paediatric immediate life support courses (PILS) and had been annually updated. This allowed the nurses to provide care to seriously ill children or children in cardiac arrest until the arrival of a cardiac arrest team. Such children were relocated to a theatre anaesthetic room until retrieval was organized.
- The matron we interviewed informed us that all nurses working in the paediatric wards were qualified children's nurses.
- All recovery staff were trained children's nurses. The senior nurse of the special care baby unit informed us that 75% of staff had a neonatal nursing qualification.
- The matron of children's services held the budget for training and was supportive of post qualifying nurse education, which was offered primarily by a local university. Nursing staff had access to a full range of modules and courses. Specifically for example, nurses were sponsored to undertake study modules to acquire skills in neonatal nursing. The need for post qualifying education was identified at the annual performance reviews and prioritised according to need.
- The sister of Dolphin Ward had recently completed a funded five consecutive study day module in clinical leadership.
- Parents we spoke to told us that they had confidence in the staff caring for their children and babies with one mother stating that "Croydon had really improved over the years."
- The doctors we interviewed told us that children's services provided good training for medical trainees. We were told that there was significant competition among applicants for training places at Croydon.

# Services for children and young people

## Multidisciplinary working

- We observed good working relationships between all grades of staff and all professional disciplines working on the special care baby unit and the paediatric wards.
- We were told by the nurses we interviewed that there was good multidisciplinary team (MDT) working on the special care unit and that neonatal networks functioned well together with good relationships between the unit and the level three referral centres.
- The neonatologists we spoke with told us that there were good relationships with the tertiary neonatal centre and the neonatal transfer team.
- We noted during handovers that there was a high level of corporate working and team spirit.
- We were told by the play specialist and the hospital school teacher, that MDT working across the service was good with both feeling very much part of the team. The liaison health visitor we spoke to told us that she liaised with school nurses, and to help her monitor the health of looked after children. She had access to the community electronic records.
- Trainee doctors told us that they had good working relationships with the physiotherapy team.
- We were informed by a ward clerk who had been in post for many years that MDT working was good throughout children's services. Nurses told us that that team working was good across children's services and that they felt supported by their colleagues in the multidisciplinary team.

## Seven-day services

- Children's services including the special care baby unit operated across the week, with day care medical procedures and surgery coordinated Monday through to Friday with differing specialities on differing days.
- Children requiring surgery outside of normal operating hours were cared for on Rupert Bear Ward before going to surgery and then subsequent recovery on Dolphin Ward on the next available operating slot. Out of hours emergencies such as torsion of the testes were dealt with on a case by case basis and operated on any time.
- Children requiring intensive care management and ventilation were stabilized by the resuscitation team before being transferred to the anaesthetic department of the operating theatres prior to retrieval by the CATS team.

- There was access to out of hour's diagnostics and pharmacy, including on call provision.

## Access to information

- Staff had access to evidence base guidance, policies and procedures via the trust intranet.
- Patient care records and information relevant for patient treatment and care was readily available.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us how consent was obtained from parents and where appropriate from the child or young person concerned across children's services in the trust. The trust had robust policies pertaining to consent and we found that consent was obtained in line with trust policy and the principles of Gillick competency assessment. "Gillick Competence" refers to any child who is under the age of 16 who can consent, if he or she has reached a sufficient understanding and intelligence to be capable of making up their own mind on the matter requiring a decision".
- Student nurses we spoke with understood the difference between consent and assent in younger age children and the play specialist helped explain to children using hospital play equipment and in language they could understand what was going to happen to them during procedure. A parent told us that the nursing staff endeavoured to explain aspects of care to children with learning disabilities and we witnessed a nurse communicating effectively with a child with a moderate learning disability who had become distressed during a procedure.
- An eleven year old child who was waiting for surgery on Dolphin Ward told us "when they (the doctors) explain something to me, if I do not understand it they dumb it down for me so I do."
- The patient records we inspected confirmed that consent procedures were robust. The WHO safety checks prior to surgery included checking that consent had been obtained.
- Whilst mental capacity issues rarely applied, staff were aware of the need to follow age appropriate guidance for children above the age of 16 years of age.

**Are services for children and young people caring?**

# Services for children and young people

Good



Care was observed and said by parents to be delivered with kindness and compassion. Children were fully involved in their care and independence was encouraged. Age appropriate play therapy and schooling was provided.

Parental involvement of care was encouraged and children's services had a family centred care philosophy which extended across each area. Strategies were used by staff to ensure that children and young people had age appropriate support during the delivery of their treatment and care.

Parents and children were involved in planning their care and information was shared with them so they could be fully informed on what would happen to them. However, there was no literature written in child friendly format available to children and young people. There was access to specialist expertise to support the delivery of children and young people's care needs.

## Compassionate care

- We observed infants, children and families being looked after in a caring and compassionate manner. One parent we spoke with told us that they thought the hospital was a compassionate organisation. On the day of admission the same parent told us that all the staff throughout the hospital had been courteous and helpful.
- We observed that there was a family centred approach to the care of patients and their relatives, which extended to the anaesthetic department. For example, the anaesthetists encouraged a parent to come to the anaesthetic room and remain with their child until they had been anaesthetised. Children were returned to the recovery bay and when the child was fully conscious parents were allowed to sit with them until they were transferred back to the ward.
- The junior doctors and other staff such as student nurses we spoke to told us that there was significant emphasis on the six Cs which underpinned their practice. The Chief Nursing Officers' campaign to encourage compassionate care in English hospitals is based on '6 Cs' which are Care, Compassion, Competence, Communication, Courage and Commitment. Although the clinical areas of Rupert Bear

Ward and the SCBU were outdated and in need of refurbishment we observed that doctors and nurses maintained high levels of privacy and dignity using the ward bay curtains. Breast feeding mothers had access to private rooms to express their milk and resident parents had access to either bedside put you beds or private bedroom accommodation within the parent suite.

Despite the lack of space within these wards staff were noted to adhere to the principles of individualised care.

- Parents had access to a child safe hot drinks dispenser and the play support volunteers offered play provision either at the bedside or in the play room.
- Parents told us that the medical staff delivered high quality safe care with one mother saying "Don't believe in everything you read in the local newspapers, actually, I cannot fault the hospital." One child we spoke with who was waiting for surgery told us he felt very safe in the hospital.

## Understanding and involvement of patients and those close to them

- Children's services had developed child and young person friendly friends and family test (FFT) report cards. Feedback from families such as FFT results, thank you cards and direct communication was discussed at staff meetings to enable all staff to more fully engage with the patient journey through children's services. The sister of Dolphin Ward showed us the data from the previous months FFT which demonstrated that 97% of parents would recommend the ward.
- The parents we spoke with told us that the doctors and nurses kept them well informed with information about their babies and sick children. The parents of children with long term conditions felt that there was good engagement and access to leaflets within the clinical areas.
- We observed staff talking with parents and children, explaining their treatment and giving information about their child's progress.
- The parents of a baby being cared for in the special care baby unit told us that the doctors and nurses explained everything to them in language they could understand. This ethnic minority family told us they had full confidence in the nurses and doctors.

## Emotional support

- We observed all staff members interacting with children and their parents in a polite and friendly manner.



# Services for children and young people

- The hospital chaplain we spoke to told us that trust chaplaincy service was available to support families in need.
- We were told by a mother we interviewed that she had witnessed nurses interacting and communicating with a child with a learning disability to offer emotional support.
- Parents were offered facilities to stay with their children in hospital and could remain at all times to provide emotional support for children.
- The children's services school service offered significant levels of support to children in hospital especially during examination periods. All children irrespective of length of stay were enabled to attend their hospital school which was designated as a non-clinical safe environment.
- The liaison health visitor was available to support children who self-harmed. To help children cope emotionally with procedures and surgery child bravery stickers and cards were used.
- Staff working in children's services told us that they had access to clinical nurse specialists and child and adolescent mental health service support.

## Are services for children and young people responsive?

Good



The children's services within the trust met the needs of young patients, aged up to 17 years, their parents and carers. There was ready access to children's services via the children's emergency department or via a GP referral service offered there. There were formal arrangements in place for children to be transferred to other local hospitals if more complex in-patient care was required.

The care ambiance and décor across children's services with the exception of Dolphin Ward was found to be clean and bright but dated with some bays within Rupert Bear Ward not having access to television for the children.

Children scheduled for day care interventions on Dolphin Ward were invited to attend pre-assessment to facilitate them meeting with the play workers and the nursing team prior to admission. This provided an opportunity for children and their parents/carers to ask any questions.

The hospital school provided on-going educational opportunities for children admitted to hospital and was fully equipped with networked computer facilities to prevent children falling behind with their school work during a period of admission.

There were close working arrangements with community based services, which ensured that children could expect to be cared for at home via community nursing services following admission. The children's nurses worked closely with the Children's Hospital at Home Team which was an integrated team of community children's nurses, drama therapists, nursery nurses. They provided a service for children at home with additional health needs, including acute nursing care to reduce the need for hospital readmission. This team worked seamlessly with the acute services team to support early discharge for appropriate children.

## Service planning and delivery to meet the needs of local people

- Services for babies and children in the trust had been developed to work in conjunction with adjacent larger local children's and neonatal services in other hospitals.
- Children and young people's services included a range of specialist support to meet the needs of the local population. This included: diabetes; adolescent medicine, nephrology, infectious diseases, cardiology, child development, sickle cell disease, haemoglobinopathies, neurology, oncology and respiratory disorders. Additionally Croydon had links to gastroenterology services at other regional hospitals.
- Children's services had short waiting list times. The consultant of the week was readily available to discuss referrals for outpatient or inpatient care with local primary care physicians.

## Access and flow

- Patient flow and bed occupancy was orientated to local demand for paediatric services from local primary care physicians and the dedicated paediatric emergency department, which also hosted an in house GP service for children requiring assessment. The children's



# Services for children and young people

services division catered for the needs of the local paediatrics population through the provision of clinics at Croydon University Hospital, New Addington and Purley.

- Doctors and nurses we interviewed told us that discharges were managed effectively with the assistance of the Children's Hospital at Home Team.
- Information provided to us in advance of our inspection indicated that the median length of stay was in line with the England average for both elective and non-elective admissions where children were under one year of age, and for elective admissions for those aged one to 17. However, the trust had a shorter median length of stay for non-elective admissions in children and young people aged one to 17.
- There were arrangements in place for the transfer of critically ill children to specialist centres in London via the CATS retrieval service. We were told by doctors and nurses that these arrangements worked well and policies for the transfer of patients could be accessed electronically.
- The Dolphin day unit had dedicated post-operative area and recovery areas for children.
- Parents were encouraged to remain with their children whenever possible and were offered accommodation in the parent accommodation suite adjacent to Rupert Bear Ward or via put you up beds within the ward bays.
- Parents of children attending for day care accompanied their child to the anaesthetic room for surgery. The children were able to drive themselves to the anaesthetic room on motorised toy tricycles, which made the experience a pleasant adventure for the children. As soon as the child had recovered consciousness parent were allowed into recovery to stay with their children until the child was able to return to their bed in Dolphin Ward.
- Although the ambiance of care in some parts of children's services was dated we observed that the main corridor leading to the day unit was very child friendly with a range of paintings lining the walls. These were painted and donated by the children of a local Primary School in 2013.

## Meeting people's individual needs

- We saw that there were a number of poster and information leaflets for families around the various areas of children's services. We noted a range of specific leaflets for families throughout children's services. For example on the special care baby unit there were a range of specific leaflets for new mothers.
- Whilst the trust reported to us that they used a wide variety of books and leaflets from official organisations and the website provided access to a range downloadable leaflets and details about the services they provided, we did not see any leaflets specifically written for young children who were having surgery.
- Although the children's ward was old the school was very well equipped with net worked computers and books. School teachers were able to liaise directly with individual children's own teachers.
- The Child and adolescent Mental Health Service (CAMHS) liaised with Rupert Bear Ward on a daily basis to ascertain if there were any children with mental health issues. Child and Adolescent Mental Health Service could be accessed 24 hours a day.
- As part of the chief executives "let's do it campaign" the staff of Rupert Bear Ward designed and produced a comprehensive welcome pack for families admitted to the ward.
- We found that parents were enabled to stay with their child whilst in hospital. A mother we spoke with on Rupert Bear Ward had a new "put u up bed" by the side of her son's bed. These new beds had been funded through the "let's do it" initiative.
- Play specialist support was found to be risk managed through the use of play volunteers. A play specialist position was to be advertised later in 2015.
- Mothers we spoke to told us that the food for children was good and that they were very happy with the specially designed and safe hot drinks dispenser on the ward for parents.
- Staff we spoke with including doctors told us that access to interpreters face to face or via phone was always available to children and their families.

## Learning from complaints and concerns

- Learning from complaints was shared via team meetings with staff receiving feedback from the Patient Advice and Liaison Service (PALS).

# Services for children and young people

- We were told by the Patient Advice and Liaison Service (PALS) team that there were low levels of complaints and when we inspected the data base of PALS incidents for the year 2014/15, the majority of complaints were minor in nature and mainly pertained to minor problems with scheduled outpatient appointments. There were very few formal complaints received which related to the care of children. Nursing staff we spoke with confirmed that complaints were reviewed as part of the divisional governance procedures.
- We were told that feedback from parents was generally good although the parent accommodation was less than optimum and in need of complete overhaul. This had been recognised and plans were being formulated for refurbishment.

## Are services for children and young people well-led?

Good



There were systems in place to ensure good governance and monitoring of standards for children, young people and infants who required acute medical care and surgical intervention and investigations.

Staff were proud to work for the trust and it was clear from speaking to parents that the public perception of the trust since its name change had improved.

Staff were aligned to, and supported the trust wide vision of providing safe, clean and personal care. Leadership of individual aspects of children's services was good with staff speaking positively about their immediate team leaders. The aspirations of the chief executive and his management team were fully supported by the staff.

### Vision and strategy for this service

- Staff spoke positively about providing high quality care that was aligned to the trust-wide vision of ensuring that patients received safe, clean and personal care. Staff members were aware of the trust wide quality improvement strategy and were able to describe the shared vision for the trust of the chief executive and the management team.
- We identified that there was an all-encompassing vision and strategy, which was attributed to the overall

provision of children's services at the trust. This encapsulated special care baby provision, acute care provision, day care, outpatients and community paediatric services.

- We were told that the strategy had included presentation on several occasions for a new paediatric assessment unit, but no funds were available to develop the service at the time. Notwithstanding this the trust's vision of delivering excellent integrated care for users of children's services when and where it was needed was fully embedded within the staff culture and the nurses and doctors we spoke with were proud of the key achievements of the trust in recent years which included a 85% reduction in hospital acquired *Clostridium difficile* infections in the past four years.
- The senior nurses we spoke with told us that Chief Executive Officer (CEO) had developed an effective communication strategy. The CEO held an open focus group meeting on the first Thursday of every month and the staff we spoke to believe that this was a very good way of finding pertinent information about the trust. Staff valued the quarterly "Listening in Action" group meetings and perceived them to be a good way of promoting better outcomes within the trust.

### Governance, risk management and quality measurement

- There were arrangements in place for governance, risk management and quality measurement associated with the care of children and infants across the trust. We found that the arrangements enabled them to measure the quality of the services they provided, as well as having appropriate governance systems in place.
- Doctors and other health care professionals we spoke with told us that the weekly serious incident meetings across children's services were an effective strategy to escalate risks where required. These meetings and the associated quality board meetings facilitated monitoring of action plans and to consider and reflect on situations when the delivery of care had not gone according to plan. These meetings allowed staff to learn from incidents and to consider and implement any actions that may have needed to be taken. Additionally these meetings considered reviews of policies, medical pathways, reviews of existing and new risks, safeguarding concerns and financial and human resource performance.

# Services for children and young people

- Children's services within the trust had 51 risks on its risk register with action plans and controls in place to reduce risks. We spoke to various members of staff who were conscious of the risk register and the actions plans that had been put in place. One of the most important aspects was the identification that the current inpatient children's ward, Rupert Bear was no longer fit for purpose and a plan had been formulated to decant the current ward to another more suitable location prior to a complete rebuild.
- Staff and parents we spoke with told us that the trust culture was on an upward trajectory where a patient centred philosophy prevailed. One of the ward sisters told us "we are a motivated team". We observed this was evident in the large number of suggested changes for patient care improvement, which the nursing staff has made under the chief executive's "let's do it campaign." One outcome from this had been the purchase new "put you up beds" for parents wishing to stay with their sick children.

