This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

**Facts and data about this trust**

Croydon Health Services (CHS) NHS Trust provides acute and community healthcare services across the borough of Croydon either in patient’s own homes or from clinics and specialist centres, including Croydon University Hospital and Purley War Memorial Hospital in Croydon. We inspected Croydon University Hospital and Purley War Memorial Hospital.

CHS has 443 inpatient beds. The Emergency Department is at Croydon University Hospital. Purley War Memorial Hospital does not have any inpatient beds and services provided include phlebotomy and outpatient clinics.

As at August 2017 the trust employed 3652 staff and had an overall vacancy factor of 14%.

CHS was entered into Financial Special Measures (FSM) in the summer of 2016. In the spring of 2017 it was stated by NHSI that the trust no longer required to be part of the special measures programme and was subsequently removed. FSM has enabled the trust to focus on reducing its deficit whilst maintaining care quality and patient experience. For this financial year its projected income is £277 million and a planned deficit of £-19135.

The population of Croydon is estimated to be 381,000 and is expected to increase to 403,500 by 2022. It has the youngest population of any borough in London with 32% of residents aged under 25 and has around 144 nursing and residential care homes.
Is this organisation well-led?

Leadership

We last inspected the trust in May 2015 and since then the trust has had a stable executive team. Immediately following the 2015 inspection a new medical director was appointed.

At the time of the last inspection the trust had just reorganised into three directorates; Integrated Adult Care Directorate, Integrated Surgery, Cancer and Clinical Support Directorate and Integrated Women’s, Children’s and Sexual Health Directorate.

The trust board had evolved and become more effective since the last inspection. Some of the progress has been as a result of the Financial Special Measures (FSM). Executive directors and the chair commented that going through the process had helped them review and improve how the board worked and was seen as a benefit of the FSM. There had also been formal board development sessions and they had received support from NHSI and external organisations. There was improved closer working between the executives and non-executives.

We were told by board members that a number of deputy directors had recently resigned and that the finance team seemed ‘thin’ and was only able to provide limited support to operational staff in making the planned efficiencies. Following the inspection the trust told us this was incorrect, the deputy director of finance had resigned but was still in post at the time of the inspection. Two new associate medical directors had been appointed earlier in 2017 to provide additional support to the medical director.

During our unannounced inspection during a weekend it was clear that the site practitioner was focussed on managing the emergency department (ED) and was unaware of the number of critical care beds available. They told us they spent most of their time in the ED. This indicated there was no one in the trust who had oversight of all the activity in the hospital, which would have significant implications if there was a major incident and the hospital would have to declare the number of beds were available.

The director of nursing, midwifery and allied health professionals was the executive lead for mental health and the trust had leads for adult and child protection, infection prevention and control and learning disability. A non executive director was the board lead for end of life care.

Allied health professionals (AHPs) reported jointly to the director of nursing and the chief operating officer. The AHP leads indicated that they did not feel so involved with decisions and future plans for the trust and had developed their own strategy. The strategy was underpinned by national and local priorities and the director of nursing had encouraged them to develop it. They told us they did not have regular meetings with the director of nursing, midwifery and allied health professionals other than through the nursing, midwifery and AHP monthly meetings, which they felt they had been added to as an ‘after- thought.’ Following the inspection the trust told us that AHPs are represented at the Quality, Experience and Safety Programme meetings.

In the core services we inspected we found significant improvement in the leadership in surgery and some improvements in outpatients. In end of life care progress was hampered by insufficient medical staff. This was highlighted in the previous inspection report and although a business had been submitted no further action had been taken.

Significant problems remained in critical care, with little progress since the last inspection. Some of this may have been due to the financial position of the trust. However, it was compounded by a lack of motivation at senior clinical level and a lack of motivation and confidence in staff working in
the unit. Following the inspection the trust sent us a letter outlining some short to medium term improvements.

The trust board had a cohesive and comprehensive knowledge of the current priorities and challenges and action was either in progress or being planned to address most of them.

Our checks of formal documentation included fit and proper person reviews, appraisal information, recruitment processes and subsequent appointments demonstrated that members of the executive team had a range of desired experience, knowledge and fit for the needs of the services provided. The trust had taken advantage of a recent increase in the number of non-executive posts to appoint a non-executive with financial turnaround skills.

All members of the board had to complete an annual self-declaration form and we saw evidence they had been completed and confirmation that appraisals had been undertaken.

During discussions with staff pre and during the core service inspection we heard many positive comments about the trust board and senior leadership team, staff told us they were visible and approachable and although there were still some issues to be resolved they felt the chief executive was open and the senior team engaged with them.

Consultants spoke about the benefits of having a stable executive team and they felt that ‘things were now better’ and there was a willingness to improve services but, the financial problems had had a negative impact on some service developments. They told us that during the period of FSM the chair and chief executive were clear that the safety of patients was not to be compromised.

**Vision and strategy**

The trust’s vision was ‘Excellent integrated care for you and your family, when and where you need it.’ Alongside this were five promises which had been developed with patients, carers and staff. The promises were about ensuring people felt cared for, safe and confident in their treatment, convenient appointment times with minimal waiting times and that patient, carers and staff felt the service was continually improving.

Members of the board and senior management team were able to articulate the long-term strategy, which involved closer working with the other health economy partners, including the local clinical commissioning group (CCG) and local authority, to develop an integrated health and social care system. There was evidence that the trust was already working closely with the local authority. Although the relationship with the CCG, which was in Financial Special Measures, had developed it was not as strong.

While the trust had a long-term strategy, executive directors were unable to describe the short to medium term requirements for the estate to ensure there was continued patient safety in the intervening period. This was particularly evident in relation to the critical care unit. At the last inspection we highlighted this as an issue and there had been little progress in terms of real action since then.

The operating plan for 2017-2019 had five key objectives. They were related to financial performance, referral to treatment times and cancer targets, future achievement of the national A&E target, developing new and innovative models of care, quality plans and objectives to help the trust achieve an outstanding CQC rating and a workforce strategy that would enable that supported the recruitment and retention of staff and recognised new ways of working.

Other priorities included encouraging more patients and GPs to choose Croydon University Hospital (CUH) for their care. We heard during the inspection that the trust had achieved some
success with some patients being repatriated from another local NHS Trust for planned surgery. Consultants were involved in discussions about the process for repatriating patients. Through engagement with mums-to-be and local GPs the trust had seen a 6% increase in maternity bookings since 2014.

Development plans for services had taken into account the needs of the local population. For example, the Edgecombe Unit combined rapid access including acute care of the elderly and prevented up to 20 unnecessary hospital admissions every day and LIFE which helped people to regain their independence more quickly when they were discharged home. LIFE brought together the trust’s community teams with adult social care and Age UK Croydon.

The trust had aligned its strategy and operating plan for 2017-2019 to local plans in the wider health and social care economy through its membership of the Croydon Local Transformation Board (LTB). Membership of the LTB included representatives from Croydon CCG, Croydon Local Authority, Croydon GP Collaborative and South London and The Maudsley Mental Health NHS Foundation Trust. The LTB was accountable to the South West London Sustainable Transformation Plan (STP) Programme Board.

The pharmacy department had good links with pharmacy departments of other local hospitals; this ensured best practice initiatives for medicines optimisation were shared.

**Culture**

Staff we spoke with prior to and during the core service inspection told us that they felt valued, the trust was a good place to work and they received support from their managers.

They described the culture as open and transparent and said they felt able to raise concerns. The trust had appointed five Freedom to Speak up Guardians from different staff groups including nursing, medicine, therapy and management. Staff across the trust were aware of the guardians and had approached them with concerns. Information provided by the trust demonstrated staff had been supported to raise the concerns with their line manager and resolve them and Freedom to Speak Up concerns were reported to the executive management board. However, some nursing staff told us they had experienced bullying from medical staff but had not raised it with anyone.

The trust recognised staff success through staff awards and feedback. In recognition of outstanding service and commitment the trust had introduced annual staff wards, ‘Croydon Stars’, which were held in the spring of each year.

The trust had a Joint Staff Consultative Committee (JSCC) and a trust-wide medical and dental local negotiating group (LNC). The LNC covered matters which were exclusive to medical and dental (M&D) employees and the JSCC dealt with other employment matters which covered all staff such as general HR policies and procedures.

We met with some staff side representatives who told us they were involved in discussions and consultations but, sometimes felt they were engaged after decisions had been made and would like to have been involved at an earlier stage. Where they had been involved at the early stage of a change it had worked well. They told us staff had access to occupational health but, funding for other health and well-being programmes was limited. They were involved and supported staff who raised issues about bullying and harassment and felt the trust responded to the allegations and took action where appropriate.

**Sickness levels**
The trust’s sickness levels between July 2016 and June 2017 were similar or better than the England average.