## Leadership of service

- Staff working with children on a daily basis told us that that day-to-day clinical leadership was good and that they received support from their immediate line managers. We observed ward managers greeting newly allocated student nurses from the local university making them feel welcome and supported.
- The matron of children's services and the matron for the children's emergency department had a close and mutually supportive relationship geared to improving the care of family service users. The staff nurses we spoke to on Rupert Bear Ward told us that the matron had an open policy regarding whistle blowing and that she had good leadership qualities. Final year student nurses we spoke to told us how supportive the matron of children's services was to them and how much they had learned from their placement allocation.
- The middle grade and junior doctors we spoke with told us that they felt very well supported by the cadre of consultants.
- The play specialist told us that sisters and matron were effective leaders. She was particularly supportive of the CEO'S 'Let's Do It' initiative, which offered the chance of winning a £1000 to improve patient services, and we saw examples of how the "Let's Do it" initiative had made improvements to children's services, such as the purchase of new parent put you up beds.

## Culture within the service

- Most staff that we spoke with told us the trust was a good place to work with many of them having worked there for many years. Staffs was confident in being able to raise concerns and felt comfortable with the transparency and openness culture being promoted by the CEO and his senior management team.

## Public and staff engagement

- Staff engagement was facilitated through regular forums with the CEO and his team, which were held on the first Thursday of every month. The "let's do it campaign" had been launched by the CEO to foster innovation in care delivery predicated on the opportunity for wards to win £1000 to improve their service delivery.
- Public engagement with children, young people and their families was still at an early stage of development and had been used for example to help in the design and décor of Dolphin ward.
- Staff we spoke to confirmed that a "15 step challenge" and "You're welcome audit had not been undertaken. The 15 Steps Challenge is a tool to help staff, patients and others to work together to identify improvements that will enhance the patient experience and was part of The NHS Institute for Innovation and Improvement's productive ward series. You're Welcome quality criteria: making health services young people friendly, guidance was produced by the DH to enable hospitals to assess how young person friendly they are.







## Innovation, improvement and sustainability

- Sustainability in driving the culture forward within the trust was evident in the openness of the way in which complaints were dealt with on the trust web pages. Feedback forms for families to complete about their experience of the hospital were available via the trust web pages in addition to the paper hard copies of the friends and family test cards..
- As a university hospital Croydon Hospital were participating in patient centred research designed to improve health outcomes e.g. Developing and evaluating interventions for adolescents with alcohol use disorders who present through Emergency Departments: Randomised feasibility study and

# Services for children and young people

Exploratory RCT and a multicentre randomised placebo controlled trial of prophylactic enteral lactoferrin supplementation to prevent late onset invasive infection in very preterm infants.

# End of life care

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

## Information about the service

The Croydon Health Services NHS Trust has a specialist palliative care (SPC) that comprises of one part-time consultant, three full-time and three part-time clinical nurse specialists (CNS), one of whom has responsibility for end of life care (EoLC) and a full time dedicated social worker. The hospital chaplain is the spiritual care lead for EoLC.

Between April 2014 and February 2015 708 referrals were made to the SPC team, and 70% of patients were seen within 24hrs of referral from the admitting team.

During our visit to the hospital, we spoke with members of the SPC team, a bereavement officer, staff at the cancer office, an organ donation clinical nurse specialist (CNS), porters, mortuary staff, the chaplain and ward staff.

We visited a variety of wards across the trust including: the intensive care unit (ICU); Duppas 1; Edgecombe 1, Fairfield 1, Heathfield 2, Purley 1, Purley 2, Queens 2; Wandle 1; and Wandle 2.

We reviewed the medical records of eight patients who were receiving end of life care and observed the care provided by medical and nursing staff on the wards. We spoke with eight patients receiving end of life care and two visiting relatives. We received comments from our public listening event and from people who contacted us separately to tell us about their experiences. We reviewed other performance information held about the trust.

## Summary of findings

Many aspects of the care provided to patients was safe. There were systems to ensure an appropriate review or investigation and lessons learned were communicated widely to support improvement across the trust. Openness and transparency was encouraged and staff understood their responsibilities to raise concerns and report and near misses.

Risks to patients were assessed, monitored and managed on a day-to-day basis. However, we found issues with the consistency of staff recording 'do not attempt cardiopulmonary resuscitation' (DNA CPR) form on the trust's electronic patient records (EPR). Some staff were also unable to open the DNA CPR records on patient's EPR.

There were clearly defined and embedded systems, processes and procedures to keep patients safe and safeguarded from abuse.

The current staffing levels did not allow the SPC team to provide a seven day service the SPC teams but were kept under review and any staff shortages were responded to quickly and adequately. There were effective handovers and shift changes, to ensure staff could manage risks to patients receiving EoLC.

Although many aspects of patient care was delivered in line with current evidence-based guidance, standards, best practice and legislation recording of DNACPR discussions and decisions was not always in line with trust policy.

# End of life care

We saw evidence that systems were in place for the referral of EoLC and palliative care patients to the SPC team for assessment, review and the ongoing management of their care. This ensured that patients received appropriate care and support with up to date symptom control advice for adults with advanced, progressive and incurable illness in their last year of life.

The SPC team supported and provided evidence-based advice and training to other health and social care professionals. Ward staff told us the SPC team were highly regarded across the trust. Between April 2014 and February 2015 708 referrals were made to the SPC team, and 70% of patients were seen within 24hrs of referral from the admitting team.

The trust's 'care of the dying person' care planning was based on the document published by the Leadership Alliance for the care of dying people, 'One Chance to Get it Right'.

Information about patient's care and treatment, and their outcomes, was routinely collected and monitored. This information was used to improve EoLC.

There was participation in relevant local and national audits. Outcomes were used to improve patients care and treatment.

End of life care patients were supported, treated with dignity and respect, and were involved as partners in their care. Patients and relatives were encouraged to make decisions, and were supported to do so.

Staff helped patients and those close to them to cope emotionally with their care and treatment. Patients were supported to maintain and develop their relationships with their families, social networks and community.

Work was in progress for EoLC services to be planned and delivered in a way that met the needs of local people. There was an EoLC steering group with a non executive director as a member. The EoLC strategy had recently been developed and was not embedded.

The leadership, governance and culture in EoLC services promoted the delivery of person-centred care.

There was a clear statement of vision and values for EoLC, driven by quality and safety. The vision, values

and strategy had been developed through a structured planning process with regular engagement from internal and external stakeholders at 'Listening into Action', (LiA) events, which included patients and staff.

EoLC strategic objectives were supported by measurable outcomes, which were cascaded throughout the organisation. The challenges to achieving the strategy, including seven day working, were understood and an action plan was in place.

The board and other levels of governance within the hospital functioned effectively in regards to EoLC. Structures, processes and systems of accountability were clearly set out, understood and effective.



# End of life care

## Are end of life care services safe?

Requires improvement



Staffing levels and skill mix were planned, implemented and reviewed to keep patients' safe at all times. Any staff shortages were responded to quickly. However, the part-time consultant cover did not reflect national recommendations.

Risks to patients were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health and medical emergencies. Patients were involved in managing risks and risk assessments were person-centred, proportionate and reviewed daily. Staff recognised and responded appropriately to changes in risks to patients receiving end of life care (EoLC).

However, we found issues with the trust's electronic patient records (EPR). Some staff were unable to open the Do Not Attempt Cardio Pulmonary Resuscitation (DNA CPR) records on patient's EPR.

The trust was reviewing and monitoring DNA CPR practice across the wards. However, these reviews were not always sufficiently thorough or did not include all relevant people. Necessary improvements had not always been made when staff experienced problems accessing DNA CPR information on EPR.

EPR systems were not always reliable or appropriate to keep people safe. Monitoring whether safety systems were implemented was not robust. There were some concerns about the consistency of understanding and the number of staff who were aware of them.

Risks to safety from service developments, anticipated changes in demand and disruption were assessed, planned for and managed effectively. Plans were in place to respond to emergencies and major situations.

### Incidents

- The palliative care team reported that there had been no serious incidents or never events requiring investigation in the 12 months prior to our inspection.
- Staff from the palliative care team understood their responsibility to raise concerns, and record incidents on the trust's electronic incident reporting system.

- Staff confirmed they received feedback on incidents that took place in other areas of the hospital as well as their own. Staff and managers we spoke with told us they were satisfied there was a culture of reporting incidents promptly.
- The SPC team had not had any reported incidents in the previous 12 months. Staff on the SPC team explained in the event of an incident requiring investigation a root cause analysis (RCA) would be completed. RCA's would identify learning from incidents; and lessons learned from incidents would be shared across teams. An action plan would be developed as a result of RCA's. We did not view any RCA's as none had been required in the 12 months prior to our inspection.
- There had been no serious incidents reported from the CUH wards in regards to EoLC in the previous 12 months.
- On Wandle 2 Ward, a band 7 nurse told us that incidents were reported to the matron and entered on the electronic reporting system. Staff across all the wards we visited told us there had been no incidents involving palliative care patients in the previous 12 months.
- A standard agenda was used for SPC team meetings. Incidents were a standard item on the agenda. Staff on the SPC team told us incidents would be discussed and disseminated to staff at team meetings and learning would be shared across the trust where applicable.
- Staff on Wandle 2 Ward told us safety alerts were sent to clinical leads by email and displayed on the trust's intranet. The alerts were reviewed by clinical leads for their relevance and disseminated to staff by email or discussed at team meetings.
- The SPC team told us that EoLC practice on the wards was safe and effective.
- We visited the mortuary where the mortuary manager told us there had been no serious incidents in the mortuary service in the previous 12 months. Mortuary staff understood their responsibility to raise concerns, and record incidents on the electronic incident reporting system.

### Cleanliness, infection control and hygiene

- We saw that the mortuary viewing area and wards we visited were clean and well maintained. In all the patient areas, the surfaces and floors were covered in easy-to-clean materials, which allowed high levels of hygiene to be maintained.

# End of life care

- We saw that personal protective equipment (PPE) was available for use by staff in all clinical areas and wards. All the ward areas we visited were clean and free from clutter. We saw housekeeping staff cleaning on the wards and departments throughout our visit.
- We saw staff on Wandle 1 Ward regularly washing their hands between treating patients. Hand washing facilities and hand sanitising gels were readily available. Staff wore clean uniforms with arms 'bare below the elbow'. A band 7 nurse told us they actively challenged anyone who did not follow this policy in the clinical area. The nurse said a programme of training and assessment was in place for 'aseptic no touch technique'.
- The importance of all visitors cleaning their hands was publicised and we observed visitors using hand gels.
- We viewed cleaning records at the mortuary and these were up to date. The mortuary had an infection control policy in place for deceased patients with infectious diseases.

## Environment and equipment

- Staff we spoke with in the SPC team and on the hospital wards we visited told us there were sufficient amounts of equipment, including syringe drivers and mattresses. Work was in progress on an audit of the hospital's syringe drivers at the time of our visit.
- Maintenance and procurement of replacement equipment was planned by the trust's equipment services team. The equipment services team was responsible for the maintenance and servicing of equipment; and updating medical device registers.
- Medical device registers were monitored by the equipment services team. The device register indicated the date equipment was due for service; as well as the date of electrical testing for electronic devices. We saw that devices had been serviced in accordance with the registered date for servicing.
- Equipment was checked by the equipment services team when it was sent out and checked again on return to ensure equipment was fit for purpose and any repairs were timely.
- The equipment service team were responsible for all trolleys except the mortuary concealment trolley, which was the responsibility of the mortuary service. We viewed the concealment trolley used by the mortuary service and saw it had been repaired using insulating tape. Porters we spoke with told us they usually

borrowed a concealment trolley from the emergency department, as the mortuary service's trolley did not promote deceased patients dignity. However, records we viewed demonstrated that work was in progress for the mortuary service to purchase a replacement concealment trolley.

- We were told by staff that the concealment trolley in emergency department would be used to transport bariatric, (obese), patients. Wheelchairs and trolleys were available to transport bariatric patients around the hospital.
- Equipment was provided out of hours (OOH) by the equipment library for the hospital.

## Medicines

- We saw that wards had been issued with the south west London palliative adult network guidelines 2011. The guidelines clearly set out the symptoms experienced at end of life and the medication required to manage symptoms effectively in easy-to-follow charts. Staff we spoke to were able to show us copies of the guidelines.
- The SPC team audited the clinical protocols for the prescription of medications for the five key symptoms at the end of life in 2014. As a result of the audit the SPC team had designed a new order set for the trust's new electronic patient record system to aid prescribing. The new order set was in use at the time of our visit. The team had also provided medical staff with training in using the order set.
- The order set for end of life symptom control prescribing had been developed by the SPC team in conjunction with the pharmacy team at CUH. This ensured minimal delays for patients if they became symptomatic and ensured medicines could be administered promptly. The SPC team said the order set had received positive feedback from the junior medical team.
- A band 7 nurse on Wandle 2 Ward who was an electronic patient record (EPR) champion demonstrated how the system was used for patients who had been prescribed anticipatory medicines. Anticipatory medicines in a palliative setting are those drugs that are prescribed for use on an 'as required' basis to manage common symptoms that can occur at the end of life. The EPR medicines tab had a section marked "future" medicines to enable staff to identify anticipatory medicines quickly and easily.
- The EoLC medication order set of PRN medications was included on patients records.

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- We were told by the ward managers on Fairfield 1 and Wandle 1 wards that medicines for EoLC were available on the wards and were easily accessible. The ward manager on Wandle 1 Ward was confident in the ability of the nursing staff to care well for EoLC patients with syringe drivers.
- On both Fairfield 1 and Wandle 2 wards we found that access to controlled drugs (CD's) was restricted to appropriate designated staff and CD's were secured inside a double locked cupboard. Medicines requiring refrigeration were stored in a lockable fridge. On both wards, a compliant CD register was in place. This was a bonded book used to record CD medicines. We found no discrepancies between the stock, controlled drugs in the cupboard, and the CD register.
- Out-of-hours (OOH's) medication was available on all wards that offered EoLC, to ensure continuity of patients care.
- We observed palliative care team staff completing and updating patients' records. All the patients' daily records we viewed were up to date.
- We noted that on Wandle 2 and Duppas 1 wards both medical and nursing staff were unable to open patients DNA CPR records on the EPR system, even though the front page of the patients records indicated that a DNA CPR decision had been made. Staff told us DNA CPR information had only recently been added to the EPR system and some staff were experiencing difficulties accessing the DNA CPR record.
- We spoke with an EPR champion on Wandle 1 ward. EPR champions were members of staff teams who had been trained to support the staff in their teams to use the EPR system. They were identifiable on the wards due to wearing orange tabards. The EPR champion told us staff had been trained on EPR and should know who to approach for support if they experienced difficulties accessing the system. The EPR champion told us that staff being unable to open a DNA CPR record should not be an issue as each team had an EPR champion who could offer support to access patients DNA CPR records.

## Records

- The EoLC electronic records system had been designed to comply with NHS Improving Quality's Transforming End of Life Care in Acute Hospitals, 2012 even though the SPC team told us they were not part of the programme. The SPC team informed us that they hadn't joined the programme because they were already delivering the components of the '5 priorities for care of the dying person' as set out in the programme.
- The trust's EPR system 'care for the dying person' care plan allowed staff across the trust to access the wishes and preferences of EoLC patients.
- Referrals to the hospital palliative care team were received verbally, face to face, by phone or by fax notification from the community palliative care team that a patient known to community services had been admitted to the hospital. A member of staff on Wandle 2 ward demonstrated how staff in the hospital could access the fax referral template.
- We reviewed eight electronic patient records during our inspection and found patients had individualised initial assessments, risk assessments, care plans, reviews and consent documentation. We found these were completed appropriately.
- Patients' records recorded referrals to the SPC team, and indicated they were receiving end of life care. Patients' care records had the facility to record when relatives had been informed of a patient entering the dying phase.
- During our review of patient records we found some DNA CPR records where information on DNA CPR decisions had not been fully transferred from paper based records onto the EPR. This meant that staff would need to refer to the paper copy to see patients' decisions and this created additional work for staff.
- The trust reviewed patients DNA CPR in January 2015 to check whether these were being completed appropriately. In total 17 forms were examined and various issues were identified with regard to completeness by medical staff. As a result of the audit the trust had implemented an action plan. This included a DNA CPR audit report using the electronic patient record to be completed annually, and a quarterly DNA CPR documentation review to be presented at the Trusts Resuscitation and Deteriorating Patient Committee.
- Nurses were asked if they were aware of which patients they were looking after had DNA CPR and 94% of them were aware.
- The mortuary manager told us that effective systems were in place to log patients into the mortuary. We were walked through the process by the mortuary assistant

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and were shown the ledger book that contained the required information. We observed that the book was completed neatly and appropriately; details about patients were recorded in a respectful way.

- Staff told us that they would follow the trust's policy on retention of hospital records in regards to managing patients' notes after death.

## Safeguarding

- A social worker was a member of the SPC multidisciplinary team. Staff told us the social worker was always available to provide the team with advice and support in regards to safeguarding.
- Staff we spoke with on the SPC team were able to describe the categories of abuse and how they would report potential safeguarding issues. Staff told us safeguarding issues were reported to the trust's safeguarding lead for further investigation. Learning from safeguarding investigations was shared at team meetings and across services where appropriate.
- The trust had an up to date safeguarding policy. Staff were able to explain their understanding of the policy and how they used this as part of their practice.
- Patients we spoke with told us they felt safe and expressed confidence in the staff that worked with them.
- Porters told us level one safeguarding training was mandatory. We viewed the training record for porters and found that most porters safeguarding training was up to date. Those who had not updated their training had dates to attend training.
- Mortuary staff and staff at the bereavement office received level 1 safeguarding training. Training records we viewed demonstrated this was up to date.
- The trust's website included contact details for the safeguarding adults unit and safeguarding advice for patients and carers. Safeguarding information leaflets for patients and visitors were available in various sites across the hospital.

## Mandatory training

- Mandatory training included equality, diversity and human rights; health and safety; infection prevention and control; information governance; and safeguarding training. Staff we spoke with on the wards confirmed that they were up to date with mandatory training, or had dates to attend scheduled training. The SPC team had 100% compliance with mandatory training.

- Staff told us work was in progress to make education and training in care of the dying mandatory for junior doctors and nursing staff caring for EoLC patients.
- All the wards we visited displayed information about training for staff in staff areas.
- Advance care planning is a means of improving care for people nearing the end of life and of enabling better planning and provision of care, to help them live and die in the place and the manner of their choosing.

Advanced care planning training was not mandatory for CNS's on the SPC team. However, 100% of staff on the SPC team had received training in Advanced care planning.

- The SPC team provided an education programme for palliative care to healthcare staff. This included an education programme for medical staff; as well as the EoLC components of staff training courses. The training included: nursing induction; monthly clinical updates for nursing staff; discharge planning study days; and ward based training for ward staff.
- Training took place on a day-to-day basis informally on the wards. The SPC team also offered informal training when liaising with junior medical and nursing staff involved in the care of patients who had been referred to the SPC team.
- EoLC training provided by the SPC team at the trust included general palliative care and some specific nurse training to enable staff to correctly assess patients and use equipment such as syringe drivers. Senior nursing staff on Queens 2 Ward, and junior nursing staff on Fairfield 1 Ward told us they had received training from the SPC team on syringe drivers. A band 5 nurse said if a member of staff didn't feel confident in using syringe drivers they could contact the SPC team for guidance. The nurse added the SPC team responded quickly to requests for support. Ward staff we spoke with confirmed they received annual training updates from the SPC team.
- Ward staff spoke highly about the training provided by the SPC team, and said this was invaluable to staff on the wards in providing appropriate EoLC to patients. The SPC team told us they were pro-active in providing EoLC and would provide this ad hoc to ward staff upon request
- We spoke with a band 7 organ donation nurse specialist who was visiting the intensive care unit (ICU). They told us training in organ donation was not mandatory; but was provided to all medical and nursing

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staff in the Emergency Department (ED) and ICU. A band 7 nurse in ED and the matron of the ICU confirmed that all ED and ICU staff had received training in organ donation.

## Assessing and responding to patient risk

- The trust withdrew the Liverpool Care Pathway (LCP) from clinical practice in July 2014, following the recommendations made in the publication: 'Independent Review of the Liverpool Care Pathway'. In its place the trust introduced a 'care of the dying person' care plan. Nursing and medical staff we spoke with on the wards told us that following the withdrawal of the LCP staff had been encouraged to refer all patients who may be approaching the end of their life to the SPC team.
  - The SPC team had adopted the '5 priorities of care for the dying person' and had developed 'care for the dying person' care plans for the nursing and medical teams to use on the electronic patient record. The 'care for the dying person' care plan focused on encouraging staff, patients and families to continue with treatment in the hope of recovery, while talking openly about people's wishes and putting plans in place should the worst happen.
  - We saw that patients assessment and planning records were based upon the '5 priorities of care for the dying person'. Patients had individualised multi-disciplinary initial needs assessments. This included space to record recognition that the patient was dying; and recorded conversations with patients and families about this.
  - The care plans covered the control of symptoms including nutrition and hydration, prescribed EoLC medicines, patients preferred place of care, whether there were any concerns from professionals or relatives in regards to patients care and the support patients required in regards to their social, psychological or spiritual needs. We viewed eight patients 'care of the dying person' care plans and saw these had been reviewed on a daily basis by the SPC team and were up to date.
  - Staff at the SPC team told us that where a patient appeared to be deteriorating the team would work with ward staff to establish the cause of deterioration and its relevance to their EoLC diagnosis. Staff said they would speak with the family and discuss any planning needs the patient had, including their preferred place of care.
  - We spoke to staff on the critical care unit. They told us that when a patient was deteriorating the team would undertake a physical assessment, liaise with the SPC team and develop a clear management plan in partnership with the patient's family. If a patient was dying the critical care unit (CCU) team told us they would deliver the appropriate care, talk to the patient and their family, and refer the patient to the SPC team. Patients would always continue to receive treatment until EoLC decisions were made. The CCU staff told us the SPC team would liaise with community teams if the patient was being discharged to their preferred place of care.
  - All the staff we asked told us they would liaise with mental health services if a patient had needs that were subject to the Mental Health Act 2005.
  - The trust didn't have an EoLC care risk register. The EoLC risk register was incorporated into the directorate risk register for cancer and diagnostics. Following our inspection the trust forwarded a copy of the cancer and diagnostics risk register dated 30 June 2015. We saw that the risk register had one identified risk for EoLC which was a lack of seven day working. There was an action plan in place to address the risk. This recorded the trust's target to provide seven day services within 12 months and on-call consultants would provide seven day out of hours (OOH's) emergency cover in the interim.
  - The SPC team operational policy stated all patients referred to the team would be seen within five working days. An audit of SPC referral times found that 68% of EoLC referrals in the year 2014-2015 were seen within 24 hours of admission, and 98% of all referrals were seen within the timescales set out in the policy.
  - The SPC team held regular handover meetings. We attended an SPC team handover and observed new patient referrals and existing patients care and treatment being discussed. The team's social worker attended handover meetings to discuss and update the team's clinical staff about patients social care needs. Staff on Duppas 1, Fairfield 1, Heathfield 2, and Wandle 1 wards told us they always discussed the needs of patients who were receiving palliative care at ward handovers.
- ## Nursing staffing
- The SPC team had 4.7 whole time equivalent (WTE) clinical nurse specialists (CNS's).



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- The trust informed us that in the community EoLC CNSs were provided by St Christopher's hospice with which the trust had close links.
- The SPC team staff informed us that nursing staffing levels in the team were sufficient for current contact and activity levels but not to provide a seven day service.
- We reviewed the SPC team's paper based rostering tool. The tool was used to achieve required staffing levels, whilst reflecting the team's skills mix and the complexity of patients' needs. The tool ensured patient safety was not compromised. Staff explained how the rostering tool was used to plan staff cover arrangements in the event of staff being absent. The team leader told us that CNS staff in the team were flexible in covering staff absence. The SPC team did not use agency, bank or locum staff, due to the high level of specialist skills required in the team.
- Staff at the SPC team told us they did not always feel there was sufficient staffing on the wards for EoLC. But, added that nursing staffing levels at the hospital had improved over the past 18 months.
- Each ward had a ward sister who was the nominated lead for EoLC. Staff at the SPC team told us they did a lot of joint working with ward staff and knew the staff on the wards well. The SPC team said they didn't assume that staff on the wards had the same skill set as the CNS's from the SPC team, and said they offered support to ward staff in regards to EoLC skills. The SPC team said generally ward staff were very responsive to advice and guidance and were quick to learn from and implement advice.

## Medical staffing

- The SPC team had one part-time palliative care consultant who worked 0.5 WTE. Staff told us no formal assessment had been undertaken of the consultant's responsibilities and whether 2.5 days per week was sufficient for the size of the hospital. However, the trust informed us that the consultant's hours had been planned in line with the trust's job planning process. For the other 2.5 days of the week the consultant provided cover by telephone, whilst working off-site at St Christopher's Hospice. The consultant told us they would visit EoLC patients in CUH if clinically required if they were working at the hospice. However, the

- consultant staffing levels were not commensurate with the 'Commissioning Guidance for Specialist Palliative Care 2012'. This recommends that there should be 2 WTE consultants in EoLC per 250,000 population.
- Some of the SPC team staff told us the team needed increased consultant cover. Some staff on the SPC team told us that the 0.5 WTE consultant working hours placed pressure on the team in completing comprehensive audits and reports. Some of the team said it was the consultant regularly working more hours than they were contracted to work that ensured audits and reports were completed.
- The trust had a contract with St Christopher's Hospice to provide cover for the SPC team consultant in the event of the consultant being absent due to holiday or sickness. Staff told us that consultants from the hospice were familiar with the trust's system and the SPC team's practices. On call palliative care consultants at the nearby hospice would provide medical advice via telephone, or visits if clinically required, when the trust's SPC consultant was on leave.
- Out of hours (OOH), telephone advice was provided by the consultant on call for St Christopher's Hospice. The SPC team referral guidelines with details of the OOH's contact details were available on the CUH intranet and on all CUH wards.

## Major incident awareness and training

- The SPC team had a plan for seasonal fluctuations in demand. During the summer months the SPC team would complete patients discharge planning and provide direct care on the wards. During busy winter months the team would act in a more advisory role, supporting staff on the wards with patients care, treatment, and discharge planning..
- The trust had a major incident plan, which set out key responsibilities and actions to be taken by staff. Training on major incidents and business continuity was provided to all new staff as part of their induction. Staff on the wards we spoke with told us major incident training was mandatory for all staff. Staff confirmed that they had completed training in major incident planning.
- The mortuary service had a major incident plan. This included guidance for staff on the retention of forensic evidence and liaison with the coroner. Staff at the mortuary service told us they had completed a desktop rehearsal for a major incident in 2014.



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- All porters received an annual update and refresher training from staff at the mortuary service. We viewed porters training records and saw 100% of porters who dealt with deceased patients had received a training update in the past 12 months from the mortuary service.

## Are end of life care services effective?

Requires improvement



Patients in receipt of EoLC received effective care and treatment that met their needs. EoLC patients care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice. Relevant people had not always been involved in discussion and agreement to their wishes around Cardio Pulmonary Resuscitation.

The hospital's 'care of the dying person' care planning provided comprehensive assessment of patients' needs, including consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. The expected outcomes were identified and care and treatment was regularly reviewed and updated.

Information about patient's care and treatment, and their outcomes, was routinely collected and monitored. This information was used to improve care. Outcomes for people who used services were positive, consistent and met expectations.

There was participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services. Accurate and up-to-date information about effectiveness was shared internally and externally and was understood by staff; and used to improve patients care and treatment.

### Evidence-based care and treatment

- The national guidelines from the National End of life Care Strategy (2008) published by the Department of Health, sets out the key stages of end of life care. The National Institute for Health and Care Excellence (NICE) end of life care quality standard for adults (QS13) sets out what end of life care should look like for adults

diagnosed with life limiting conditions. Croydon Health Services NHS Trust had implemented NICE quality standards for improving palliative care for adults, with the introduction of a SPC team.

- The SPC team had introduced both medical and nursing 'care for the dying person' care plans to enhance the quality of life for people with life limiting conditions, and ensure they had a positive experience of healthcare. The 'care of the dying person' care plan was informed by the 'One Chance to Get it Right' document which outlines the duties and responsibilities of health and care staff in the care of dying people.
- A CNS from the SPC team demonstrated the 'care for the dying person' nursing care plan on the trust's EPR system. We saw that the system had built in prompts to offer guidance to staff on information they needed to record. The CNS explained that a staff acknowledgement was built in to the care planning system to indicate when each priority of the '5 priorities of care' had been met. A care after death plan was covered on the 'care of the dying person' care plan. The care plan also included information on discussions that had taken place with patients or families.
- The SPC team had a baseline assessment tool to ensure the team's practice was managed in accordance with NICE CG140 Opioids in palliative care guidelines. Opioids are medicines that relieve pain. The SPC team had also designed and launched an opioid information leaflet giving patients information on opioid medicines, including the purpose of patients taking opioid painkillers, storage of opioid medicines, and information on prescriptions. The SPC team were in the process of auditing the uptake of the leaflets at the time of our visit.
- We saw evidence across all wards and departments we visited that the SPC team supported and provided evidence-based advice to other health and social care professionals, especially where patients were in need of complex symptom control. For example, all junior doctors were given copies of the palliative care adult network guidance (PANG) also known as 'the blue book'.
- We saw that the hospital had a comprehensive 'Resuscitation: DNA CPR and decisions relating to resuscitation' policy, which was based on best practice guidance from the General Medical Council (GMC). Staff we spoke with were aware of the policy and could access the policy on the trust's intranet.

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- While visiting the ward areas, we randomly checked eight medical records containing 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms. These are advanced decisions made by an individual who is deemed mentally competent. DNA CPR decisions were recorded on the front page of patients' records and would alert staff that a patient had made a DNA CPR decision.
- Generally our findings showed that DNA CPR forms were completed in accordance with the trust's 'Resuscitation: DNA CPR and decisions relating to resuscitation' policy. However, the trust audit team had reviewed compliance with the DNA CPR policy in January 2015 and found that the majority of clinicians had not documented having a discussion with the patient during the DNA CPR decision making process, nor had they documented the reasons for not having this conversation. They also found that documentation of a discussion with the patients' family was documented in only 35% of forms reviewed. Other findings included; 47% of the forms audited did not detail the clinical rationale for the resuscitation decision and only 58% of forms in circulation at the time of the audit were completed in accordance with the trusts 'Resuscitation Policy', and therefore 42% were not valid. The audit also identified the omission of a counter signature within 48 hours as being the direct cause of 50% of DNA CPR forms being classed as invalid.
- The SPC team annual report 2014 stated that 70% of patients were referred to the SPC team for symptom control. The SPC team had also identified an increase in referral patterns of patients with non-complex end of life needs, following the LCP being withdrawn. The report stated that this reflected the work the SPC team had done to promote the benefits of palliative care for life limiting conditions, other than cancer, and the progress the SPC team had made in engaging staff from other wards and departments.

## Pain relief

- Patients commenced on the hospital's end of life care pathway required regular pain assessments to ensure that symptoms were managed effectively. We noted from our review of records that nursing staff had completed pain assessments. Staff on Fairfield 1 Ward told us EoLC patients had their pain control reviewed

- every day by the SPC team. SPC team staff liaised with ward staff to ensure that PRN medication was prescribed, to ensure any breakthrough pain could be managed whilst patients adjusted to their pain control.
- Staff on the wards told us they had received training on the use of syringe drivers, for when patients' symptoms required pain to be managed in a controlled way. Ward staff told us they regularly had their competency assessed in the use of syringe drivers. A ward sister on Purley 2 Ward told us the SPC team responded quickly to requests for support and advice from ward staff and were available to advise on any issues ward staff were experiencing in regards to caring for EoLC patients.
- On Wandle 1 Ward we were told that the SPC team was actively involved in the pain management of EoLC patients. We saw that medicines guidance was available on all the wards we visited. Staff on Wandle 1 Ward were able to demonstrate medicine pathways on the trust's electronic patient record (EPR).
- We reviewed three patients' pain assessments on Duppas 1 and Heathfield 2 wards. We saw that patients had had their pain reviewed every four hours by senior nursing staff. Pain relief was provided if required. Records were completed for four hourly checks and any pain relief patients had received.
- Staff we spoke with told us there was no specific care plan for managing the pain of patients with dementia. Patients we spoke with told us they were regularly asked if they were experiencing any pain and provided with pain relief when required.