(Source: NHS Digital)

NHS Staff Survey (2016) Performance on questions relating to bullying, harassment and equal opportunities

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2015.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

<table>
<thead>
<tr>
<th>KF25</th>
<th>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives</th>
<th>Trust 2016</th>
<th>Average (median) for combined acute and community trusts</th>
<th>Trust 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>31%</td>
<td>27%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>BME</td>
<td>31%</td>
<td>27%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>KF26 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------------------------------------------------------------------------</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>White</td>
<td>BME</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>26%</td>
<td>28%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>22%</td>
<td>26%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>KF21 Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>White</td>
<td>BME</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>85%</td>
<td>70%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>88%</td>
<td>75%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Q17b In the 12 last months have you personally experienced discrimination at work from Manager/team leader or other colleagues?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>White</td>
<td>BME</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8%</td>
<td>14%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6%</td>
<td>14%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Results for KF21 and Q17b had a statistically significant difference between responses from BME and white staff.

(Source: NHS Staff Survey 2016)

There was an improvement in some of the results of the trust’s 2016 NHS Staff Survey when compared with the 2014 survey. The percentage of staff who would recommend the trust as a place to work had increased by 6% and care of patients being a top priority for the organisation had increased by 9%. The trust had scored better when compared with other trusts for the quality of appraisals and non-mandatory training and learning and development.

The trust had performed less well for staff satisfaction with resourcing and support. This was supported by comments from some nursing staff who told us about the negative impact staff shortages had on patient care and how the increasing number of patients with mental health problems had placed a strain on them. They felt they had not received sufficient training in how to care for these patients.

The trust applied duty of candour appropriately, as evidenced within our review of documents of adverse events and serious incident investigations. They took appropriate and learning was shared as a result of concerns raised, and were open and honest in their communications with patients and families concerned. The family liaison support officer provided training to staff and developed leaflets for patients and staff on duty of candour.

The number of staff who had appraisals had increased since the last inspection and more than three quarters of staff who responded to the 2016 staff survey said the trust provided equal opportunities for career progression and promotion.

The trust had an Equality, Diversity and Inclusion Strategy 2016-2019 and nearly half of the workforce was from a Black or Minority Ethnic (BME) background. At board level 30% of the members were BME and the trust is aware it needs to continue to improve this. Although staff did not raise any issues about inequality in relation to ethnicity the trust was aware it needed to increase diversity at bands 8/9. The trust had recently introduced a staff networking group which
provided an opportunity for staff to raise concerns or make contributions to the equality agenda. The trust’s 2017 submission for the Workforce Race Equality Standard (WRES) demonstrated that it had an understanding of the differences for BME and white in terms of employment, bullying and harassment and career progression.

The trust’s values had been reviewed with staff involvement and were included in the recently developed ‘Quality Guide’ for staff. The values were about being professional, compassionate, respectful and providing safe care.

**Governance**

Interviews with staff and documentary evidence demonstrated that the trust had improved its governance systems at both trust and directorate level. There had been a corporate governance re-structure and the system was constantly under review. Executive and non-executive directors we interviewed felt the system was working. One person told us ‘there is a developed conscience on the board about doing things properly’.

The trust had a range of sub-board quality groups/committees, directorate committees and team meetings. We did not attend a board meeting but a review of minutes demonstrated that quality and safety issues were discussed including mortality rates and the recent inpatient survey. Non-executive directors we interviewed who were chairs of the three main committees (audit, finance and performance, and quality and clinical governance) were clear on their respective responsibilities and worked closely to ensure that all issues received appropriate challenge, and the balance between finance, performance and quality was maintained.

The director of nursing, midwifery and allied health professionals was the named executive lead for quality improvement. The trust’s Quality Strategy for 2016 - 2019 and was linked to the trust’s business strategy. A quality report was presented monthly to the executive management board, the quality & clinical governance committee and the trust board. It provided an update on progress against the objectives which were set out under the five CQC domains. Each directorate produced a quality report which was discussed at their monthly quality board. Clinical directors were responsible for the local delivery of the strategy through their quality governance structures and activities.

A good level of information was available at board level and included a clear statement of the financial position of the trust. Although the remit of the finance and performance board committee was very wide, interviewees felt that an appropriate balance between the different elements of the agenda was maintained.

The director of nursing, midwifery and AHPs was the trust lead for mental health. The trust did not have a strategy for the care of people with mental health needs although improving support and care for people with mental health needs was a priority in the trust’s 2016/17 quality account. At the time of the core service inspection, the administration of the Mental Health Act (MHA) was ineffective. The site practitioners, who held the detention papers for patients detained under the Mental Health Act, did not know who was responsible for explaining patients their rights. There was a mental health liaison team based at CUH but the service level agreement (SLA) with the local NHS mental health provider had not had final sign off. This meant there was no system to ensure detained patients were read their rights, or had access to a tribunal or an advocate. This was escalated at the time of the inspection, and the trust signed the SLA a week after the core service inspection.
Bi-monthly reports were submitted to the trust board and these focussed on the mental health pathway in the emergency department including waiting times, waiting times/reasons for delay in the number of patients referred to mental health services and the number admitted.

On some of the wards we visited we found there was a lack of understanding and awareness among some staff about the Mental Capacity Act (2005), the management of Deprivation of Liberty Safeguards (DoLS) and how the legal rights of patients detained under the Mental Health Act were ensured. This has been reported on in more detail in the core service reports.

The pharmacy team comprised of 65 pharmacy staff, including pharmacists, pharmacy technicians and pharmacy assistants. The chief pharmacist was well supported by two deputy chief pharmacists; one was responsible for patient facing services and the other led on procurement and technical services. Pharmacy was well integrated into the governance structure of the Trust.

In line with national recommendations, almost 80% of pharmacy staff were in a patient facing role. There are also designated staff to manage expenditure on high cost drugs. The medicines safety officer reviews medicines incidents and shares learning both internally and externally. An antimicrobial pharmacist and new microbiologist are currently working together to optimise antibiotic prescribing.

We found in the core services we inspected that although information about learning from incidents was shared with staff they did not always receive information about low/medium harm incidents. Information about learning from complaints was shared with staff and they were aware of when to seek advice and knew how to access senior people.

We saw evidence that the trust was working with third party providers effectively to promote good health. Examples of this included MacMillan and Age UK.

In most of the core services we inspected we saw there had been an improvement in the governance arrangements. This had been a particular concern in surgery at the last inspection. Interviews and documentary evidence indicated there had been a significant improvement in the systems for monitoring and oversight of the quality and safety of care. The directorate structure enabled clear lines of reporting and accountability.

**Management of risk, issues and performance**

The chief executive was the accountable officer, and had responsibility for ensuring an effective risk management system was in place. The executive medical director (MD) was designated as the individual responsible for leading on patient safety and risk management. In addition, the director of nursing, in conjunction with the MD was required to maintain an overview of clinical governance arrangements, which included the reporting, management and investigation of adverse incidents. The trust had a risk management framework ratified in October 2017.

At this inspection we found there had been significant improvement in systems for reviewing and improving patient safety and much of the work had been driven by the medical director. Incident reporting had increased, with an increase of 25% in the first six months of 2017. At the 2015 inspection the trust was noted to be under reporting when benchmarked against other comparable trusts. Increased reporting has helped the trust have a better understanding of the risks/potential risks to patients and the incident investigation process had improved. One area they were continuing to develop was escalation of the deteriorating patient.
The trust’s HSMR was as expected within the London peer group. The trust had established a mortality review group which monitored the reporting and review of all categories of in hospital deaths. The group reported to the patient safety and mortality committee. A multi-disciplinary group met monthly under the clinical leadership of a consultant physician. A consultant was invited to attend the monthly meetings on a rotational basis to discuss/present cases.

We carried out a review of serious incident investigations, mortality reviews and complaint investigations and found the trust was following national guidance. In terms of mortality reviews there was an effective process which had a mechanism to identify individual reviewers who were continually finding ‘no concerns’ and track recurring themes.

Since the last inspection the trust had reviewed and improved its processes for managing and reporting risk and had recruited a head of corporate affairs who was responsible for signing off the board assurance framework (BAF) and corporate risk register.

Key risks from the directorates were included on the corporate risk register which was presented monthly at the executive management board, trust board and bi-monthly to the trust’s audit committee. There was evidence of actions, dates and nominated staff responsible for risks on the corporate risk register. The corporate risk register reflected the majority of risks found during the inspection, however here was no reference to patients with mental health needs.

A review of risk registers in the core services we inspected found that most of them were up to date with actions, timescales and named staff for each risk. However, the risk register for end of life care had one risk related to the shortage of palliative care consultants. It had been on the register since 2015 but there was no review date. It was not on the corporate risk register. In outpatients we found that the matron did not have access to the risk register and did not know how to add risks to the register or who was responsible for adding risks for outpatients.

In terms of the environment in the critical care unit, it was noted on the corporate risk register and had been reviewed regularly. Improvement of the environment was reliant on the success of a business case which had not been submitted at the time of the inspection and the director of estates and facilities was unable to provide us with any detail about this issue. Some action had been taken to mitigate risks in terms of infection prevention and control. Following the inspection we received an update from the chief executive. The trust had put in a bid for funding as part of the Sustainable and Transformation Plan (STP) to rebuild the unit.