## Nutrition and hydration

- Patients' nutrition and hydration had been audited by the SPC team as part of NCDA4, (National Care of the Dying Audit).
- Staff on Wandle 1 Ward told us they had received training from the hospital's speech and language therapists (SALT) on the use of thickeners for drinks for people who experienced swallowing difficulties.
- Patients' nutrition and hydration was assessed as an aspect of their 'care for the dying person' care plan. Patients also had multi-universal screening tool (MUST) assessments in place. MUST is a screening tool to identify adults, who are at risk of being under nourished, or obese. Staff on Duppas 1, Fairfield 1 and Heathfield 2 wards told us they would always discuss the nutritional

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needs of patients in receipt of EoLC with the SPC team; and would refer EoLC patients to the speech and language therapy team (SALT) team and dietitian's to ensure their needs were met.

- SALT and dietitian's wrote their notes on the patients EPR care record to ensure the information could be accessed by all clinical staff associated with a patient's care.
- Staff on Wandle 1, Duppas 1, and Heathfield 1 wards told us EoLC care patients in the dying phase were encouraged to drink or sip water to avoid dry mouth. Staff at the SPC team told us they provided training in oral care for ward staff. A band 7 nurse on Wandle 1 Ward was able to explain how staff would provide mouth care to a patient. We saw that mouth care kits were available on the wards we visited.
- Staff across the wards told us they discussed spiritual/religious diets with patients or their families. We did not see any patients who had spiritual/religious dietary needs. However, we noted that the patients' records we viewed had specialist dietary needs recorded where required. Staff on the wards told us families could provide assistance with patients' personal care and feeding upon request. We saw a relative on Wandle 2 Ward providing assistance with their parents feeding. The relative told us they had asked to assist with their parents feeding, and staff had been more than willing to assist them with this by providing pureed food and feeding utensils.
- The SPC team told us the general medical guidance (GMC) for doctors in supporting nutrition and hydration had informed both the medical and nursing 'care of the dying person' nutrition and hydration care plans. Staff at the SPC team told us they referred staff to the guidance when they provided EoLC training for staff.

## Patient outcomes

- Information collected on each patient was recorded electronically on the hospital database. Patient information was entered by the SPC team's secretary and was used when preparing the annual Minimum Data Set (MDS) statistics for the National Council for Palliative Care (NCPC) and in preparation for the SPC team annual report. The MDS for Specialist Palliative Care Services is collected by NCPC on a yearly basis, with the aim of providing an accurate picture of hospice and specialist palliative care services nationally.

- The hospital contributed to the National Care of the Dying Audits (NCDA). For example NCDA 4 audit results found the trust performed well in the areas of: access to information relating to death, continuing education, training and audit, medication protocols around symptom control and protocols promoting patients privacy, dignity and respect, including after the death of the patient.
- The hospital had an action plan in place in response to NCDA4. The trust was partially compliant in meeting five of the audit's six organisational key performance indicators (KPI). However, the KPI for access to face to face specialist palliative care seven days a week was not met. In response the trust had employed an additional CNS. The SPC team had extended its services to six days a week; and seven day working had been added to the cancer and diagnostics risk register. The trust had also responded to the audit in regards to EoLC being represented on the trust board by appointing a non-executive director (NED) responsible for EoLC.
- Patients had their care assessed and audited by the NCDA4. The trust met six of the 10 clinical KPI's from the NCDA4. The four unmet KPIs related to: health professionals discussions about recognition of dying with the patient and family: communication regarding the plan of care: medication prescribed PRN for the five key symptoms: and documented reviews of patients nutritional needs. An action plan had been developed in response to the audit, this included: a prescribing 'order set' of medications on the EPR for the five key end of life symptoms; and a 'care of the dying person' nutrition and hydration care plan on the trust's electronic patient records system.
- The trust, as part of the NCDA4, had completed the optional local survey of the views of bereaved relatives or friends in regards to care delivery in the last days of life. However, the SPC team told us the response rate had been low with only seven questionnaires being returned.
- The trust told us they had not specifically undertaken an audit of the quality measure, 'People in the last days of life are identified in a timely way and have their care coordinated and delivered in accordance with their personalised care plan, including rapid access to holistic support, equipment and administration of medication'.

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However, they had participated in the NCDA4; and the 'end of life care strategy: quality markers and measures for end of life care' were a source for the NCDA4 comprehensive audit.

- Bereavement care was covered on the nursing 'care of the dying patient' care plan. The SPC team had designed a bereavement leaflet which was due to be discussed at the trust's Health Information Group in July 2015.

## Competent staff

- The trust had a capability policy. This outlined that in order to deliver high quality, responsive and accessible patient care, employees should possess the knowledge, skills and competence essential for staff to carry out their roles. The policy emphasised that employee performance should be regularly reviewed in line with the trust's staff performance and development review (PDR) process. The policy identified training and supervision as essential to the achievement of satisfactory staff performance.
- The SPC team staff told us that opportunities to assess ward staff competence and educate ward staff were actively sought at weekly palliative care ward rounds. The team provided formal and informal teaching to ward staff as requested. The team also offered attachments for doctors who wished to enhance their knowledge of palliative care. Most staff on the wards told us the SPC team could be contacted and would respond quickly if ward staff needed support or advice on managing an EoLC patient's care or treatment.
- The SPC team used regular clinical supervision to discuss both clinical and staff support issues. All of the SPC team had had an annual appraisal in the previous 12 months.
- The SPC team offered to facilitate support meetings for ward staff on a formal basis. SPC staff told us this was available when ward staff needed to reflect on complex situations. The chaplaincy service told us they offered debriefing meetings with groups of staff following complex situations, as well as a confidential staff counselling service upon request.
- Staff on all the wards we spoke with told us agency or bank staff did not provide care to EoLC patients. Staff said permanent staff would be allocated to care for patients who had been assessed as EoLC.

- A ward sister on Purley 2 and a band 7 nurse on Wandle 1 wards told us the EoLC training provided by the SPC team included communication skills training, and skills for supporting the families and close friends of patients receiving EoLC.
- The SPC team's annual report 2014 recorded that the SPC team took the lead at the trust in providing EoLC training updates to: Ward sisters, band 6 nurses, band 5 nurses, health care assistants and student nurses.
- The SPC team also participated in the South West London Cancer Network nurse palliative care training. Training offered to hospital staff included monthly study day teaching on syringe drivers: annual study days to all healthcare professionals on palliative care issue. The hospital also had a cancer education programme, which included doctors teaching twice a year. All the ward staff we spoke with confirmed they had received training in EoLC from the SPC team and that this was updated regularly.

## Multidisciplinary working

- The SPC team had a weekly multidisciplinary team (MDT) meeting. This demonstrated a high level of specialist knowledge, service delivery and strategic planning, providing wards and departments across the trust with up-to-date holistic symptom control advice for patients in their last year of life. The weekly meetings were attended by the SPC team and included discussion of all new and known referrals. In addition to the SPC team, occupational therapy (OT), chaplaincy, the community liaison nursing team and the cancer counsellor were invited to MDT meetings. Other healthcare professionals were also invited to attend on an ad hoc basis, to discuss EoLC patients they were working with.
- Staff told us they occasionally had residents of other London boroughs referred to the hospital. Staff told us they liaised with the corresponding community palliative care teams about "out of borough" patients when needed.
- The SPC team had developed close links with the admissions team at St Christopher's hospice due to requesting patient transfers. The SPC team had formal meetings with the St Christopher's admissions team annually.
- A member of the SPC team attended the lung cancer and upper gastrointestinal MDT meeting on a weekly

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basis. The SPC also attended the urology and colorectal MDT meeting when required. The SPC CNS would also attend the haemato-oncology ward round when requested

- A band 5 nurse on Fairfield 1 told us that if treatment was being withdrawn it would always involve an MDT meeting with the patient's family or carers.

## Seven-day services

- The trust provided a face to face 9am to 5pm SPC CNS service Monday to Saturday. However, staff at the SPC team told us they did not currently have the resources to provide seven day face to face services. We spoke with the NED for EoLC who told us that seven day a week working was under review at the time of our visit, but no plans were currently in place to extend SPC face to face services to seven days a week. NICE guidance (QS13) recommends that palliative care services should ensure provision to: visit and assess people approaching the end of life face to face in any setting between 9am and 5pm, 7 days a week. However, the cancer and diagnostics risk register recorded that the trust was working towards a seven day a week service by June 2016.
- The trust had a contract with St Christopher's hospice to provide OOH's cover. The contract with St Christopher's hospice provided OOH's cover on Sundays and bank holidays and overnight daily from 17.00 to 09.00. OOH's cover was provided by the consultants on call at St Christopher's hospice. Ward staff told us they knew the consultants at the hospice and they were always available to provide advice and guidance OOH's. This meant staff on the wards had round the clock access to specialist advice, and ensured patients continuity of care.
- The chaplaincy team could be contacted via the ward staff 24 hours of the day, seven days a week.
- Staff at the mortuary and on the wards told us bereaved relatives who wished to visit the mortuary outside of regular hours could request this. Close relatives would receive an accompanied visit with a nurse who was familiar to the family.

## Access to information

- Senior staff we spoke with were aware of the trust's Caldicott Guardian (this is an appointment whereby the holder has responsibility to ensure the protection of

patient confidentiality). This meant the trust had systems in place so that patients could be sure that their confidential information would only be shared appropriately.

- Information for patients on access to patient records was available in corridors around the hospital. The leaflets explained people's rights to access medical records under the Freedom of Information Act 2000.
- The SPC team explained that GPs were not routinely informed when a patient was receiving EoLC. The GP would be informed by phone if there were specific concerns, particularly if there were concerns about a family member. However, 'best practice' guidance, 2012, from the 'college of emergency medicine' recommends discussions about a patient's treatment preferences should be communicated to GPs to ensure continuity of patients EoLC planning.
- Following our inspection the trust informed us that GPs were not routinely informed during the inpatient stay that a patient was receiving EoLC but they were informed on the SPC team and ward team discharge letter that the patient was being discharged home with EoLC as their management priority. These letters would mention priorities and patient's preferences for EoLC and whether the patient had been referred to the community palliative care team. The GP was always informed if the patient died during the admission procedure.
- If a patient who was imminently dying was discharged home, the managing medical team would discuss this with the patient's GP before discharge by phone so that an urgent GP visit could be arranged. This ensured that considerate and timely death certification could take place in the community avoiding unnecessary distress for relatives and avoiding the unnecessary involvement of the coroner's service
- When a patient died the Bereavement Service would inform the patient's GP, as part of the service's day after death procedures.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- One hundred per cent of staff on the SPC team had completed training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). DoLS are part



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of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

- The trust's DoLS database did not keep information about whether a patient was receiving EoLC. However, between June 2014 to May 2015 information from the trust's database showed that the hospital had 27 DoLS referrals where urgent authorisations had been put in place. Out of those 27 patients, two of them had died before the DoLS process had been completed.
- A band 7 nurse on Wandle 1 Ward showed us an example of the mental capacity assessment form the trust used. The form included an assessment of the patients' capacity, consultation with others and details of any decisions taken. We did not see any completed forms during the visit.
- Staff told us that if there were concerns about a patients capacity to make decisions a multi-disciplinary (MDT) meeting would be arranged with nurses, doctors and the patient's family. If the patient was able, they would attend the meeting. The meeting would be used as a forum to ascertain the wishes of the patient and family.
- Staff on the wards we spoke with told us they had received training in the Mental Capacity Act 2005.

## Are end of life care services caring?

Good



End of life patients were supported, treated with dignity and respect, and were involved as partners in their care.

Verbal feedback from people who used the service and those who were close to them was positive about the way staff treated patients and their relatives. Patients were treated with dignity, respect and kindness during all interactions with staff. Patients and relatives described their relationships with staff in positive terms. Patients felt supported and thought staff were caring.

Patients were generally involved and encouraged to be partners in their care and in making decisions, and were supported to do so. Staff spent time talking to patients, or those close to them. Patients and their relatives were communicated with and received information in a way that

they could understand. Patients told us they understood their care and treatment. Patients, relatives, and staff worked together to plan care; there was shared decision making about care and treatment.

Staff helped patients and those close to them to cope emotionally with their care and treatment. Patients social care needs were understood. Patients were supported to maintain and develop relationships with their families, social networks and community.

## Compassionate care

- We spoke with eight patients and two relatives who were visiting the hospital. All the patients and relatives we spoke with were positive about the end of life care (EoLC) provided by staff at CUH.
- The specialist palliative care (SPC) team appointed a key worker to each of their patients to ensure continuity of care for both the patient and family.
- On the wards we visited, we were told that all patients had a named nurse, who would remain with the patient during their stay in hospital.
- We observed caring, compassionate care being delivered by staff to patients receiving EoLC. Staff were seen to be very considerate and empathetic towards patients. Staff we spoke with demonstrated a good understanding of patients' emotional wellbeing.
- We saw staff pulling curtains around people when they were receiving examinations or care and treatment. This meant consideration was given to patient's privacy and dignity.
- Staff on the wards told us the care the SPC team provided was sensitive and caring. We observed an SPC nurse reviewing EoLC patients. We saw that patients were reviewed in a professional, caring and compassionate manner.
- We spoke to a patient who was receiving EoLC care. They told us, "They look after me very well. The staff are polite and patient."
- On Wandle 2 Ward, we observed an EoLC patient being nursed in a single room. We were told by the ward manager that they always offered EoLC patients a single room if available, as families could stay by the bedside overnight.
- On Purley 2 Ward, a patient who was receiving EoLC told us they felt very settled and that the nurses were, "Very nice and approachable."



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- Throughout our inspection we found the approach staff used was consistently appropriate and demonstrated compassion and consideration for the patient. Staff interacted with patients in a respectful and considerate manner.
- Relatives we spoke with were positive about the care and treatment patients received from both the SPC team and staff on the wards. The relative of a patient who was receiving EoLC told us, "The nurses are really caring. I have never been made to feel as if I am bothering them. They answer any questions I have and answer the phone quickly when I phone."

## Understanding and involvement of patients and those close to them

- The SPC team had advanced care planning skills to ensure that patients' quality of life was enhanced as they moved towards their end of life.
- We were told by ward staff the SPC consultant was, "Very good at communicating with the patients and families." The ward doctors would review patients daily and talk to families where necessary to ensure that patients and families were involved in decision-making.
- A patient's relative told us the staff had involved them in every step of their parent's assessment and decision making process.
- The electronic patient record (EPR) had a section for staff to record patient discussions and involvement. Patients preferences and wishes were also recorded on the EPR.
- On Wandle 1 Ward, the ward manager told us they encouraged relatives to get involved in the mouth care of EoLC care patients.
- The organ donation specialist nurse explained to us in detail how families could get involved and support their relative through the organ donation process.
- The bereavement officer told us the bereavement service offered individualised appointments, offering advice and guidance to bereaved relatives and friends.
- A patient told us their CNS from the SPC team took time to talk to them and involve them in decisions about their care. The patient said their care had been planned in consultation with them, and their decisions about their care had been respected by the staff.

## Emotional support

- Staff on the SPC team told us ward staff provided good EoLC in terms of tasks. However, some staff at the SPC team thought that staff shortages on the wards meant

ward staff occasionally did not have the time to provide emotional support to EoLC patients and relatives. All the staff on the SPC team told us staffing on the wards had improved in the past 18 months.