Finance was one of the biggest risks for the trust and was on the corporate risk register. The directorates were involved in the budget setting process with the aim of ensuring the outcome was “owned” by local teams. Efficiency plans had been informed by benchmarking against Model Hospital and Dr Foster data. There was a regular process for holding divisions to account for their financial delivery including a financial improvement delivery board and weekly “lock-in” meetings within directorates. This seemed to be understood by the directorates, although it had not been successful in delivering the planned savings in 2017/18.

Board members had a consistent view of the financial position of the trust, with a shared understanding of the reasons for the under-performance during 2017/18. There was universal acceptance that the FSM process the trust went through during 2016/17 had provided a useful focus on the trust’s financial position, raising the issue in an effective way with clinical staff, and also introducing a better financial reporting methodology. Interviewees felt that that staff at all levels of the organisation had pulled together well in response to the FSM process. Executive and non-executive directors we interviewed noted that the arrangement where non-executive directors...
“buddied” the executive directors with overall responsibility for delivery of efficiencies had proved very useful, and this structure had been maintained since the end of FSM.

However, once the trust had returned to normal financial supervision, the level of focus on financial delivery seemed to have regressed. The trust entered into 2017/18 with a very challenging efficiency plan. Following the inspection the trust told us the plan had been agreed in conjunction with NHSI who had provided additional support throughout the FSM. The director of finance, supported by the non-executive directors, stated they were aware that the trust was struggling with delivery of its financial position by early summer 2017. However this recognition was not universal, with other directors still feeling that the position was under control and the plan could be delivered. The board was unable to resolve this difference, and this has led to a slow response by the trust to the developing financial issues. As at November 2017, the trust was just about to appoint turnaround support following discussion with NHS Improvement, but in the meantime the position continued to deteriorate and the organisation will not achieve its Control Total for 2017/18. The use of turnaround support was considered to be an appropriate response but could have been brought in much earlier in the year.

The trust had a major incident plan, ratified April 2017, which included plans for a flu outbreak and other event that could disrupt business continuity such loss of water or power. However, some sections were incomplete. In November 2016 the trust responded to an external major incident following the Croydon tram derailment and provided care for 38 people. The trust also responded to one internal major incident in 2016/17 relating to a temporary IT failure. All systems were back on within approximately 30 minutes, with paper-based support systems used in the interim.

From discussions with staff and other external organisations it was clear that the cost improvements were not compromising patient care, however, they were hampering plans for developing and improving services.

Information management

The board received holistic information on quality and sustainability. Board papers covered finance, quality, strategic and performance updates. Minutes of the audit committee, finance and performance committee and quality and clinical governance committee were shared with board attendees.

There was a performance dashboard for each directorate which reported on performance and safety and quality e.g. waiting times, falls, infection prevention and control, patient experience and length of stay. The dashboard was rag rated and information was grouped using the CQC domains and informed the board assurance framework.

The trust was aware of its performance and staff we interviewed during both the core service and well-led inspection were able to share with us specific information about their directorate’s performance/service.

Some staff in some of the core services we inspected were less aware of how their wards/clinical areas were performing, although they were using the Safety Thermometer. We did find some examples where information had been used to inform care. For example a staff led ‘Listening into Action’ campaign set out to reduce catheter-associated urinary tract infection through extra staff checks and staff awareness and a pressure ulcer taskforce group met on a monthly basis to discuss incidents and formulate plans to help reduce the risk to patients of pressure ulcers.
The trust had reduced the number of falls at CUH and in 2016/17 had an average falls percentage of 0.66%, which was below the national average of 1.59%.

The trust was using both paper and electronic patient records (EPR) and regular record audits were carried out. Electronic records were password protected and paper records were stored securely. Staff did not experience any difficulties in accessing the EPR, however during the core service inspection many of them were unable to locate information about patients’ mental capacity and capacity assessments.

The trust shared information with staff through intranet and each directorate/clinical area had their own system for cascading information to staff.

Systems were in place to collect data from wards and staff were supported by clinical governance facilitators and clinical business unit managers to do this. Staff had access to IT equipment and systems needed to do their work.

A major IT infrastructure project was completed in 2016-17 which allowed CUH to use up-to-date telephone systems. The changes will also make the hospital computer network more reliable.

The trust submitted data to external bodies including CQC, NHS, NHSI and Croydon Clinical Commissioning Group.

**Engagement**

Engagement with patients and staff is an area that the trust has worked very hard to develop over recent years and with some degree of success in both terms of engagement and changing perceptions about the trust.

It was clear from discussions with board members, clinical directors and documentary evidence that the trust worked closely with other local providers of health and social care, staff and the local population.

The trust had a structured and systematic approach to engaging with people who use services, their families/carers, representatives and staff. The main mechanism, which the trust had adopted in 2013, was Listening into Action (LiA). It is a mechanism for both engaging and allowing patients/carers/public and staff to share their views about the trust and ideas for improvements.

In March 2017, the trust launched the Listening into Action Ambassadors network. Staff had identified 30 areas they wanted to develop/improve. Thirty LiA ambassadors, including pharmacy staff, had been appointed to take the work forward. Improvements as a result of LiA included shorter waiting times for blood tests and minimising waste medicines as well as improving medicines counselling for people discharged from the acute medical unit (AMU). This has been facilitated through pharmacy technician led nurse training sessions.

The trust had introduced ‘Visible Wednesday’ when senior staff including the chief executive and chief pharmacist, visited clinical areas to hear directly from staff. Staff commented this enabled them to approach the leadership team directly to discuss concerns with them.

We heard many positive comments about how the trust engaged with staff but, also a few indicating they thought LiA wasn’t as effective as it used to be.
Other opportunities for staff to provide feedback included team meetings and comment cards and the Family and Friends Test for patients and carers. Matrons undertook regular weekly quality rounds which they used as an opportunity to seek feedback from patients and service users.

In March 2017, in response to requests from patients/families/carers for more convenient ways to contact the trust and manage their appointments, the trust had introduced point of delivery (PODs) teams. The PODs gave patients a single direct telephone number and a dedicated email address for contacting groups of specialist services. For some staff (medical and administrative) this was a significant change and they were unhappy with the outcome, while others told us it was definitely an improvement. Staff had been consulted about the proposed change and there was on-going follow up to embed the change.

The POD teams had dedicated staff who kept track of patients’ care, from start to finish, which helped the trust monitor waiting times and keep patients and their GPs better informed. During the inspection we heard from administrative and clinical staff about the PODs and how they had been implemented and the resulting problems. There were some positive comments about the benefits of the PODs. Evidence provided by the trust demonstrated that staff had been consulted with and information about the rationale for introducing the PODs, the new structure and how the change would be implemented, including support and training was shared with staff in July 2016.

In March 2017, the trust had a ‘Big Conversation’ where 50 members of the public and local groups discussed improvements in their mystery shopper programme, catering, reducing patient isolation and other areas. The trust had established a mailing list of people who wanted to attend regular events. It has also introduced ‘Croydon health News, a newsletter for community groups and partners across the borough and people on the mailing list.

Just over four hundred patients responded to the 2016 NHS Inpatient Survey. In many areas the trust was about the same when compared with other trusts, however the responses were worse for questions about discharge and if they had confidence in nurses caring for them. They were worse for patients feeling that overall they had a good experience. Staff we spoke with were aware of the findings from the survey and the trust was developing an action plan to address the issues in the survey. However, we heard many positive comments from patients during the core service inspection.

Communication systems such as the intranet and newsletters were in place to keep staff, patients and carers up to date with the work of the trust. The trust was using Twitter and Facebook to support its outreach work to engage with its local community.

**NHS Staff Survey Performance**

In the NHS Staff Survey 2016, the trust performed better than other trusts in four questions, about the same as other trusts in 15 questions and worse than other trusts in 13 questions.

The five questions for which the trust performed most favourably compared with other combined acute and community trusts were:

- **KF13** – quality of non-mandatory training, learning and development (4.12 compared to the national average of 4.07)
- **KF12** – quality of appraisals (3.27 compared to the national average of 3.11)
- **KF4** – staff motivation at work (4.00 compared to the national average of 3.94)
• KF24 – percentage of staff / colleagues reporting most recent experience of violence (71% compared to the national average of 67%)
• KF22 – percentage of staff experience physical violence from patients, relatives or the public in the last 12 months (12% compared to the national average of 13%)

The five questions for which the trust performed least favourably compared with other combined acute and community trusts were:

• KF23 – percentage of staff experiencing physical violence from staff in the last 12 months (3% compared to the national average of 2%)
• KF14 – staff satisfaction with resourcing and support (3.19 compared to the national average of 3.28)
• KF21 – percentage of staff believing that the organisation provides equal opportunities for career progression or promotion (78% compared to the national average of 87%)
• KF25 – percentage of staff experience harassment, bullying or abuse from patients, relatives or the public in the last 12 months (31% compared to the national average of 26%)
• KF10 – support from immediate managers (3.69 compared to the national average of 3.74)

The engagement score for this trust was 3.79, which is about the same as other trusts.

(Source: NHS Staff Survey 2016)

In March 2017 the trust established the staff networking group which covers all protected characteristics with particular focus on disability, race, religion and LGBT.

The trust was actively engaged in collaborative working with external partners such as the sustainability and transformation plan. The trust was working with six local clinical commissioning groups (CCGs); Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth and with NHS England to develop a five-year strategy for the local NHS in south west London. They had agreed to look at out of hospital services first before considering any changes to hospital care.

Learning, continuous improvement and innovation

The trust sought and participated in national improvement innovation projects and clinical research trials.

In 2016/17 the number of participants involved in clinical trials had increased by 29%. In total, 646 patients took part in 55 clinical studies and were looked after by 134 clinical staff using the latest techniques and research. In the last three years, 49 publications have resulted from the trust’s involvement in research. An example was the ongoing trial of a special electronic vest, which enables clinicians to remotely monitor a patients’ respiratory health whilst the patient is in the comfort of their own home.

The trust was part of the Croydon Health and Care Alliance, other partners were the local authority, Age UK Croydon and the local NHS mental health trust. Working together they had created the Personal Integrated Care Programme which was beginning to join up services to look after people’s physical and mental health wellbeing.

A new emergency department was being built which due to delays was estimated to be completed by spring 2018. However, the new resuscitation unit has been completed and was in use at the time of the inspection. It is a much bigger unit and has six adult bays and four bays for children
compared with four and one respectively in the previous unit. We visited the unit during the well-led inspection and it is very spacious and staff were pleased with the new environment.

---

**Surgery**

**Facts and data about this service**

The trust had 19,194 surgical admissions between April 2016 and March 2017. Emergency admissions accounted for 5,087 (26.5%), 12,477 (65.0%) were day case, and the remaining 1,630 (8.5%) were elective.

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. The trust has ten main operating theatres and four surgical wards at Croydon University Hospital:

- Queens 2 - 20 beds
- Queens 3 - 28 beds
- Fairfield 1 - 20 beds (vascular)
- Fairfield 2 - 24 beds

There is an area for pre-assessment, admissions, and discharge. There is a day surgery unit with four theatres and a surgical assessment unit with six beds.

We talked with 12 patients and over 30 members of staff, including administrators, domestic staff, healthcare assistants, nurses, theatre staff, doctors in training, consultant surgeons and anaesthetists, senior nurses, managers, 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.

**Is the service safe?**

**Mandatory training**

The trust set a completion target of 95% for all mandatory training modules.

A breakdown of compliance for mandatory courses as of July 2017 for medical/dental and nursing/midwifery staff in surgical care is shown below. The table only includes courses delivered specifically to medical and nursing staff:
Training for manual handling people had the lowest completion rate at 49% with only 19 of 39 required medical staff completing the training.

Since our inspection, the trust provided updated mandatory training figures, and as of September 2017, the overall compliance figures for general surgery, trauma, and orthopaedics and urology was approximately 87-90%. Manual handling training had significantly increased and the trust was a seeing a month on month improvement. The trust found the period February to September 2017, challenging due to consultant sickness, retirements, and seven new members of staff who had started throughout the year.

The trust had a directorate winter plan to close theatres to elective surgery between the 23 December 2017 to 2 January 2018, when they would encourage staff to undertake cores skills training, which included safeguarding if they were not needed clinically. However, they would continue to carry out cancer elective procedures along with urgent and trauma cases.
Training completion rates for nursing were generally at or near to the trust target of 95%. Fire safety and manual handling people had the lowest completion rates, both at 85%. Following the inspection the trust told us the target was 90%.

Training was delivered by e-learning or face-to-face sessions. Ward managers we spoke with demonstrated the systems they used locally to monitor their staff attendance at mandatory training to ensure it was completed or refreshed. Staff and managers received an e-mail in advance of when modules needed to be completed. Ward sisters told us they often faced difficulties in releasing staff for training where the wards had high vacancies.

Staff received training to help them recognise, diagnose, and act for patients with sepsis. This training was included in induction, and within immediate life support (ILS) training. Staff we spoke with across surgical services were able to describe the processes they would follow for a patient with sepsis.

**Major incident training completion rates**
The trust did not report on major incident training courses.

**Safeguarding**

**Safeguarding training completion rates**
The trust set a target of 95% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses as of July 2017 for medical/dental and nursing/midwifery staff in Surgery is shown below. The table only includes safeguarding courses at the appropriate level for medical and nursing staff, therefore level 1 and level 4 courses are not included in the tables:
Safeguarding adults level 2 training had the lowest completion rate across both staff groups although the compliance for medical staff was much lower than that for nursing staff at 59% (23 of 39 eligible medical staff completing the training).

There was a trust wide policy for safeguarding and safeguarding flow charts were available throughout all surgical wards, to help staff identify and escalate concerns. There were separate adults and children’s safeguarding policies and these had been ratified in July 2017. The policies included the PREVENT strategy, which focuses on stopping people at the
risk of radicalisation as well as female genital mutilation (FGM), sexual exploitation, hate crime and domestic abuse.

Staff we spoke with knew how to recognise abuse and how to report it. They were clear about the trust’s safeguarding escalation process. Safeguarding information, including contact details for the trusts safeguarding lead was displayed in all surgical wards. Ward staff told us the safeguarding lead was accessible and responsive.

Safeguarding concerns were discussed in ward multidisciplinary (MDT) team meetings. We observed an MDT meeting, where a social worker from the local borough was present. This meant patient needs were assessed and monitored for their care once they were discharged.

There was a domestic abuse advocate and nursing staff told us they had used their services with regards to a safeguarding incident. Staff said the advocates input, advice and management of the patient was good.

At our last inspection, staff compliance for safeguarding training was below the trust target of 90%. Although compliance for safeguarding adults level 2 and 3 was still not fully compliant, the trust and directorate level had action plans in place and compliance was monitored by the human resources department.

Cleanliness, infection control and hygiene

The trust had an infection control policy and guidelines for staff. Staff were able to access this through the trusts intranet. Staff we spoke with were aware of the IPC policy.

Most of the clinical areas we visited were visibly clean and tidy. These areas included surgical wards, theatres, storage areas, and clinical rooms. “I am clean” stickers were visible on equipment such as electrocardiogram (ECG) machines, resuscitation equipment, and commodes.

Alcohol-based hand sanitising gel was available in all clinical areas and at the entrance of all surgical wards. There was clear signage in place asking all staff and visitors to wash their hands and to follow the trust policy on infection prevention, protection, and control when entering or leaving wards or departmental areas.

We observed surgeons, anaesthetists, and nurses wash their hands in line with the World Health Organisation’s “Five Moments of Hand Hygiene” guidance between personal care treatment with patients, and used the hand sanitiser where appropriate washing their hands between patients on wards and in theatres.

The trust conducted monthly hand hygiene audits to ensure staff were following The National Institute for Care and Excellence (NICE) QS61: People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact and care. Information we reviewed from the trust’s monthly dashboard, showed most departments achieved above the trusts 90% compliance rate.

Nursing and theatre staff adhered to ‘bare below the elbows’, which is good practice to prevent the spread of cross infection.

Staff did not always adhere to trust policies and guidance on the use of personal protective equipment (PPE), to help prevent the spread of infection or the uniform dress code. We saw one nurse in theatre wearing jewellery that did not conform to trust policy. We observed theatre staff not wearing over gowns when entering the main hospital area and several staff brought their personal bags into the main theatre and anaesthetic rooms.
Staff had good infection control practices in theatre with regards to waste management, specimen handling, surgical techniques, and maintenance of sterile field.

Staff cleaned theatre equipment appropriately between cases using neutral detergent or disinfectant wipes in adherence to the trust decontamination procedure.

Cleaning audit results from 2017 showed, within orthopaedics and general surgery, scores were higher than the trusts compliance rate of 90%. A score of over 90% scored a green rating from the trust and this helped monitor and track infection control.

Domestic cleaning staff worked on a two-shift rota, which started in the morning and finished in the evening. We saw cleaning records were kept, logged and up to date on all surgical wards. Housekeeping staff used the correct nationally recognised colour coded equipment when cleaning the surgical wards, bathrooms, and patient areas.

There were IPC link nurses who worked in theatres and surgical wards, to re-enforce best practice and assist with audits. They completed competencies and received additional training to carry out their role. Nursing staff were able to tell us who their IPC link nurse was. On the surgical wards, the name of the IPC link nurse was displayed on notice boards.

Disposable curtains were in place in each bay area and dated appropriately to indicate the minimum change date.