- The SPC team referred patients or carers to the trust's cancer counselling service, where they thought this would be helpful.
- The SPC team social worker told us they helped patients and their families to cope emotionally with their EoLC; as well as supporting patients with their social care needs.
- Relatives told us the staff had supported them to maintain and develop their relationship with their family member who was receiving EoLC. For example, families were welcome to stay at the dying person's bedside overnight to provide the patient with both practical and emotional support.
- The Chaplaincy told us they could provide emotional support upon request to both patients and their families. This included accessing multi-faith support for patients.
- The SPC team did not offer a formal bereavement service. However, telephone follow up of the next of kin of all palliative care patients who had died was undertaken by the team where the family was known to the team. Where the team were unable to make contact, a letter was sent with the details of the bereavement service at the hospital. The co-ordinator of bereavement support for the trust was the hospital chaplain.

## Are end of life care services responsive?

Good



End of life care (EoLC) services were generally planned and delivered in a way that met the needs of local people. EoLC services had recently introduced a steering group for EoLC and had appointed a non-executive director for EoLC.

The importance of flexibility, choice and continuity of care was reflected in EoLC services at CUH.

The needs of different people were taken into account when planning and delivering EoLC and services.

EoLC and treatment was coordinated with other services and other providers.

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## Service planning and delivery to meet the needs of local people

- The SPC team held a Listening into Action (LiA) event in 2014 that looked at the '5 priorities for end of life care' and also responded to the results of the NCDA4. Following the withdrawal of the LCP the SPC strategy was to embed 'care for the dying person' care planning with staff at CUH. Staff told us the publication in June 2014 of 'One chance to get it right' by the Leadership Alliance for the Care of Dying People was the focus for the SPC team in 2015. The trust had created an EoLC steering group met on 7th November 2014 to agree the 'terms of reference' for the group in 2014/15.
  - The SPC team's annual report 2014 reported on an audit the team had completed under the NHS Transform programme. The Transform Programme aims to improve the quality of end of life care within acute hospitals across England, enabling more people to be supported to live and die well in their preferred place of care. The outcome of this audit was that 18.7% of referrals in 2014 did not achieve their preferred place of care.
  - The SPC team's analysis found the reasons patients did not achieve their preferred place of care were the clinical deterioration of the patients condition and a perceived inability of patients to cope at home. An action plan was in place as a result of the audit, this included further training for junior doctors and the introduction of the 'care for the dying person' care plans on the EPR. This made it easier for different teams and health care professionals to access patients' records. Staff we spoke with on the wards confirmed they had been working collaboratively with the SPC team to improve EoLC patients' outcomes in achieving their preferred place of care.
  - The mortuary service had an annual audit plan. This included audits of patients' traceability and temperature monitoring.
  - The manager of the mortuary service told us work was in progress to amalgamate the bereavement office and mortuary into the same directorate. Staff said this would ensure uniformity of documentation and a seamless service for bereaved families.
  - All of the trust's information leaflets informed patients of the languages the leaflet was available in. Staff told us interpreting services were available to patients and relatives upon request and were easily accessible. Staff on Queens 2 Ward told us the ward clerk had a list of staff who spoke languages and they would be approached first if an interpreter was required. Staff also had access to a telephone interpreting service.
  - The SPC team told us they could direct patients, relatives and friends to the Macmillan cancer information centre, which was based on the hospital site, for information and advice.
  - The SPC team supported carers by: providing support for complex issues that could not be supported by the ward team, and by contacting and updating community services as appropriate.
  - The NCDA4 key performance indicator for assessment of patients' spiritual needs, achievement was low for the hospital at 41%. However, this was slightly better than the national average of 37%. The trust was addressing this by requiring patients' spiritual needs to be assessed as part of the 'care of the dying person' care plan. During our visit we saw that staff had access to information in patient care records on patients' religious and cultural needs, and this assisted them with making decisions in regards to patients care.
  - Community services could provide equipment for patients who were returning home as a small store of equipment was held in the community. For example, walking aids, toilet surrounds, commodes, drip stands, pressure relieving cushions, perching stools and bed pans. The trust had access to a trust delivery van for the supply of equipment or staff would carry small pieces of equipment in their cars.
  - If a patient required a bed it could be ordered in exceptional circumstances for two hour delivery during office hours. At weekends equipment could be delivered during the day, but there were no night time deliveries at weekends.
  - The ward managers on the wards we visited were able to explain the procedures following the death of a patient. We were shown the pack staff used, which contained all the necessary documentation, including wrist bands. Body bags and shrouds were available on the wards.
- ## Meeting people's individual needs
- Patients receiving EoLC were allocated a key worker. The team had a policy for allocating key workers; this would be the CNS who did the first assessment.

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- Staff at the mortuary service demonstrated the systems the trust had in place to identify patients on the ward, and in the mortuary, if two patients had the same surname.
- Wards had multi-faith guidance for staff to refer to in relation to care for the dying. This ensured staff were able to respect the traditions of different faiths at the time of death. For example, booklets: 'Manners and etiquettes of an Islamic burial'; and 'Spiritual and religious care', were available to staff.
- The bereavement office carried out the administration of deceased patients' documents and belongings, issuing the medical certificate of cause of death, providing practical advice, and signposting relatives to support services, such as funeral directors.
- We were told by staff on several of the wards that normal visiting times were waived for EoLC and that families were able to visit at any time.
- The chaplaincy told us they could contact representatives from most world faiths. There were no multi-faith rooms available at the hospital, however people of all faiths were welcome to use the hospital chapel. The chapel had prayer mats and a screened area for private religious observance.
- The organ donation CNS explained to us that they would approach patients and families to give information around tissue and organ transplantation. Information booklets on organ donation were available for patients and families to read to aid their making a decision without feeling pressured.
- The mortuary service had a viewing suite where families could visit their relatives. We visited the area and saw that the viewing suite was divided into a reception and viewing room. The suite was clean and provided seating and tissues for relatives. We were told by the mortuary staff that families were supported during the viewing and that they would ensure that relatives knew what to expect. During out of hour's families would be supported during a viewing by a nurse they were familiar with.
- SPC team staff told us patients could be referred to the service by phone, bleep, or face to face when the team were on the wards. The SPC team had a 'hot bleep' to indicate urgent requests from staff.
- Prior to assessment a patient's name, ward, and referral date would be written on the board in the SPC team's nurse's office. On a daily basis members of the SPC team prioritised referrals according to clinical need and existing workload. Each morning members of the SPC team reviewed and discussed current patients, and prioritised and allocated new referrals. Patients who had complex problems were seen on the consultant's ward round.
- On a weekly basis all new patients and all on-going patients, including those who had died or had been discharged were discussed at the extended multidisciplinary team (MDT) team meeting. In the case of urgent referrals, if the SPC team couldn't assess the patient immediately, the SPC team would offer symptom control advice, until the patient was assessed.
- Patients were discharged from EoLC under the following situations: discharge home, hospice or nursing home: patients who no longer required specialist palliative care involvement: palliative care problems were not the main reason for admission: at the request of the patient, family or treating team.
- The SPC team had a flowchart that clearly outlined the discharge pathways for patients. On discussion with the patient and on assessment of need, referrals were made to the relevant community palliative care team if the patient was going home or to a nursing home. A standard discharge letter, to complement the medical discharge summary, was sent to the doctor into whose care the patient was being discharged. A copy of this was sent to the appropriate community palliative care team, the treating consultant and the patient, or relative if they had given their consent. Discharged patients who had made a DNA CPR decision, always carried a copy of a paper based community DNA CPR form for transfers. Ambulance services, G.P services, and community services were familiar with the red form.
- The trust had a clear fast-track discharge process for completing the NHS continuing health care funding paperwork for eligible patients who were considered to be in the last four to six weeks of their life. The process clearly detailed the actions both medical and nursing

## Access and flow

- We saw referral guidelines for the SPC team were available on all the hospital wards and the trust's intranet. The SPC team received verbal referrals from both medical and nursing staff on CUH wards or from community palliative care teams, whose patients had been admitted to hospital.

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staff should take as an aspect of the process. This ensured people received their care funding in a timely way and could be transferred to their preferred place of care quickly.

- Staff on the wards and the SPC team told us patients could be moved to their preferred place of care rapidly. Staff on Wandle 1 Ward told us that they had one patient who had been discharged to their preferred place of care in two hours. However, ward staff said they wouldn't discharge patients after 6pm due to the logistics of getting out of hour's support for people and getting equipment in place.
- Between April 2014 and February 2015 708 referrals were made to the SPC team; 54% of these were cancer related. The SPC team operational policy stated that all patients referred to the team would be seen within five working days. The team were actually performing better than the policy in the year 2014-2015, with 70% of patients being seen within 24hrs of referral from the admitting team.
- Portering services told us they had key performance indicator (KPI) of a 90 minute standard response time for transfer of deceased patients to the mortuary. We saw portering service records that confirmed that the service was achieving this in an average time of 30 minutes. Staff on the wards confirmed that portering services responded quickly to requests for a porter.

## Learning from complaints and concerns

- There had been no formal complaints about mortuary services, bereavement services, or EoLC services in the past 12 months.
- The trust had complaints handling policies and procedures in place. All complaints to the trust were recorded. Information on the trust's complaints policy and procedures was available on the trust's internet website.
- Information available to patients and visitors to the hospital included leaflets about how to make comments and compliments; or how to raise concerns or complaints. The patient advice and liaison service (PALS) was based in the hospital's main entrance. Most patients we spoke with were unaware of the complaints procedure. However, the relatives we spoke with were aware of their rights to make complaints and told us there was information available in the hospital if they wished to make a complaint.

- Staff we spoke with were aware of the trust's complaints policy and of their responsibilities within the complaints process. Formal complaints from patients were directed to the trust's complaints team.
- The SPC team explained the trust's complaints procedure and actions the team would take following the investigation of a complaint. Staff told us all complaints would be discussed with the patient. The SPC team told us the completion of actions following a complaint would be monitored by the non-executive director (NED) and the 'quality and governance' committee. The SPC team lead told us information from complaint investigations would be fed back at team meetings.

## Are end of life care services well-led?

Good



The local leadership, governance and culture in end of life care (EoLC) at the hospital promoted the delivery of high quality person-centred care.

There was a clear statement of vision and values for EoLC, driven by quality and safety. This had been translated into a credible strategy and well-defined objectives.

The vision, values and strategy had been developed through a structured planning process with regular engagement from internal and external stakeholders at 'Listening into Action', (LiA) events, which included patients, staff, and others.

Strategic objectives were supported by measurable outcomes, which were cascaded throughout the organisation. The challenges to achieving the strategy, including seven day working, were understood and an action plan was in place.

Staff in all areas knew and understood the vision, values and strategic goals of the trust.

The board and other levels of governance within the organisation functioned effectively in regards to EoLC. Structures, processes and systems of accountability were clearly set out, understood and effective.

## Vision and strategy for this service

- Staff on the wards and in the SPC team told us the trust's LiA initiative was part of the trust's strategy in

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2014. Staff explained that the 2015 initiative was, 'Let's do it', this involved the implementation of ideas the trust had gained from feedback from members of the public and staff during LiA in 2014.

- The LiA's informed the EoLC strategy in regards to the development of the 'care for the dying person' care plan. The strategy for EoLC had been developed but was not yet embedded.
- Staff in the SPC team were aware of the EoLC steering group's values. These were identified in the group's terms of reference as, 'To advocate and develop care planning with palliative patients across specialties and teams to achieve preferred place of care and death.'
- The SPC team had a plan for identifying team objectives and an action plan in place to monitor the team's performance in meeting the objectives. For example, the SPC team's objectives for 2015-2016 included embedding the palliative care discharge process across the trust. The team had also scheduled a review of the trust's syringe policy for November 2015.
- Minutes from the end of life care clinical reference group (CRG) February 2015 recorded how the CRG was working with the clinical commissioning group (CCG) to deliver a plan of work to meet CUH EoLC strategic objectives.
- Staff at the SPC team told us the trust's vision and values, "Excellent integrated care for you and your family, when and where you need it", fitted well with the EoLC service, and were used as an aspect of the assessment of new staff to the SPC team. The trust's vision and values were also part of the trust's corporate induction for new staff.
- The trust's value statement was displayed on notice boards around the hospital, as well as on the trust's intranet and internet. Most staff we spoke with told us the trust's vision and strategy was publicised on the trust's intranet and on emails. Staff said they incorporated the trust's values into their practice.

## Governance, risk management and quality measurement

- EoLC services had been involved in the NCD4 national audit. This enabled the service to measure their performance against the Royal College of Physician guidelines for the care of dying patients. We saw that the trust had an action plan in place following the NCD4 and this was regularly reviewed and updated. The April 2015 review recorded that the trust had achieved all the recommendations from the audit, with the exception of

access to specialist support for care in the last hours or days of life. The action plan recorded that the trust had started a six day a week; but lacked the resources to offer a seven day service. However, this was being considered and worked towards.

- The trust's EoLC steering group met on 7th November 2014 to renew the group's terms of reference for a further two years. The group monitored EoLC key performance indicators. Including how the trust was performing in regards to: National end of life care strategy (2008); NICE quality standard for end of life care for adults QS13 (2011); The national council for palliative care guidance and reports; CQC standards; National cancer peer review palliative care measures.
- The trust collected information between 1st April 2013 and 31st March 2014 for the purpose of the palliative care annual report. This aligned data collection with that required for the annual MDS return for the NCP.
- SPC team staff told us they felt there was a clear vision for EoLC services and a strategy of improvement and change to service delivery as a result of the appointment of a NED for EoLC.
- Managers and staff told us regular team meetings and handover meetings took place. Our review of documents showed that these meetings were recorded and included case discussions. Actions taken were documented and reviewed in subsequent meetings.

## Leadership of service

- Staff at the SPC team expressed confidence in the SPC team's leadership, led by the SPC team consultant and the SPC nurse team lead. SPC team members told us they felt well supported within the team.
- The SPC consultant and the SPC nurse team lead oversaw strategic team development. This included ensuring that the objectives of the MDT were met; ensuring that recognised guidelines underpinned care and treatment; ensuring audit information was collected to inform clinical decision making; implementing education and training across CUH on EoLC.
- The trusts had appointed a designated NED board member with specific responsibility for care of the dying. Staff at the SPC team told us that the appointment of a NED for EoLC had been a positive development for the services at CUH. Staff said the NED was approachable and visible, and that their appointment had increased the profile of EoLC at board level.



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- We were told by the NED that the role provided executive support for the SPC team in developing and implementing the end of life care strategy across the trust.
- Staff at the SPC team told us they were confident in the trust boards skills, knowledge, experience and integrity.
- Staff at the SPC team told us the medical directors had been supportive of EoLC during the transition from the Liverpool Care Pathway.
- The staff we asked on the wards and in the SPC team told us directors of nursing were easy to recognise, as they were visible by their red uniforms.

## Culture within the service

- Staff at the SPC team told us they felt respected and valued by the ward staff. The quality of patient experience was seen as a priority by the SPC team.
- The CNS who leads for the team on EoLC matters told us that they had not had to address any member of staffs' behaviour or performance due to it being inconsistent with vision and values of the trust or the team. However, the SPC team leader told us procedures were in place via staff PDP's to manage performance issues. The team leader said the team placed an emphasis on staff development and not criticism.
- Staff at the SPC team told us the team culture was open, honest, and fair.
- Staff at the SPC team told us they were patient focused in that they always prioritised patients care. Staff used an example of a recent preferred place of care audit the team had conducted. The SPC team lead told us, "We do the things we need to do to improve patient care and outcomes."
- The staff we spoke with told us the SPC team worked collaboratively with staff on the wards in providing EoLC. The SPC team told us ward staff worked constructively with the SPC team to ensure patients received good quality EoLC. Across the wards we visited, we saw that the SPC team worked well together with both nursing and medical staff.

## Public engagement

- Relatives and patients we spoke with told us they felt actively engaged by staff in the SPC team and staff on the wards.
- The SPC team undertook regular bi-annual patient satisfaction survey in order to obtain feedback from patients' relatives' experience of the service. The results of the survey informed the SPC team's annual report.

For example, the 2014 results indicated that 49% of initial EoLC assessments were undertaken by a CNS from the SPC team and another 26% of patients received joint assessments that included doctors or social workers as well a CNS from the SPC team.

- The trust held public and staff engagement events, LiA, in June 2014, to inform the development of the 'care of the dying person' care plan. The events prioritised the participation and involvement of patients, relatives, and staff in constructing the EoLC strategy for the trust.
- The SPC team undertook a bereaved relatives survey using the CODE (care of the dying evaluation) questionnaire offered by the NCDA4 in 2014. The response rate was low with seven people returning the questionnaire, which was the equivalent of 23% of the people asked. Overall, 76% of people who responded to the questionnaire felt adequately supported during the patient's last 2 days of life. Based on their experience, 68% were either likely or extremely likely to recommend the trust to family and friends. 8% were extremely unlikely to do so.