Two operating theatres had higher levels of air filtration (laminar flow) in place, which was best practice for ventilation within operating theatres. This was important for joint surgery to reduce the risk of infection.

There were single rooms with toilet and showering facilities on each surgical ward. These were used for patients requiring isolation, particularly if they posed a risk of infection to other patients. Precautions and signage on the doors were visible and clear.

Syringes and other disposable single use medical equipment was discarded appropriately in sharps bins, which were labelled and dated. All of the sharps bins we saw were within date and none were overfilled.

Data showed there were no hospital cases of Meticillin-resistant Staphylococcus Aureus (MRSA) and three hospital cases of Clostridium difficile (c.diff) between April 2016 and September 2017.

Patients were screened for MRSA as part of their pre-assessment. This reduces the risk of patients getting an MRSA infection or passing it on to other patients. During our inspection we found in all records we, viewed patients were appropriately screened for MRSA as part of the infection control risk assessment.

Theatre staff followed NICE CG74 guidelines, which sets out explicit guidance based on best evidence in respect of the pre-operative, intra-operative, and post-operative phase of a patient’s journey. Patients were provided with the appropriate theatre gowns and received information such as, bowel preparation and nasal decontamination. Staff wore the appropriate theatre scrub garments and shoes, and covered their hair.

Surgical site infection (SSI) rates from the most recent Public Health England audits covering October to December 2016 showed an SSI rate of 2.4% in neck of femur, which was worse than the national average of 1.4% and vascular, showed an SSI rate of 3.5%, which was better than the national average of 4.7%.
Environment and equipment

At our last inspection in 2015, we raised concerns with the state of repair in main theatres, and the lack of equipment availability in main theatres and the Day Surgery Unit (DSU). During this inspection, we could see the trust had made improvements. Four theatres had been refurbished, although the flooring had not yet been completed for some. The business case to develop theatres was under development and we saw capital funding was included within the 2017/18 capital plan, to proceed through to the business case process. A theatre refurbishment user group had oversight of the refurbishment options.

There was a medical devices replacement programme in place. We viewed the report, which showed the plans to replace those pieces of equipment, which were a priority, costings, and progress. From the report, we could see most of the devices listed had been replaced. During our inspection, we saw main theatres and DSU now had an x-ray machine. There was a variety of new equipment throughout theatres such as new anaesthetic machines, and monitors.

Staff told us although they had seen an improvement with the replacement of equipment, they still faced problems with the upkeep of older equipment, and this had an impact on the working environment. They felt the equipment replacement programme was a slow process. There were still areas within theatres that required immediate attention. For example, there were no signs above the theatre doors to indicate what theatre it was and whether it was in use. We fed this back to the theatre manager and they made arrangements for it to be addressed. Staff told us lighting in theatres was a constant problem. Although there was a theatre refurbishment project in place, the trust was not taking intermediate action in rectifying minor repairs. During observation of a procedure, a piece of laparoscopic equipment was faulty, and although the situation was immediately rectified by staff, they told us this was a common occurrence.

It was easy to access theatres and we found there was no distinction between theatre and non-theatre staff as their uniforms were standard throughout. The new theatre manager said this was an issue they wanted to address immediately, as we found different staff entered theatre during procedures to ask the team lead various queries. The reception desk was next to the entrance and we did raise secure access as an issue with them at the time of the inspection.

Wards were in the main, well-laid out to promote safety, with nurse stations in position to view all bays and side rooms. Overall, wards appeared clean, tidy, and uncluttered. All sluice rooms we visited were tidy and equipment was stored appropriately. Visitors accessed wards by ringing a buzzer near the entrance and waiting for authority to enter from staff.

Nursing staff carried out daily checks of resuscitation trolleys and emergency equipment within the surgical wards and theatres. These checks were consistent across all surgery areas. Checklists were in place and records were complete. Records evidenced that there were daily anaesthetic equipment checks. This met the Association of Anaesthetists of Great Britain and Ireland guidelines.

The storerooms we checked had adequate stock of sterile instruments and consumables and items we checked were in date.

Waste in all clinical areas was separated and in different coloured bags to identify the different categories of waste. This was in accordance with HTM 07-01, Control of Substances Hazardous to Health and the Health and Safety at work regulations. Waste was managed well, there were no overflowing bins, and waste was collected at regular intervals throughout the day.
Assessing and responding to patient risk

At pre-assessment patients were assessed for their suitability for surgery. Staff in the pre-assessment unit used a pre-operative assessment tool to assess patients’ suitability. This included assessments of the patients past medical history and social circumstances. Health assessments included electrocardiogram (ECG), blood pressure, weight, height and Meticillin Resistant Staphylococcus Aureus, (MRSA) screening and discussions on the procedure itself. The assessment also reviewed whether the patient had any previous history of problems with anaesthesia. We reviewed three patient pre-operative assessment tools and found these to have been completed appropriately. Any potential safety concerns were escalated to the anaesthetist.

Patients were seen at the pre-operative assessment unit, and their admission criteria was based on patient physical classification, approved by American Society of Anaesthetists (ASA). An ASA 1 grade meant patients were normal and healthy and this could escalate to a grade ASA 4 where more monitoring and assessments undertaken by the consultant and anaesthetist would occur.

Surgical ward staff used an electronic monitoring system to observe patients vital signs and these were entered into an electronic touchpad system. Patient’s vital signs such as blood pressure, pulse, and breathing rates were measured and escalated using the Early Warning Scores (EWS). This system provided an escalation trigger protocol. Patients who scored above a seven were referred to the critical care outreach team. If staff had concerns at any point during patient care, they could escalate for urgent review by the consultant. We saw EWS was used in all patient records we reviewed. The trust audited the completion of the EWS, and the latest audit showed all surgical wards had scored 100% for correctly escalating patients to the outreach team.

Risk assessments were undertaken on each patient on admission to the wards. These assessments included a falls risk score, manual handling assessment, malnutrition universal screening tool (MUST) score, waterlow and safeguarding assessments. There was a white board displayed in wards, which showed what assessments had been completed for each patient. Treatment was tailored to meet patient needs. For example, allergies were recorded on all patient records, pressure ulcers (PU) and venous thromboembolism (VTE) were assessed, and equipment was used to help mitigate the risks. Special mattresses were used to alleviate pressure ulcers and anti-embolism stockings were used for those patients with a higher risk of VTE. Patients at risk of falling were monitored in an assigned bay where a staff member was present at all times. Other assessments conducted included dementia assessments, breath sound assessments, frailty score, and neurological assessments. The outcome of these assessments meant patients sometimes required one to one care.

VTE rates were monitored by the trust and we saw from October 2016 to September 2017 surgical services met the trusts compliance of 95% for all inpatients being VTE risk assessed on admission as an inpatient.

The trust used the World Health Organisation (WHO) five steps to safer surgery checklist. This is a checklist used before, during and after surgery to help minimise errors. The hospital audited the WHO checklist to enable trends to be identified. From July 2016 to June 2107, quarterly compliance met the trusts target of 95%.

We observed surgery staff use the WHO checklist for various procedures and found the system to be well embedded in theatres. On one occasion, the scrub nurse was able to raise concerns regarding a patient who had been brought into theatre too early before they had checked all equipment. The whole team agreed to alter the arrangements and this was recorded on the team briefing. This showed a good culture for challenge and discussion was in place to ensure patient safety. In day case, theatres we observed a good consultant led debrief session.
Nursing staff carried out intentional rounding’s (a structured process where nurses carry out regular checks with individual patients). We saw this took place and it was documented in patient records. Patients confirmed nurses regularly visited and carried out checks on them.

Patients who required intensive or high dependency care after surgery were assessed to ensure a bed was available. We observed such discussions taking place at the morning site meeting between all divisions on bed capacity.

Staff followed the National Institute for Care Excellence (NICE) guidelines NG51: Sepsis: recognition, diagnosis, and early management. Staff had received sepsis management training and there were screening and action tools for staff to follow.

There was a haemorrhage protocol in place. We were told that within theatres major haemorrhage training was completed on a yearly basis by a medical lead.

Medical outliers were managed by a medical consultant and care of elderly consultant if the patient was over 80 years of age. Nurses said this system worked well.

Surgery staff took appropriate action and cancelled patient’s treatment if they felt the risks were too high and their patient safety would be compromised. Staff reported these as incidents on the trusts electronic reporting system and followed this by reporting the reasons why. Such reports included cancelling a patient due to high blood pressure.

**Nurse staffing**

The trust had reported their staffing numbers below as of March 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>45.95</td>
<td>38.29</td>
</tr>
</tbody>
</table>

Staffing was planned and reviewed regularly in theatres and ward areas. The service used acuity tools to calculate whether staffing levels were meeting the needs of patients. All ward sisters we spoke with said staff shortages was their top risk.

Despite some of the gaps being filled with bank and agency staff, staff told us they were frequently moved to other wards to fill gaps and help minimise risks to patients. Staff described the consequences of staff shortages, which sometimes meant they were unable to support patients as they hoped to, for example, answering call bells, and attending to patients sooner than they could. Staff felt overstretched and said they were ‘firefighting’ situations.