## Staff engagement

- The trust conducted an annual staff survey. However, the SPC team told us the results were currently being collated and were not available at the time of our visit.
- Staff participation in the LiA event informed: the development of the 'care of the dying person' care plan, new prescribing guidance for symptoms that occur at the end of life as well as new medical guidance and a review of end of life care education across disciplines at CUH.
- Staff we spoke with told us they felt they could raise concerns with team leaders or the boards trust. Staff were aware of whistleblowing information and a confidential telephone service was available for staff who wished to raise concerns.
- The SPC consultant told us they had raised issues with the trust board and that these had always been resolved satisfactorily.

## Innovation, improvement and sustainability

- The trust is one of 26 trusts in England who were pioneering the 'Listening into Action' (LiA) way of working. This puts patients and staff at the centre of change initiatives in hospital trusts.
- The SPC team told us they produced an annual report for the trust's Improving Patient Experience Committee (IPEC). In the report the SPC team had reported on



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developments to services, efficiency changes, and the impact of these on quality and sustainability. For example, the team reported they had delivered training across the trust on advanced care planning and co-ordinate my care (CMCR). CMCR is an electronic palliative care co-ordination system to facilitate patients achieving their preferred place of care. The SPC team had also trained staff across the trust on utilising the CMCR system and had added patients to the system as part of delivering the EoLC Commission for Quality and Innovation (CQUIN) for 2013/14.

- The SPC team delivered 100% of their CQUIN targets. The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of healthcare providers' income to the achievement of local quality improvement goals.
- The SPC team reported to the quality and clinical governance committee (QCGC). Minutes of the QCGC meeting from September 2014 recorded that the former hospital registry had been renamed the bereavement

service and signage at the hospital had been changed to reflect this. The change of name was to reflect the services function, as registrations of death did not take place at the hospital.

- The SPC team told us financial pressures had never compromised the safety of patients care. However, the team highlighted that they did not have the resources to provide a seven day a week face to face service for patients. Staff also told us that they had to ask for funding for bank holiday staff cover.
- The trust were involved in the LEGACY study for secondary breast cancer, in collaboration with the Royal Marsden and the Institute of Cancer Research. The study allows patients with secondary breast cancer to donate their secondary (metastatic) cancer tissues for research shortly after death. The objectives of the LEGACY study are to provide researchers with the best opportunity to understand secondary breast cancer, how it works, and how to stop it.

# Outpatients and diagnostic imaging

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

## Information about the service

There were 302,846 first and follow up outpatient appointments attended in total at Croydon University Hospital and Purley War Memorial Hospital in 2014/15. Clinics in the main hospital site were held in 13 outpatient areas including main outpatients, cardiology, dermatology, orthopaedics, gynaecology, children's, dentistry, cardiac rehabilitation, and the diabetic retinal screening service.

Purley War Memorial Hospital had one general outpatient area. Physiotherapy, orthopaedics and gynaecology were among the most attended clinics, followed by the anticoagulant service, haematology, cardiology and dermatology.

The imaging department at Croydon University Hospital included computerised tomography (CT) scanning, ultrasound, DEXA scanning (Bone Densitometry) and X-rays. Purley War Memorial Hospital provided DEXA scanning, ultrasound and X-rays. Magnetic resonance imaging (MRI) was run by another provider within the grounds of Croydon University Hospital.

We visited the general outpatients, haematology, dermatology, women's clinics, cardiac rehabilitation, the cardiology department and the orthopaedic, fracture clinic and plaster room at Croydon University Hospital. We also visited general outpatient clinics at Purley War Memorial Hospital. At both locations we observed phlebotomy clinics and diagnostic imaging services. We spoke with 43 patients and four relatives or carers. In addition we spoke with 59

members of staff, including managers, doctors, nurses, healthcare workers, radiographers and radiologists, administrators, receptionists and members of the health record team.

At the previous inspection there had been compliance actions for outpatients. Before our inspection, we reviewed a range of performance information from, and about the hospital and we requested additional information from the trust after our inspection.

# Outpatients and diagnostic imaging

## Summary of findings

Outpatients and diagnostic imaging were not always safe or responsive and required improvement to address this. The service was caring but needed to address aspects of leadership.

There was a gap in leadership at matron level and some staffing shortages both in nurses and administrative staff.

There was inconsistency in infection prevention control measures and safety checks, with a variance in safeguarding and mandatory training compliance and some clinic accommodation was inappropriate.

Concerns had been found at previous inspection of the trust in September 2013 in relation to the care and welfare of people in outpatients. The main concerns had been the environment and patient flow through outpatients. There had been physical improvements in main outpatients and the fracture clinic and patient flow had improved. Four clinical areas did not have enough space to treat patients appropriately and one was located a distance away making it difficult for patients to access. Most of the tasks from the outpatient transformation programme were on schedule.

There were effective systems for managing referrals, making appointments and collecting data. The hospital was meeting the majority of the national waiting time targets. Patients and staff spoke about delays and waits in outpatients and diagnostic imaging ranging from 30 minutes to over an hour.

Staff were caring; patients told us that staff always kept them informed and were kind and approachable.

The majority of the performance targets in referral to treatment times were being met. The trust learnt from complaints and sought people's views on how to improve the experience.

There was a comprehensive plan guiding the improvement and sustainability of outpatients with systems in place to monitor the performance.

## Are outpatient and diagnostic imaging services safe?

Requires improvement



We observed and gathered evidence from both Croydon University Hospital and Purley War Memorial Hospital. At Croydon University Hospital we observed many staff not using the clearly labelled hand sanitiser at the entrance to main outpatients. Action identified in infection control walkabouts was not always taken. There was inconsistency in checking emergency equipment and medicines at Croydon University Hospital.

Staff worked across both hospitals and we found there was a variable level of compliance with mandatory and safeguarding training. In safeguarding we noted that only 77% of staff requiring level 2 training were compliant. Some nursing staff told us there were nursing shortages and at times healthcare assistants had difficulty accessing a nurse promptly in clinics.

At Croydon University Hospital three of the main outpatient areas and the rooms in the cardiology department did not have enough space to treat people appropriately and the fourth clinic area for orthopaedics was located a distance away from the fracture clinic and plaster room.

There were systems for reporting incidents and most staff knew how to report concerns. A few staff did not know how to do this, and there was a risk that some incidents may not have been reported. From the incidents reported we saw there had been learning and evidence of action taken.

Most clinical areas were clean, however we saw two areas that did not comply with infection prevention control. Monthly hand hygiene audits we saw for outpatients mostly showed good practice. There were sufficient doctors to run scheduled clinics and diagnostic imaging services.

Records were stored securely, there were robust systems to manage appointments, records and collect clinical data.

### Incidents

- Four incidents were reported for the outpatients and diagnostic imaging services through the Strategic Executive Information System (STEIS) from March 2014 to February 2015 for both Croydon University Hospital

# Outpatients and diagnostic imaging

and Purley War Memorial Hospital. One of the incidents related to delayed diagnosis, one to outpatient delay, one to a fall and one to dentistry. There was also a serious incident in dermatology where the patient gave consent for one mole to be removed and two were removed. The incidents were adequately investigated and root cause analysis had been completed with learning points identified. For example, after the delayed diagnosis the process for checking images was reviewed and rewritten, and after the dermatology incident a checklist was now attached to every referral.

- Staff had access to an online reporting form, and most staff in the two hospitals knew and felt confident in using the system. In the gynaecology clinic staff did not know how to report incidents, they spoke of incidents occurring in clinics that had not been recorded on the incident reporting system.
- We saw in formal minutes that incident handling was discussed in the monthly clinical governance meetings held by the main outpatients and diagnostic imaging staff who worked across the two hospitals. Sixty five incidents related to imaging and outpatients had been reported between the 1st December 2014 and 31st March 2015 via the incident reporting system used by the trust. In outpatients there were trends in booking with incorrect details and problems with patient's specimens delaying a patient's treatment. In imaging there were delays in ultrasound for patients due to a shortage in sonographers.
- We observed that in all cases reported through the system (incidents related to outpatients and imaging), that there were clear action plans. For example, related to the shortage in sonographers, a sonographer had been recruited, and the administrative processes in bookings had been revised.
- The duty of candour requires staff to be open and transparent with people about the care and treatment they receive. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred. The principles aim to improve openness and transparency in the NHS.
- Most staff in the two hospitals were aware of the duty of candour and told us they had received training in relation to this. Staff could provide examples of how the duty of candour was adhered to in their work. For example, staff within diagnostic imaging wrote a letter

of apology to a patient about a diagnostic scan of the wrong part of the body and they were invited to discuss matters further. We saw a poster in the main outpatients waiting area explaining the duty of candour to patients.

## Cleanliness, infection control and hygiene

- In both the hospitals most of the clinical areas we visited appeared clean, and all the waiting areas and toilet facilities were clean. In diagnostic imaging at Croydon University Hospital we observed stained tiles and damaged skirting boards. Cleaning records were not available at this site to indicate when these areas had been cleaned. These matters had been identified in infection control and prevention walkabouts five months before our inspection and had not been addressed.
- The cardiology department did not comply with infection prevention control guidelines. In clinical areas such as the Ultrasound room, we found water leak marks in the ceiling and holes and cracks in the walls. The carpet was old, worn and stained. We found in one examination room that, following building work more than 12 months ago, the walls had not been replaced leaving brickwork exposed. The rooms were small making wheelchair and resuscitation trolley access very difficult. Many of the rooms were not properly ventilated and became too hot in the summer.
- Cleaning schedules and records were available in the consulting and treatment rooms in outpatients at both sites. Staff told us that cleaners were available throughout the day to clean if necessary.
- Personal protective equipment, such as gloves and aprons, was available for staff use in all areas where it was necessary.
- There were monthly hand hygiene audits and infection control walkabouts across both sites. Monthly hand hygiene audits mostly highlighted good practice. However at the entrance to the main outpatients at Croydon University Hospital we observed during a twenty minute period that only one member of staff out of 32 who passed through used the clearly signed hand sanitiser.
- Both outpatients and diagnostic imaging were compliant in their disposal of clinical and domestic waste.
- Staff had infection prevention training as part of their mandatory training. Outpatients collected infection control data with the lead nurse being the link person

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for infection prevention. Infection control data was not collected in diagnostic imaging and action identified in infection control walkabouts had not always been taken.

- We saw processes and records were kept for cleaning invasive diagnostic imaging equipment. The monitoring process for the decontamination of invasive ultrasound probes had been implemented in April 2015 to ensure infection prevention.

## Environment and equipment

- Outpatient services were provided in designated clinical areas.
- All mobile electrical equipment we looked at had current Portable Appliance Testing (PAT) certification. A central register of equipment was held by the trust.
- Emergency resuscitation equipment and equipment used in the diagnostic imaging department at Croydon University Hospital had been checked regularly and serviced in line with published guidance. We saw documentation of the checks and action taken to ensure diagnostic imaging equipment for both sites was safe. The trust's radiation adviser also confirmed actions had been taken to ensure equipment was safe, used correctly and decommissioned safely.
- A radiation safety survey was completed in January 2014 to ensure compliance with the Ionising Radiations Regulations 1999 (IRR99) and the Ionising Radiation (Medical Exposures) Regulations 2000 (IRMER). There were clear standard operating procedures set for diagnostic x-ray as required by IRMER. These addressed patient identification and responsibilities of individual staff members and training requirements.

## Medicines

- In one clinic we noted that many daily checks of the emergency medication and equipment had been missed, in the remaining clinics in Croydon University Hospital we saw they had been checked daily.
- We observed at both sites that medicines were stored securely, they were kept in locked medicine cabinets. In one clinic we observed expired saline solution and sterile water for irrigation, with expiry dates ranging from August 2014 until April 2015. In other outpatient areas we visited the medicines were in date. Fridge temperatures were checked daily and were in line with national guidance. We did not see evidence of audits of

medicines. There was one medication error recorded as an incident when a wrong medicine was prescribed, the learning from this was to ensure that the past medication history was checked in the medical notes.

- We found that three medicines, including Adrenaline stored in the cardiology department, were out of date by up to two months.
- Prescription pads at both sites were stored securely. Medicines required urgently following an outpatient appointment could be obtained from the Croydon University hospital pharmacy with a prescription, otherwise a letter would be sent to the GP to produce a prescription. We saw that staff had access to guidance on the administration of medicines.

## Records

- The clinical records in the outpatients at both sites were paper files. Secure lockable trolleys were used for records transfer and records were stored securely in the outpatient department. The trust had procedural arrangements for retrieving records.
- Staff in the administration team and medical records team showed us the systems they used to manage appointments, records and collect clinical data for both sites. Electronic patient information was only available to authorised people, and computers and computer systems were password protected. Administrative and clinical staff told us that the systems were working well and they had seen a big improvement in the last six months in working practices.
- In diagnostic imaging two separate electronic systems being used that were unable to communicate. Staff told us this meant they had to transfer work from one system to another and this increased the likelihood of errors.

## Safeguarding

- Staff we spoke with working within outpatients and the diagnostic imaging department in both sites had relevant knowledge of the safeguarding procedure and were able to access the trust's protocols related to safeguarding.
- We observed in the main outpatients waiting area on the notice board, a poster with safeguarding children information and contact details.
- All staff were required to complete level 1 safeguarding training for children and adults every three years, there was 88% compliance up to the time of our inspection. In addition doctors, nurses and other staff dealing with patients were required to complete level 2 training every

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three years, compliance was 77%. Compliance with safeguarding for adults training at level 1 was 95%. Managers and the lead nurse in outpatients told us that named nurses for safeguarding had emailed heads of service to prioritise training, the provision of bespoke training was being considered. We also saw this action noted in the safeguarding and child protection May 2015 annual report

## Mandatory training

- Staff were required to complete mandatory training in equality, diversity and human rights every three years, fire safety every year, health and safety and welfare every two years, infection control either every year or every three years depending on their role. Information governance was to be completed every year, moving and handling every two years, conflict resolution every three years, and safeguarding children yearly for level 3 and every three years for safeguarding adults and children at levels 1 and 2. Nurses and healthcare assistants were also required to undertake yearly basic life support training. The target for completion was 90%. Records showed diagnostic and imaging staff were fully compliant. The outpatient manager reported the administrative team were 90% compliant, while information received from the trust showed a compliance of 74% for the outpatient nurses and healthcare assistants.

## Assessing and responding to patient risk

- There was a rapid access chest pain clinic. This provided early specialist cardiology assessment for patients with new onset of chest discomfort due to coronary heart disease, who were referred by their GP.
- At Croydon University Hospital there was emergency equipment available to respond in the event of an emergency and staff told us they were trained to use it.
- All staff we spoke with were clear of the procedure to follow if a patient deteriorated while visiting outpatient clinics or diagnostic imaging departments.
- In diagnostic imaging there was evidence of risk assessment tools for patients having MRI and CT scans.

## Nursing staffing

- There was no matron for the outpatient department. A nurse lead for the main outpatient department was responsible for overseeing the day to day running and management of this service at both sites. This included organising the rota, supervising and assessing the staff

within main outpatients on a daily basis. The lead nurse told us they were putting forward a proposal for an additional band 5 nurse and healthcare assistant to ensure there were sufficient numbers of staff to meet clinical activity. Two nursing vacancies were identified in outpatients in information the trust provided after the inspection.

- Clinical specialities such as rheumatology, and cancer care had nurses with specialist skills, who were assigned to those clinics. The majority of nurses and healthcare assistants in outpatients rotated their working days between Croydon University Hospital and Purley War Memorial Hospital.
- Some staff told us there were staff shortages, that clinics were busy and at times healthcare assistants working with nurses at Croydon University Hospital were unable to promptly get the attention of a nurse. In the gynaecology clinic we were told there was a lack of nurse cover in many clinics and sickness information and rosters provided by the trust confirmed this.
- The overall rate of staff leaving outpatients and diagnostic imaging for the previous twelve months had been 11.8%. Staff leaving figures were made up of 6.5% medical staff, and 20.9% administrative staff. Administrative staff we spoke with told us that for the last six months there had been more stability in their teams. Information provided by the trust after our inspection showed that there were seven whole time equivalent (WTE) administrative vacancies.