Staffing was discussed in all surgical speciality clinical governance meetings. From all the minutes we reviewed, we saw annual leave and future staffing demands were discussed.

Patients who required one to one care were nursed by permanent staff members, dependent on the patient’s requirements. Wards sisters told us they would not use agency or bank staff to care for those patients who required specialist one to one care.

Ward staff said they had seen an increase in patients with mental health concerns and the wards budgets were being used to recruit additional bank or agency staff, to allow permanent staff to care for these patients. This put considerable strain on the wards.

There were handover meetings between nursing staff at every shift change in the morning and evening. Discussions took place on patient care and treatment.
Vacancy rates
Between August 2016 and July 2017, the trust reported a vacancy rate of 9.7% in surgical care. Queens 2 was the ward with the highest vacancy rate, averaging 34% over the period and had a rate of 37% as of July 2017 (7.16 WTE vacant out of an establishment of 19.18).

The trust was running an ongoing recruitment campaign at the time of our inspection.

Turnover rates
Between August 2016 and July 2017, the trust reported a turnover rate of 20.2% in surgical care. Fairfield 1 was the ward with the highest turnover rate, having four leavers over the period out of an average establishment of 11.3.

We discussed staff retention within surgical services and were told that staff left for other local NHS trusts that were able to offer inner London weighting to their pay scales. The trust’s location meant they were unable to do so.

Sickness rates
Between August 2016 and July 2017, the trust reported a sickness rate of 4.5% in surgical care.

Bank and agency staff usage
The trust was unable to provide the appropriate data to calculate bank and locum usage as a percentage of the total establishment.

Medical staffing
The trust had reported their staffing numbers below as of March 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>76.84</td>
<td>81.13</td>
</tr>
</tbody>
</table>

Theatre staff told us if staffing needs did not meet The Association for Perioperative Practice (AFFP) recommended guidelines, they would not run theatre lists, as they would not compromise patient safety.

Staffing was discussed at monthly meetings with the assistant director of nursing. At the time of inspection, new consultant appointments were being made. When appointing new consultants the clinical director involved consultants in the specialism to agree what type of consultant they needed. Decisions taken were clinically driven with input from other consultants. A new upper gastrointestinal consultant had been recruited to deliver hot gall bladder surgery, as well as a hand surgeon and restorative dental surgeon.

Medical staff we spoke with said there was adequate consultant presence at the weekends within surgical services. A consultant was on call throughout the weekend period as well as a specialist registrar. After 8pm on weekdays, a consultant and anaesthetist consultant was on call and covered all emergencies. The consultant on call led the ward rounds at weekends.

We observed one to one training for a medical student, who told us the training was better than other NHS trusts. We observed good teaching for a surgical resident with the surgeon in theatres. There was a consensus amongst medical students that the teaching provided was of a high calibre. There were good initiatives in place for teaching. A list was introduced on a Friday for hernias and this allowed residents to complete under consultant supervision. Junior doctors told us consultants were approachable and could be contacted at any time for support. Junior staff said they were given adequate time to attend teaching and to prepare for exams.

There was some sharing of consultants with a neighbouring trust.
**Vacancy rates**
Between August 2016 and July 2017, the trust reported a vacancy rate of 8.3% in surgical care.

**Turnover rates**
Between August 2016 and July 2017, the trust reported a turnover rate of 12.7% in surgical care.

**Sickness rates**
Between August 2016 and July 2017, the trust reported a sickness rate of 1.6% in surgical care.

**Bank and locum staff usage**
The trust was unable to provide the appropriate data to calculate bank and locum usage as a percentage of the total establishment.

Of the bank and locum shifts used, 566 were for locum staff and 1365 shifts were for bank staff.

**Staffing skill mix**
As of June 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

**Staffing skill mix for the whole time equivalent staff working at Croydon Health Services NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>42%</td>
<td>48%</td>
</tr>
<tr>
<td>Middle career</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>28%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>19%</td>
<td>11%</td>
</tr>
</tbody>
</table>

**Records**
Records were both electronic and paper form but predominately staff on the surgical wards used electronic records. We reviewed 10 records which included a range of pre-operative, surgery waiting areas and surgical ward records. Overall, the records were clear and provided alert prompts showing patient allergies and patient risks. The advantage of the electronic records meant there was a consistent layout and legible notes. However, there were two occasions when patient pain scores taken by the nurse had not been transferred from the handheld portable electronic device to the main system. The staff member said this was a rare occurrence.

All records we reviewed were fully complete. Patient risk assessments had been completed which included infection control, falls, pressure ulcer, VTE, nutritional assessments, and manual handling. Patient records were completed by all members of the multi-disciplinary team (MDT). For example, pharmacy and MDT discussions of physiotherapy reviews were documented in patient’s notes.
On surgical wards, paper records were stored securely to ensure patient confidentiality. Access to electronic systems were password protected. However, in the pre-assessment area we found paper records were stored on top of an open trolley near to the nurse station. This posed a risk of unauthorised access, despite staff being present in the area. Discharge patient records were electronic and any paper notes were securely stored.

Ward inpatients had bedside observational charts and overall nursing staff had completed these records in a timely manner.

Staff told us the request for pharmacist input could be requested through the patient’s electronic record and as they had access to the patients record this made requests and actions taken quicker.

**Medicines**

On surgical wards, medicines were appropriately stored in locked cupboards. Doors to rooms containing medicines were accessed via a keypad entry. Controlled drugs (CD) were locked in metal cabinets and the most senior member of staff on duty held the keys to maintain security. CD registers were correctly counter signed by two signatures to confirm who had removed drugs and who had checked drugs.

All medication storage areas were clean and tidy and records demonstrated fridge temperatures were checked on a daily basis. However, our pharmacy inspectors found several recordings were missed for the months of July to October 2017.

Medications spot checked in recovery were all in date and all labelled correctly. However on Queens 1 Ward, opening dates were not always on liquid medicines to ensure they were used within the correct expiry date.

All surgical wards had dedicated pharmacist input in reconciliation of patient’s medicines and clinical screening of patient prescriptions. The pharmacists were able to screen those patients ready for discharge in the morning and the patient were sent to the discharge lounge, which helped release bed space. However, staff told us that the Trust dispensary sometimes caused a delay in discharge due to having to wait for people’s medicines.

Medicines waste was not always handled appropriately. We were told that waste controlled drugs from patient controlled analgesia syringes were disposed of down the sink. This was not in line with the trust policy.

We saw medicines were given to patients by nursing staff in accordance with prescriptions and safety checks were carried out during administration. On admission nursing and medical staff confirmed patient allergies, medical history and medications with the patient. Patient medication was discussed in daily MDT meetings involving the consultant, ward sister, occupational therapists, and physiotherapists as part of the patient care plan.

Staff knew how to report medicines errors and were able to give an example of changes made to practices as a result of learning.

Patients told us they received their medication in a timely way and knew what medicines they were taking and what they were for.

Medical gases were safely stored in purpose holders above floor height.

**Incidents**

There was a good incident reporting culture and staff were encouraged to report all incidents. Staff were knowledgeable about incident reporting. They were able to describe how they would report incidents through the electronic system and how learning would be disseminated. Staff were able to give examples of recent incidents reported.
Staff told us they did not always receive feedback on incidents they reported. They told us there was a good sharing of learning from serious incidents, but not from low harm incidents. If they reported a low harm incident through the system, it was often closed with no feedback on the outcome.

The monthly clinical governance meetings discussed incidents and shared learning from incidents. Minutes we reviewed showed, learning outcomes were discussed and actions taken as a result.

The hospital carried out serious incident reports in line with the National Patient Safety Agency NHS guidelines. There was evidence of lessons learned and duty of candour. Reports we reviewed were comprehensive and included root cause analysis, descriptions of the incidents, identified learning points, discussions with patients, relatives, and staff and action plans to mitigate the risk of re-occurrence.

There was a much improved and robust system in place for the review of patient mortality and morbidity. The monthly surgical clinical governance meetings included a review of patient mortality and morbidity. This meant that medical staff reviewed recent patient deaths to identify any concerns and identify potential learning to improve patient safety. We reviewed a variety of minutes for 2017. Meetings documented comprehensive discussion of patient deaths and a breakdown of the contributory factors.

Nursing staff were aware of the principles of duty of candour. Staff were able to tell us examples when they had invoked the duty of candour. For example, a patient was unable to get their blood test results because the sample had been labelled incorrectly. They informed the patient that this had happened, apologised, and reported the incident through the electronic system.

Never Events

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

Between September 2016 and August 2017, the trust reported no incidents classified as never events for Surgery.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 13 serious incidents (SIs) in Surgery, which met the reporting criteria set by NHS England between September 2016 and August 2017.