## Medical staffing

- Staff told us there were a sufficient number of doctors to run all scheduled outpatient clinics. In diagnostic imaging staff told us that they were able to run services with doctors working extra hours and that a business case had been submitted for the recruitment of additional radiology staff. The rotas and trust documentation we looked at confirmed this.
- Information provided by the trust following our inspection showed there was one whole time vacancy in the anticoagulation service, out of a total allocation of 1.70 WTE doctors and 1.88 WTE vacancies out of a total of seven WTE in dentistry.
- Ear nose and throat (ENT) medical had the highest sickness rate of 7.14% over the year but in the last three months of 2014 had rates from 18.37% to 15.43%.
- Medical staff gave six weeks' notice of any leave in order that clinics could be adjusted in a timely manner.



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Doctors in training gave six months' notice for training. Managers told us that there was a job planning review with doctors looking at how best to ensure there was medical cover for clinics throughout the year. The main reasons for cancelling clinics were annual leave, study leave, training, conferences, and on-call responsibilities. New job plans for doctors ensured clinics were covered over the year.

## Major incident awareness and training

- There was a business continuity plan drawn up in February 2015 and ratified in May 2015 by the executive management board. It informed local managers and staff at both sites how to act in the event of a major incident. Staff were aware of their roles and responsibilities during a major incident and knew who to contact if they required assistance.

## Are outpatient and diagnostic imaging services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We observed and gathered evidence at both Croydon University Hospital and Purley War Memorial Hospital. Suitable clinical guidelines were followed and targets were informed by national guidance. The trust had improved its performance from the 2013 national cancer patient experience survey and patient's confidence and trust in doctors treating them had increased. Most staff had regular supervision, in main outpatients they had introduced a daily team huddle to share information to facilitate the running of clinics. There was multidisciplinary working within the trust, with local clinical networks and national organisations using established pathways.

The system for managing referrals, appointments and collecting data had been nationally validated and was monitored monthly. Extra clinics had been introduced to reduce waiting times in some specialities. Staff were clear about responsibilities in line with the Mental Capacity Act and provided excellent support for patients with a learning disability.

## Evidence-based care and treatment

- The trust had met the majority of the referral to treatment targets for the last six months, we observed the access and management policy was up to date and informed by the national access targets, as defined in the technical guidance issued by NHS England.
- There was a policy on radiation in line with the Ionising Radiation (Medical Exposure) Regulations 2010 (IRMER). The radiation survey completed in January 2014 to ensure compliance with the regulations.
- There were clear standard operating procedures set for diagnostic x-ray as required by IRMER. These addressed patient identification and responsibilities of individual members of staff, and also set training requirements.
- The National Institute for Health and Care Excellence (NICE) quality standard for breast care was being met in the outpatients department with a clinical nurse specialist being present during appointments.

## Pain relief

- Results of the National Cancer Patient Experience Survey 2014 showed the trust was in the highest 20% of trusts in staff definitely doing everything they could to help control pain for those attending hospital as a day patient or outpatient.
- There was a chronic pain service run by the trust. There was also a rapid access chest pain clinic that provided an early specialist cardiology assessment for patients with chest discomfort.

## Patient outcomes

- The trust's follow up appointment to new appointment ratio for the trust was 2.29 this was worse than the England average of 2 as of January 2015.
- The trust had been one of the best performing trusts in the quality of cancer staging data in 2012/13. In 2013/14 as a member of the London Cancer Alliance it was in the highest performing geographical cancer network. This was the process of identifying the severity and treatability of a patient's cancer.
- The trust scored amongst the ten poorest performing trusts in the National Cancer Patient Experience Survey 2013. By 2014 it was out of the bottom 10 performing trusts, in April 2015 Croydon University Hospital was the top performing trust for meeting national cancer targets against other London trusts. The 2014 survey showed that patient's confidence and trust in all doctors treating them had increased from 72% in 2013 to 91% in 2014.

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## Competent staff

- Nurses, healthcare assistants, doctors and staff working in the diagnostic imaging department and outpatients clinics across both sites were mostly competent and knowledgeable. We saw competency frameworks for healthcare assistants and staff were clear about their roles and responsibilities. Nursing staff were aware of their responsibilities and of revalidation ensuring they maintained their continuing professional development and required hours of practice.
- In one gynaecology clinic at Croydon University Hospital we found healthcare assistants who had not received additional training when their role and responsibilities had been extended. They told us they sometimes had difficulty in accessing nurses if they were in a clinic in another part of the building.
- There was an induction programme for new members of staff and staff told us they felt well prepared for their role. The appraisal rate was 98% in diagnostic imaging, and 67% in nursing. Staff told us that they had training opportunities to develop professionally. Staff working in diagnostic imaging told us that they 'get and provide the best training'.
- In main outpatients at Croydon University Hospital there was a daily team huddle where all administrative staff and supervisors met with the nurses and healthcare assistants before clinic started. The purpose of this meeting was to share information to facilitate the running of the clinic. For example we heard a discussion concerning cover for the ENT clinic, and information about the dental clinic being very busy. Staff told us it was helpful to know what was going on so that they were aware of challenges for colleagues and worked to minimise any impact on patients.
- The lead nurse in outpatients told us they had recently set up supervision teams where a band 5 nurse had a supervision meeting weekly with their team of healthcare assistants. The cancer nursing team had one to one supervision once a month and a monthly supervision session facilitated by a psychotherapist from an external organisation. The staff in diagnostic imaging received supervision from staff in and outside the trust, this was not documented. Staff we spoke with in gynaecology clinics did not receive supervision.
- Administrative staff and staff working with records, appointments and data collection for services at both

sites told us they felt well equipped to do their role. There were data champions, these were staff trained to a high standard in data that were able to offer support to colleagues.

## Multidisciplinary working

- Managers and staff working in radiology and cancer services told us of various pathways that had been developed with local clinical networks, staff told us the pathways worked well. One example was a direct access pathway for patients experiencing complications from cancer being able to have tests within a few hours with a specialist nurse present rather than attending A&E and being admitted.
- Staff in outpatients and diagnostic imaging reported that staff worked well together, many staff told us that the service had become more efficient other the last 18 months with improved communication. Members of the team each have a specialist interest and attended those speciality meetings for example A&E. Staff told us that they had good working processes with other providers such as the pathology service as well as the company providing the MRI scanners on the hospital site.
- Administrative and medical records staff told us that reporting outcomes of outpatient consultations back to the referring GP varied from 24 hours for urgent cases, to seven days, this being within the target time for letters to be sent. Two disciplines were taking longer and the staff had arranged to meet with medical staff from one discipline to look into this. There was a traffic light system on the electronic system used to track performance in relation to sending out reports and patient discharge letters. Nurses told us that GPs would get letters in a week or if urgent the GP they would either receive a phone call or written information within 24 hours.
- Meetings were held twice a month with the CCG to monitor the pathways, there were also weekly reports to the Trust Development Agency (TDA) to look at breaches in performance.

## Seven-day services

- At Croydon University Hospital and Purley War Memorial most of the outpatient clinics ran from Monday to Friday between 9am to 4.30pm. The phlebotomy service started at 7am and finished at 4.45pm three days a week and at 7pm on two days a week.
- Saturday and evening clinics had been introduced in the main outpatients at Croydon University Hospital in

# Outpatients and diagnostic imaging

some specialities such as ENT, vascular and urology to minimise waiting times. Extended clinics had been trialled at Purley War Memorial Hospital but there had been insufficient uptake.

- Diagnostic imaging operated a seven days service in Croydon University Hospital and a Monday to Friday 9-5 service at Purley War Memorial Hospital.

## Access to information

- The trusts reported 1% or less of patients' records were not available at the time of appointment (February 2015) across both sites. When the patient record could not be found a temporary record was made. The clinic consultation recorded on the temporary record was then added to the main set of records. This was confirmed by staff working in outpatients.
- We spoke with staff and observed systems used by administrative and medical records staff from receiving referrals, to making bookings, sending appointment letters out, preparing records for clinic, collecting data on treatment, waiting times, and doctors letters. The patient tracking system was observed, it was validated by NHS England in July 2014 and monthly since, with any issues being brought to the attention of managers. We also saw a report on hospital record numbers and the importance and actions necessary to ensure one record with the correct information was maintained. Notes also had labels which were bar coded.
- The records were stored securely with restricted access both onsite and offsite, these were monitored by the trust's head of information.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff across both sites were clear about their responsibilities in line with the Mental Capacity Act 2005. Adult learning disability staff reported excellent support for patients with a learning disability in diagnostic imaging services.
- Staff told us that were required to complete a one-off course on patient consent. Patients told us that they were asked for consent to procedures appropriately. Patients told us that staff always spoke to them about any procedures before carrying it out.

## Are outpatient and diagnostic imaging services caring?

Good



At both Croydon University Hospital and Purley War Memorial we observed staff being friendly, approachable and kind. Patients told us they were happy with the care they received, and were treated with kindness and compassion by staff within outpatients and diagnostic imaging. Patients told us they were given information in an understandable way. Main outpatients had a volunteer who gave patients directions and guidance to patients as they entered the clinic, patients told us this was useful. We saw patients being offered emotional support.

## Compassionate care

- Following the previous inspection compliance action was taken with regard to various elements of patient care which included developing specific customer training to all outpatients staff. At both hospitals during this inspection we observed patients being treated with compassion, dignity and respect. Staff were friendly and approachable.
- Reception staff were polite, they explained if there was a waiting time. If a patient was unsure where to go or if they had come to the wrong department the receptionist would personally take them or direct them to the correct place.
- Patients we spoke with reported a positive experience. For example, one patient told us, "The doctor and reception were excellent", and another patient told us, "I'm very happy with the staff, and a good environment."
- At both sites staff knocked on doors and waited for a response before entering. Chaperones were provided whenever needed or requested. Patient consultations took place in private rooms.
- The NHS Friends and Family Test had been used in the trust's outpatients in April 2015 and in the diagnostic imaging service. This was a single question survey asking patients whether they would recommend the department to their friends and family. Outpatients achieved a score of 94.3% of patients, with a response rate of 12.7%, who would recommend the department to their friends and family. Services provided by diagnostic imaging achieved a score of between 93% and 100%, with a response rate of 6% who would

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recommend the department to their friends and family. We were unable to compare scores with other hospitals as there was no national data yet for outpatients and diagnostic imaging departments.

## Understanding and involvement of patients and those close to them

- All of the patients we spoke with told us that their care was discussed with them in detail, and in a manner they were able to understand. Patients told us they felt included in decisions about their care. Listening in action workshops (LiA) had been introduced by the trust to get people's views on how to improve the service. LiA is a national accredited scheme promoting engagement with staff and people who use NHS services so that they can contribute to improvements in patient care.

## Emotional support

- A Macmillan Cancer Support centre operated at Croydon University Hospital Monday to Friday. This provided support and advice to patients who had cancer and their relatives and friends. There was a wide range of printed information available, for example about types of cancer, signs and symptoms of cancer, and going home from hospital.
- The cancer nursing team was able to offer emotional support to patients and was present during certain clinics for example, at the breast care clinic.
- We observed a member of staff supporting a patient discretely who was upset. The member of staff offered a private area for them.

## Are outpatient and diagnostic imaging services responsive?

Requires improvement



Improvements were required in the responsiveness of the service at both Croydon University Hospital and Purley War Memorial Hospital. This was because staff and patients told us that they expected delays before patients would be seen ranging from 30 minutes to an hour or more. Three outpatient areas at Croydon University Hospital and the cardiology department did not have enough space to treat patients appropriately. The distance from the orthopaedic clinic to the fracture clinic was inappropriate.

The trust was meeting most of its performance targets in referral to treatment times. The percentage of clinics cancelled had fallen and the 'did not attend' rate had fallen, although it was still above the England average. Patients told us they had seen major improvements in the way the service was organised. Although we saw some clinics running late, patients felt informed and staff apologised about any delays. The trust was looking at why clinics ran late and were working to address this. The introduction of text messaging to remind patients of their appointments had reduced the rate of patients not attending. We saw in most clinics that the trust learnt from complaints and sought people's views on how to improve the experience.

## Service planning and delivery to meet the needs of local people

- All the staff we spoke with had seen an improvement in the planning and delivery of the outpatient's service. Patients told us they had seen major positive changes to the way the service was run. Patients were receiving appointments and follow up text messages reminding them of their appointment. Initially the text messages were introduced to specialty clinics and then rolled out to all clinics in March 2015, to address cancellations and patients not attending. Patients were responding to the text messages.
- Saturday and evening clinics had been introduced in the main outpatients at Croydon University Hospital in some specialities such as ear, nose & throat (ENT), vascular and urology, to minimise waiting times. Extended clinics had been trialled at Purley War Memorial Hospital, but there had been insufficient uptake.
- The main outpatients at Croydon University Hospital had introduced a ticket machine where patients took a ticket sat down then were called up to reception. At reception their details would be checked, they would be informed of any estimated wait and if there was a wait given an apology. The patient would then be called in by the nurse running the clinic. Patients told us this had really improved the clinic preventing long queues of people and keeping people informed. At Purley War Memorial Hospital there was more than one receptionist and waiting areas which patients were directed to, there was no queuing.
- The hospital undertook a late starts audit of the 259 clinics audited for a week in May 2015 of which 13%

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started late. Of those that started late 8% were due to clinicians who were delayed by clinical matters elsewhere in the hospital, 3.4% were due to transport issues and 2% to personal matters. The managers told us and we saw noted in the audit documentation that these results had been shared with them and they were looking at where work patterns could be modified to prevent delays. When individual clinics had waiting times at both sites, the receptionists informed the patients and it was also written on a notice board in the waiting area. Patients told us that they appreciated being informed. The majority accepted waiting to be seen.

- Some patients in outpatients at both sites told us they expected to wait for an hour or more. The majority expected to wait for about 30 minutes. Diagnostic imaging staff told us that patients waited on average for twenty to forty minutes to have an x-ray. Staff in outpatients told us that if a clinic was running late patients could talk to them and they would inform the car park attendant, in order to avoid penalties. This was documented in the outpatient leaflet each patient was given with their clinic appointment.
- Following the previous inspection compliance action was taken with regard to various elements of patient care which included waiting times and organisation of outpatient clinics. We found the trust had been responsive to this and had improved and upgraded the environment in main outpatients, at both sites and made short term improvements to the environment in the fracture clinic.
- The trust had increased the use of Purley War Memorial and had analysed its management of waiting lists as a compliance action. It had also developed a Standard Operating procedure for booking patients into clinics as a result of this. Compliance action related to communication with clinicians around the management of clinics was in progress, the development of templates was partially developed and measuring of outcomes and completing audits progressing.
- During this inspection we visited three outpatient areas and the cardiology department in Croydon University Hospital that did not have enough space to treat patients appropriately. The plaster room at this site was not accessible to patients on a ward bed, so patients had to be moved into a wheelchair for treatment. In the cardiology department the rooms

were small making access for wheelchairs and resuscitation trolleys difficult. In the haematology clinic at Croydon University Hospital, there was no space between patient's chairs for curtains and no single sex provision. In the cardiac rehabilitation room at Croydon University Hospital it was hard to accommodate the 10-12 patients who attended the classes.

- The haematology clinic was on the trust's risk register as not maintaining the privacy, dignity and safety of patients with the lack of space not allowing for curtains, and there being no single sex separation. The four chairs where patients were treated were uncomfortable and due to the lack of space pressed against the other chairs being used. We saw that building had commenced in a new clinic facility.
- The distance from the orthopaedic clinic to the fracture clinic and the size of the plaster room were unsuitable for their use. The outpatients' transformation plan proposed a move and was to submit this for the 2016/17 spending round.
- Most of the outpatient clinics ran from Monday to Friday between 9am to 4.30pm. The phlebotomy service started at 7am and finished at 4.45pm three days a week and at 7pm on two days a week. Saturday and evening clinics had been introduced in the main outpatients at Croydon University Hospital in some specialities such as ENT, vascular and urology to minimise waiting times. Extended clinics had been trialled at Purley War Memorial Hospital but there had been insufficient uptake.
- Diagnostic imaging operated a seven day service in Croydon University Hospital and a Monday to Friday 9-5 service at Purley War Memorial Hospital.