Of these, the most common types of incident reported were

- Surgical/invasive procedure incident meeting SI criteria with three (23% of total incidents).
- All other categories with 3 (23% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with two (15% of total incidents).
- Slips/trips/falls meeting SI criteria with two (15% of total incidents).
- Medication incident meeting SI criteria with two (15% of total incidents).
Sub-optimal care of the deteriorating patient meeting SI criteria with one (8% of total incidents).

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported four new pressure ulcers, three falls with harm, and three new catheter urinary tract infections between August 2016 and August 2017 for Surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Croydon Health Services NHS Trust
The service had oversight of performance and took action to help improve outcomes. There was a dedicated falls service, which provided individual assessments, tailored home exercise programmes, and exercise classes for over 65s to reduce the risks of falls and fractures. A staff led ‘Listening into Action’ campaign set out to reduce catheter-associated urinary tract infection through extra staff checks and staff awareness. A pressure ulcer taskforce group met on a monthly basis to discuss incidents and formulate plans to help reduce the risk to patients of pressure ulcers.

Is the service effective?

Evidence-based care and treatment

Care and treatment was delivered based on current legislation and nationally recognised evidence based guidance. Policies and guidelines were developed in line with the Royal College of Surgeons, Royal College of Anaesthetists, and National Institute for Health and Care Excellence (NICE) guidelines.

Staff were able to access policies and local protocols via the trust intranet, ward portfolios and flip chart booklets based on each ward.

Surgery and trauma managed and based their care in line with professional guidance. Such guidance included the National Confidential Enquiry in Patient Outcomes and Death (NCEPOD). They participated in national audits, which included the National Hip Fracture Database, and National Emergency Laparotomy Audit.

Patient notes demonstrated pre-operative tests such as electrocardiogram for patients with pre-existing heart conditions followed NICE guidance NG45: Routine pre-operative tests for elective surgery. The NEWS was used by staff to identify a deteriorating patient.

The trust followed NICE NG51: Sepsis: recognition, diagnosis, and early management. Staff used a sepsis screening and action tool.

There was a clinical audit programme formulated to comply with local and national priorities. Local audits conducted, included the WHO checklist, VTE and IPC monitoring. Audits and outcomes were discussed in each surgical divisional meeting.

A Clinical Audit Effectiveness Committee met on a quarterly basis to monitor national and local clinical audits and discuss improvements.
Enhanced recovery programmes followed recommendations by NHS Institute for Innovation and Improvement. Enhanced recovery is a modern evidenced based approach that helps people recover more quickly after surgery by receiving the best possible care during surgery and while recovering. There were enhanced recovery pathways for all major surgery procedures.

**Nutrition and hydration**

Since our last inspection in 2015, there had been minimal change to ensure patients did not become dehydrated before surgery. Nurses told us anaesthetists did not have a standard approach with allowing patients to drink small amounts of clear fluids up to two hours before surgery. As a result, nursing staff said they often had to tackle patient complaints.

The trust used the Malnutrition Universal Screening Tool (MUST), to monitor patients who were at risk of malnutrition. The assessment tool aided identification, so patients had further malnutrition intervention if required. Where patients were identified as at medium or high risk of malnutrition, food intake was to be recorded, and the patient was to be encouraged and given assistance with meals. The meal hostess was also alerted on the menu card. Patients identified as at risk of dehydration also had fluid balance charts to monitor fluid intake and output. There was a dietetic, speech, and language therapy team (SALT), who were available to assess and recommend care plans for patients, such as recommendations, which included special dietary requirements.

Each of the surgical wards displayed nutrition boards. These boards displayed information on patients who required special diets. The board provided information on a 10-step meal distribution, which was a list of instructions for staff to follow. The list included the roles of different staff members in checking and distributing food to patients to make sure they received the correct meal and assistance.

There were protected meal times and an updated protected mealtime policy ratified in October 2017. We observed patients who required assistance receive one to one care from members of staff with the supervision of the ward sister. A special dietary order form and checklist was recently introduced. Each morning the ward sister would complete the sheet, which listed those patients requiring special assistance during meal times and the special meals requested. This was checked with catering staff and distributed to other nursing staff to ensure patients received the correct meal and help during their meal times.

Behind each patient bed, a yellow sheet indicated those patients who required special assistance with dietary requirements. We saw a yellow sheet showed one patient required no straws for their drinks and meals.

**Pain relief**

There were effective processes in place to ensure patient’s pain was managed. Nursing staff used an assessment tool to rate patient’s level of pain. We saw from patient records pain scores were recorded at regular intervals throughout the patients stay.

All patients we spoke with were satisfied with their pain relief and said staff checked on their comfort regularly.

There was an onsite pain team available throughout the day during weekdays. An on call service was operated outside of these hours.

Sometimes, staff told us there were unable to administer pain relief quickly to those patients admitted from the emergency department, due to a delay in the electronic process being completed. Although staff received paperwork of observations and medicine given in the emergency department, they had to wait for authorisation from the prescribing doctor before they could administer pain relief. Staff often contacted the site practitioner for assistance. Staff told us they had fed this back to their respective managers who were in the process of escalating this further.
Patient outcomes

Relative risk of readmission
Between June 2016 and May 2017, the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

The Trust had an expected or higher than expected risk of readmission for non-elective admissions when compared to the England average, notably for colorectal surgery.

Elective Admissions – Croydon University Hospital

Non-Elective Admissions – Croydon University Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity

(Source: HES - Readmissions (01/06/2016 - 31/05/2017))

Hip Fracture Audit
In the 2016 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 10.1% which was within the expected range. The 2015 figure was 9.3%.

The proportion of patients having surgery on the day of or day after admission was 63.7%, which was worse than the national standard of 85%. The 2015 figure was 79.1%.

The perioperative medical assessment rate was 97.9%, which failed to meet the national standard of 100% but was still in the top 25% of trusts. The 2015 figure was 95.4%.

The proportion of patients not developing pressure ulcers was 83.6%, which falls in the bottom 25% of trusts. The 2015 figure was 83.9%.

The length of stay was 19.6 days, which falls in the middle 50% of trusts. The 2015 figure was 21
days.

The trust had received two alerts regarding increased mortality rates in fractured neck of femur (NOF), the first in July 2017 and second in September 2017. We reviewed the report in reply to the alerts and actions the trust were and had taken. The trust conducted a deep dive review of all NOF mortality cases over the past five years, to derive and understand possible causes and actions to take. Three key messages showed the trust was taking action to address issues.

The trust now had ring fenced beds established on Queens 3 Ward with enhanced peri-operative nursing care. Time to theatre on the National Hip Fracture Database had fallen since 2012 and as the trust now had a dedicated trauma list Monday to Friday and reintroduced a half day Saturday list and incorporated into the CEPOD lists on Sundays.

Patients were provided with airflow mattresses and early physio assessment and mobilisation of patients was improving. We observed a good MDT meeting on Queens 3 Ward, where patient’s mobilisation and physical assessments were discussed at length.

The trust were still advertising for a trauma co-ordinator and we saw the reinforcement of the deteriorating adults policy was being discussed in team meetings.

Fractured neck of femur alerts were discussed at the Patient Safety and Mortality Committee monthly meeting. Each case was investigated and outcomes discussed with action points taken.

A pressure ulcer taskforce group met on a monthly basis to monitor incidents and undertake root cause analysis with recommended actions on their findings. Staff had received training and we saw assessments and observational checks were completed on inpatients.

**Bowel Cancer Audit**

In the 2016 Bowel Cancer Audit, 81.7% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than national aggregate. The 2015 figure was 68.3%.

The risk-adjusted 90-day post-operative mortality rate was 2.9% which was within the expected range. The 2015 figure was 0%.

The risk-adjusted 2-year post-operative mortality rate was 22.6% which was within the expected range. The 2015 figure was 31.1%.

The risk-adjusted 30-day unplanned readmission rate was 8.4% which was within the expected range. The 2015 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 40% which was within the expected range. The 2015 figure was 34.8%.

The trusts action plans showed an enhanced recovery programme after surgery (ERP) nurse had been recruited to champion enhanced recovery and help reduce the length of stay for patients.

**Oesophago-Gastric Cancer National Audit**

In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 13.3%. This placed the trust within the middle 50% of all trusts for this measure.

The 90-day post-operative mortality rate was not eligible for inclusion for this trust.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 42.2%, which was significantly higher than the national aggregate.
This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

Case ascertainment for the trust was over 90%, which was better than the national aggregate.

**National Emergency Laparotomy Audit**

In the 2016 National Emergency Laparotomy Audit (NELA), Croydon University Hospital achieved a red rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 27 cases.

The hospital achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 12 cases.

The hospital achieved an amber rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 10 cases.

The hospital achieved an amber rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on four cases.

The risk-adjusted 30-day mortality for the hospital was within expectations, based on 121 cases.

**Patient Reported Outcome Measures**

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.
In 2015/16 performance on groin hernias was worse than the England average, particularly in the EQ-5D index.