## Access and flow

- NHS England validated the trust's patient access service in July 2014 with a high score of 98%, with the service being responsible for data collection on referral to treatment times.
- The trust had performance dashboards for outpatients and diagnostic imaging, both showed how the trust was performing against targets set nationally and those set by the Trust Development Authority (TDA). This is the government agency responsible for overseeing performance management in NHS trusts. The majority of the targets were being met.



# Outpatients and diagnostic imaging

- The trust was meeting the referral to treatment waiting times target for non-admitted pathways; percentage within 18 weeks.
- The trust was meeting the two week urgent referral wait performance target in March 2015 (people seen by a specialist within two weeks from the time when an urgent GP referral was made; all cancers).
- The system used for monitoring patient's referral to treatment times to identify those who had waited for a prolonged period usually worked effectively. Three patients in 2014/2015 had waited for longer than 52 weeks for an outpatient appointment, the patient access manager explained how it had occurred and the action taken to prevent it reoccurring. The local clinical commissioning group (CCG) had been informed of the three incidents.
- The trust had performed worse at 81% than the target of 85% for March 2015 for the year to date in relation to the 62 days target, (percentage of people waiting fewer than 62 days from urgent GP referral to first definitive treatment; all cancers).
- The trust was meeting the target related to the percentage of people waiting fewer than 31 days from diagnosis to first definitive treatment; all cancers).
- The percentage of clinics cancelled fell from 11% in November 2014 to 2% in February 2015.
- Since the introduction in March 2015 of text messages reminding a patient of their appointment, the rate of patients not attending had dropped from 16% to 10.5%, the England average was 7%. The demography of the local area would suggest a higher rate than the English average in non-attendance.
- Two audits of unanswered phone calls between January 2015 and February 2015 in twelve speciality outpatient clinics showed a major reduction in the number of phone calls unanswered, for example from 34 in the physiotherapy clinic and 20 in the warfarin clinic to 16 in physiotherapy and one in the warfarin clinic.
- Waiting times for patients on arrival in the outpatient clinics at both sites varied. Current waiting times were available on a noticeboard in all the clinics.

## Meeting people's individual needs

- Staff told us they had access to a translation service should they need it. There was a poster in the main outpatients waiting area and information on how to book an interpreter or British Sign Language interpreter in the outpatient information leaflet that was sent with

each appointment. Staff were also able to book or directly access a telephone interpreting service. This meant that patients, for whom English wasn't their first language, could engage fully in their consultation. There were no signs or leaflets available in other languages.

- Staff in outpatients told us they had received dementia awareness training, the receptionists told us how much this had helped them. We were shown part of the training video used and staff gave examples of what they did to help patients. We observed that patients with additional needs were prioritised in clinics. Diagnostic imaging staff received information about patients on the request form they received prior to seeing the patient so they were able to prepare for those patients with additional needs. Staff told us that patients with dementia were always accompanied to the service.
- Patients with mobility difficulties were prioritised, and in main outpatients there were higher chairs for people to use if needed. Both Croydon University Hospital and Purley War Memorial outpatients and diagnostic imaging departments were accessible for patients with mobility difficulties and those using wheelchairs. There were disabled toilets and accessible hand washing and sanitising facilities. There were separate waiting areas in diagnostic imaging for inpatients and outpatients at Croydon University Hospital. The distance from the fracture clinic and plaster room to the orthopaedic clinic at Croydon University Hospital was not suitable to walk for those with mobility difficulties. At the previous inspection there had been insufficient seating in the fracture clinic this had been addressed. The haematology clinic had uncomfortable chairs and patients were unable to have privacy with the lack of space not allowing for curtains. A new facility was being built.
- There was a specialist nurse for people with a learning disability who staff could call for advice and who could visit patients in the outpatient clinics who was available daily. The nurses we spoke with felt they had a good understanding of the needs of people with a learning disability.
- There was drinking water and other refreshments available in the waiting areas.

## Learning from complaints and concerns

- Information on how to complain was available in waiting areas and on the outpatient information sheet,



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which went out with every appointment together with information on the Patient Advice and Liaison Service (PALS). PALS offered assistance, advice and support for patients and their families.

- Complaints were appropriately recorded and responded to. We reviewed the minutes of the clinical governance meetings and saw that complaints and trends were discussed at the monthly clinical governance meetings. In outpatients the complaints were mostly about administrative errors (for example cancellation over appointments). We saw in information provided to us that there had been 43 complaints, which related to outpatients between June 2014 to May 2015.
- Eight complaints related to imaging were reported in the same period and 25 for outpatient gynaecology. In imaging we saw in minutes provided that individual complaints were discussed and learnt from, there were no apparent trends. Staff working in gynaecology outpatients did not have regular meetings and there was no evidence of learning from complaints.
- A Listening in Action (LiA) workshop was used to seek people's views following the Cancer Patient Experience survey 2014, which highlighted key areas where the trust wasn't performing well. The key areas in the Cancer Patient Experience survey included: when communicating bad news what would this look like? and how can we make people aware of financial help & free prescriptions? Another LiA had been used to get people's views on the outpatients department in 2014 for them to give suggestions on how to improve the environment and experience and from this improvements had been made to the environment and processes to help the flow of patients.

## Are outpatient and diagnostic imaging services well-led?

Requires improvement



There had been a focus on improving and responding to the compliance action from the previous inspection, although some tasks from the outpatients transformation programme were behind schedule, the trust had made good progress.

There was a clear focus on meeting performance targets. The environment in main outpatients and fracture clinic had been renovated following the previous inspection and had improved patient flow. All staff understood their role in meeting targets and those having monthly clinical governance meetings found them informative.

The views of both patients and staff were actively sought and used to improve services.

There was a gap in leadership at matron level for nurses and healthcare assistants in outpatients.

The majority of staff we spoke felt that the trust had made improvements and said morale had improved in outpatients.

### Vision and strategy for this service

- Both outpatients and diagnostic imaging strove to provide services that were responsive to their patients. Outpatients wanted to improve patient flow and have enough staff to meet the demand for clinics. Diagnostic imaging aimed to provide the right care and be the hospital of choice.
- The previous inspection set out compliance actions with improvements required in the care and welfare of patients in outpatients. There were concerns about the environment and the flow of patients through the main outpatients.
- An outpatient's transformation programme with five work streams had been started in August 2014. In documentation from the 1st of June 2015 we saw the five work streams were: patient communications, and appointment letters, to improve and streamline the choose and book process, the creation of outpatients performance dashboard, and referral processes and clinic utilisation, and the use of outcomes forms to capture data accurately. In the patient communications work stream five tasks out of 62 were running behind schedule these included changing clinic letter templates and signage for patients. In the choose and book process there were five tasks out of 37 running behind schedule these included training staff but awaiting recruitment to train and the lack of capacity of staff. In the creation of the dashboard all the tasks had been completed. The referral processes and clinic utilisation work stream had 16 tasks out of 69 running behind schedule these included preventing overbooking in certain specialities. All the tasks had been completed in the outcome forms work stream.

# Outpatients and diagnostic imaging

- Staff were able to identify the challenges they saw in their own service, in outpatients this was the limited capacity to accommodate more patients in the busy clinics. In diagnostic imaging both staff in the service and managers identified a challenge with aging equipment. Staff across both services spoke of the hospital having improved over the last 18 months, most staff were aware of key performance indicators and their role in improving performance.

## Governance, risk management and quality measurement

- Staff told us that main outpatients and diagnostic imaging both had their own monthly clinical governance meetings and we saw minutes from these. Staff working in outpatients, not including gynaecology, met for the first half of the meeting. We noted that in these meetings, both outpatients and diagnostic imaging staff spoke about complaints, incidents, learning from these, looking at the flow of clinics, patients, staffing and performance in these meetings. Staff told us that they found these very useful.
- The main outpatient nursing team met with the outpatient band 6 lead nurse looking at clinical issues or had a short training session, while the outpatient supervisors and admin staff met with the outpatient's manager. The main outpatients had made good progress in achieving compliance with regulations. For example the environment in main outpatients and fracture clinic had been renovated with attention to improving patient flow. However the relocation of the orthopaedic, fracture and plaster room were seen on the transformation programme to be submitted for the capital spend round 2016/17. This was confirmed by senior managers we spoke with.
- We saw the majority of targets on the key performance indicator dashboards for outpatients and diagnostic imaging had been met over the last six months. The risk register had identified a risk of failing to deliver on nationally set referral to treatment times, this risk was identified as low by the trust. There were weekly access meetings to monitor performance, we saw this evidenced in the work stream document and trust minutes.
- Risks identified on the risk register such as in the haematology unit, the anti-coagulation waiting times and capacity issues in urology clinics were either being addressed or we saw plans to address them. For

example in urology and anti-coagulation increasing the number of clinics held, while for haematology building a new unit. However the cleanliness issue in diagnostic imaging at Croydon University Hospital was not on the risk register and there was no plan to address the infection control risk.

- There had been a restructure in the previous three weeks with the cancer and core functions directorate joining the surgery directorate with four directorates going into three. There was a plan to trial a single quality and performance board to review risks, targets and directorate issues.

## Leadership of service

- An independent report published in September 2014 following the previous Care Quality Commission inspection, identified a lack of leadership and of mapping the end to end process for outpatients. A transformation programme with work streams had been started in August 2014 with progress made in the five work streams and an interim lead responsible for the performance of the service being appointed in February 2015.
- There was a gap in leadership at matron level for nurses and healthcare assistants in outpatients, with the current band 6 responsible for covering clinics herself and supervising staff.
- Staff told us that the chief executive officer (CEO) was visible and did walkabouts within the various departments.

## Culture within the service

- Staff in diagnostic imaging we spoke with were focused on providing a good service to their patients. They aimed to provide a better service for their patients. The majority of staff in outpatients and diagnostic imaging felt the trust had made improvements. Staff in outpatients told us morale had improved in outpatients. Staff in main outpatients had found the customer care training provided had helped them in their jobs. They felt valued and that the organisation was more open and honest.
- Dermatology and cancer care had introduced Schwartz Rounds, these were meetings which provided staff from all disciplines an opportunity to reflect on the emotional aspects of work. Feedback had been very positive.

# Outpatients and diagnostic imaging

- A minority of staff told us they had used the correct channels to raise a matter but had not had these resolved.

## Public engagement

- Patient's views on service improvements were sought through LiA events such as workshops and we saw patients being given feedback cards at their clinic appointments. We saw that views from patients had shaped services for example, the environment in outpatients and the customer care training provided for staff. Patients told us they were pleased to see the improvements.
- We saw positive responses from those patients surveyed on the cardiac rehabilitation programme they attended.

## Staff engagement

- Staff told us they were positive about the Listening into Action – and the changes that came about from them.

They liked the physical improvements in outpatients and the improved flow of patients. We saw in the NHS staff survey May 2015 75% of their staff felt able to contribute to improvements in patient care and working lives.

## Innovation, improvement and sustainability

- The transformation programme for the outpatients department was still in progress. Out of 192 individual pieces of work, there were 40 ongoing. The main outpatients was planning to introduce self-serve kiosks for patients to book in for outpatient appointments.
- A few members of staff spoke of a lack of succession planning, identifying and developing staff within the organisation to fill leadership positions, for the workforce.

# Outstanding practice and areas for improvement

## Outstanding practice

- The Specialist Palliative Care team had engaged with the public and staff to inform the development of the 'care of the dying person care plan.' This included new prescribing guidance for symptoms that occur at the end of life, as well as new medical guidance.
- The trust was involved in the LEGACY study for secondary breast cancer, in collaboration with the Royal Marsden and the Institute of Cancer Research. The objectives of the LEGACY study are to provide researchers with the best opportunity to understand secondary breast cancer, how it works and how to stop it.
- The diabetes team for children and young people was recognised for providing excellent care.
- The special care baby unit had level 2 UNICEF accredited baby-friendly status where breast feeding was actively encouraged and mothers were given every opportunity to breast feed their babies.
- The urogynaecology and pelvic floor reconstruction unit at Croydon Healthcare had an international profile in relation to research, provided courses to the obstetric community and had won many awards.
- The maternity service was currently developing and piloting a programme of antenatal courses designed to support women with limited English.

## Areas for improvement

### Action the hospital MUST take to improve

- Improve clinical governance and risk management in the surgical directorate.
- Implement promptly plans to refurbish theatres and to put in place an equipment replacement programme.
- Ensure that 90% of staff receive up-to-date safeguarding and mandatory training.

### Action the hospital SHOULD take to improve

- Ensure that mental capacity assessments are undertaken and that consent is recorded in patient notes.
- Continue to recruit to vacancies across all staff groups in all areas and ensure staffing levels are reviewed in line with increased demand for services.
- Ensure the environment in all clinical areas complies with national guidance and promotes privacy and dignity.
- Review with staff the results of the 2014 staff survey and develop an improvement plan.
- Ensure that Emergency Department patients are assessed and treated within the nationally agreed standards by an appropriately qualified member of staff.
- Ensure that all equipment used by patients in the Emergency Department is clean.
- Fully implement the Emergency Department computer system functionality to allow contemporaneous recording of accurate patient records and patient risk assessments.
- Improve the processes for recording mortality and morbidity meetings.
- Involve all relevant staff in reviewing the scheduling of operations to maximise efficiency and improve the patient experience.
- Consider how to make a trauma service available on Sundays.
- Ensure that all work streams in the outpatients transformation programme are completed.
- Ensure that medicines are correctly stored and are in date.
- Improve bed flow between the critical care unit and medical wards.
- Provide a specific risk register for end of life care.
- Review resources for end of life care to provide a seven day service.
- Review how it ensures patients and their families are kept informed about their care.
- Develop a range of health-related leaflets in child-friendly formats for Children's Services.
- Provide a fridge suitable for the storage of expressed breast milk on Rupert Bear ward.

# Outstanding practice and areas for improvement

- Ensure that the planned improvements to parent accommodation in children's services is completed to time.
- Ensure that the planned maintenance work and equipment replacement in maternity are completed in a timely fashion.
- Review midwifery staff's awareness of the action to take in the event of activity levels escalating outside normal working hours. Consider reviewing the triage area in the Emergency Department in order to improve privacy and confidentiality.
- Improve the experiences of women being cared for on the gynaecology ward after a pregnancy loss.
- Improve the level and range of information available to women following pregnancy loss regarding the disposal of the pregnancy remains.
- Consider how to meet its internal objectives to monitor compliance with guidelines on an annual basis.



This section is primarily information for the provider

## Requirement notices

### 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
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>The provider was not complying with Regulation 12 (1) (c), as persons providing care and treatment to service users did not always have the qualifications, competence or skills to do so safely. Staff were not always trained in safeguarding vulnerable people and mandatory safety related training subjects were below the trust targets.</p> <p>The provider was not ensuring that Regulation 12 (1) (d), (e) and (f) was being met.</p> <p>The provider was not ensuring that the equipment used for the surgical services in the provision of care or treatment to a service user was safe for such use and was used in a safe way;</p> <p>The environment in Cardiology was not sufficiently clean or maintained. Operating theatres were in a poor state of repair.</p> <p>There was lack of equipment provision in theatres on some occasions and some equipment items were old and required replacement.</p> <p>Equipment used in the emergency department had not always been cleaned to a required standard.</p>

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Termination of pregnancies	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>The provider was not complying with Regulation 17 2 (a) and (f). Systems and processes were not sufficiently established or operated effectively to ensure the</p>

## Requirement notices

Treatment of disease, disorder or injury

provider was able to assess, monitor and mitigate risks relating to the health, safety and welfare of service users and other who may be at risk, which arise from carrying on of the regulated activity because;

- 1) Within the surgical division the clinical governance structure was not sufficiently robust. There was an absence of standardised practice in relation to incident reporting and risk management.
- 2) The risk register had been regularly updated, but items had remained on the risk register for months and sometimes years without being addressed.
- 3) Mitigation of risk was reliant on steps taken by clinical staff, without appropriate checks of their effectiveness.
- 4) Risks related to patient access and flow to the Emergency Department were not fully identified and addressed in conjunction with external service providers.

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.