For Varicose Veins, performance was about the same as the England average, although the EQ-VAS measure was notably poorer than the England average.

(Source: NHS Digital)

Patient outcomes were discussed in each surgical speciality clinical governance meetings. We saw action plans were put in place to help establish improvements for the areas that were not performing well.

Competent staff

Appraisal rates

Between April 2017 and July 2017, 75% of staff within Surgery at the trust had received an appraisal compared to a trust target of 95%. Qualified nursing staff had the lowest appraisal completion rate at 59% (20 out of 34 eligible staff having completed an appraisal). However, figures provided only represented four months of the year. Surgery services still had time to ensure appraisals were completed for the remainder of the year.

A split by staff group can be seen in the graph below:

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

There was varied response to the effectiveness of personal appraisals. Some staff could describe development opportunities they had been given, while others were frustrated at the lack of personal development. For example a member of staff who was a qualified operating department practitioner in their birth country, (but was unable to perform the equivalent role in the UK unless they undertook an external course and qualification), had not received the support of the trust and was now personally funding and seeking alternative external routes to follow.
There was an induction programme for all staff. The training included covering mandatory core topics, understanding policies and the values of the trust and competency sign off for the area they worked in. We spoke with a member of staff who had recently competed induction. They felt the training was good, useful and they were well supported.

Bank and agency staff were provided with induction relevant to the area they were working in. Ward sisters were able to describe the inductor training they offered bank and agency staff and said this included how to report incidents.

Ward sisters described the leadership courses they had attended and the benefits this had provided for their role.

We saw courses staff could attend included phlebotomy and cannula training; however, staff sometimes had their courses cancelled due to staff shortages.

We spoke with a HCA who had just completed their induction and had been working at the hospital for three weeks. They told us their induction package of two weeks included training on how to report incidents, mandatory training and competency assessments in the area they worked.

Multidisciplinary working

There was good multidisciplinary team (MDT) collaborative working across surgical services. We saw good examples of MDT to ensure patients received good care.

We observed a comprehensive MDT meeting in Queens 3 ward, which involved the consultant, ward sister, junior doctors, occupational therapists, physiotherapists, and a social worker from the local borough council. Each patient's care and treatment needs were discussed along with care packages for discharge. Staff demonstrated a good understanding of the patients they were caring for.

Patient records showed input from a range of healthcare professionals including pharmacy and dietitians.

We observed the daily morning huddle where each division across the hospital attended to discuss patient flow, in terms of bed requirements, discharge, staffing levels, and patients requiring mental health support.

There was a daily handover on each ward between nursing staff, doctors, physio team, and occupational therapists at the start of each shift. Patients' care plans and any risks were discussed during the handover.

We observed good MDT working in theatres. Staff communicated effectively and there was good teamwork, which made the patient list run more smoothly. Team briefing sessions were completed in the morning in the presence of all staff within theatres. However, we observed a team briefing where the consultant surgeon was not present, but the surgical register and senior house officer (SHO) were present to make the meeting effective.

There were no meetings between GP’s and community teams. However, staff described relationships as good and that there was an access policy in place.

Staff were able to contact the mental health liaison team for assistance and guidance for those patients with mental health concerns. However, staff reported they did not know the team well and said on occasions bleeps to the mental health team went unanswered.

Seven-day services

Since our last inspection, there was now a Sunday trauma service. On Sundays, the trust combined the trauma and CEPOD in theatre where there was an orthopaedic and general surgery
consultant to cover treatment. The consultant and anaesthetist met and discussed priority on a list and agreed what work would be completed on a Sunday.

The majority of patients were operated on during the weekday. Elective surgery took place Monday to Friday with the occasional Saturday sessions booked when required. Emergency theatres operated seven days a week, 24 hours a day, 365 days a year.

The physio team were available on call at the weekends but this was as an acute response service only. Occupational therapy was available one day a week at the weekend. Ward staff told us this had a positive impact on patient care.

Investigations such as blood test, CT scans and x-rays, could be accessed 24 hours a day, seven days a week.

**Health promotion**

National priorities to improve the population’s health were factored into care. People requiring extra support was identified during pre-operative consultations. There was a smoking cessation team, which covered each ward and an alcohol liaison member of staff.

The trust held diabetes sessions for vascular referrals patients to help promote a healthy lifestyle. We saw leaflets available and contact numbers

Following surgery, staff helped support patients to manage their own health, care, and wellbeing following surgery. The use of enhanced recovery programmes helped enable patients to be actively involved in their recovery following surgery. The pathway included encouraging patients to be as healthy as possible before their planned operation. Staff in the pre-assessment unit discussed eating well, exercise, and relaxation prior to surgery.

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

The trust had consent to examination or treatment policy, recently ratified in September 2017. Staff used the up to date policy to help them assess and record consent, mental capacity, and liberty safeguard requirements. The policy outlined who was responsible for obtaining consent, how this should be obtained, and what course of actions staff should take if they identified it had not been obtained.

We observed consent was checked before surgical procedures. This was included as part of the WHO checklist and was monitored and audited on a monthly basis. Consent was recorded in paper form, and from the patient records we reviewed, we saw consent had been completed and there was information on the treatment, risks, and benefits.

For patients who did not have the capacity to give or withhold consent, there were separate consent forms. The form included an assessment of the patient’s capacity, why the health professional believed the treatment to be in the patient’s best interests and the involvement of people close to the patient. An audit conducted in 2016 showed for those patient records monitored, consent was followed for patients who lacked capacity and discussion with family or a second opinion had been followed.

Consent was usually a two-stage process, where the patient was provided with information before the treatment and again consent was confirmed that the patient still wished to proceed. For emergency surgery, consent was signed in a single stage due to time constraints.

Patients we spoke with said consent before treatment was sought and treatment and care had been explained. Patients said they had been told about the risks to their treatment and they had been provided with information on the benefits and risks of their surgery before they signed the
consent form. In patient records, we saw completed consent forms with risks recorded by doctors. Interpreters were booked to assist with taking consent if patients needed this.

The trust did not report on either Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards training.

**Is the service caring?**

**Compassionate care**

**Friends and Family test performance**

The Friends and Family Test response rate for Surgery at Croydon Health Services NHS Trust was 34% which was better than the England average of 29% between September 2016 and August 2017.

**Friends and family test response rate at Croydon Health Services NHS Trust, by site.**

![Bar chart showing the response rates.](chart.png)

Ward level recommendation rates were generally high. Although Purley 3 ward showed some fluctuation, this is likely due to low response numbers.

<table>
<thead>
<tr>
<th>Site</th>
<th>Total Resp</th>
<th>Respo Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queens 1</td>
<td>761</td>
<td>29%</td>
</tr>
<tr>
<td>Queens 2</td>
<td>820</td>
<td>44%</td>
</tr>
<tr>
<td>Fairfield 1</td>
<td>407</td>
<td>56%</td>
</tr>
<tr>
<td>Purley 3</td>
<td>250</td>
<td>26%</td>
</tr>
</tbody>
</table>

(Source: NHS England Friends and Family Test)

The FFT results were conflicting with the Croydon Health Services NHS Trust inpatient survey results from May 2017, which found a number of areas that were worse when compared with other similar trusts. The areas that were worse were for; patients getting support with eating, nurses acknowledging patients, patients being involved in decisions about their care and treatment, patients being explained about the risks and benefits of procedures, advice after discharge, who to contact if they are worried about their condition, and explanation of side-effects of medicines.

Whilst visiting the wards we observed FFT ‘trees’ displayed on the walls at the entrance. Patients had commented that they were ‘extremely likely’ to recommend the service they had used. Comments such as ‘staff were caring and compassionate from morning to night’ and ‘nurses were very helpful and looked after me well’ were amongst the common theme of the feedback.
We spoke with twelve patients some who had family members with them. The majority of these patients and relatives were happy with the care and treatment that they had received from staff members. Comments included: “the care has been exemplary”, “I couldn’t have asked for better care, staff were very friendly and approachable”, and “I was recognised by a ward clerk as I had been here before and she was very friendly.” There were many comments about the improvements in care over the past two to three years and one long term patient commented on how “the service has improved vastly” and that she had seen a “positive change over the last couple of years”.

Staff introduced themselves to patients and explained their role. They asked patients if they required any assistance during mealtimes and patients were asked how they wanted to be addressed.

Thank you cards were displayed on the walls of the wards with patients commenting on how grateful they were for the care they had received.

**Emotional support**

There was a chaplaincy service available for patients, relatives, and staff. Their role was to provide holistic care, which included not only a person’s physical health but also their social, emotional and spiritual health or well-being.

One of the senior charge nurses was very positive about the chaplaincy service and commented that they catered for all religions and general emotional support and responded very quickly.

Staff were aware of the emotional impact treatment could have on a patients wellbeing and recognised when patients needed additional support. Patients reported that staff took time to talk to them and explain processes and procedures to reduce any anxiety or worry.

The hospital provided leaflets on the wards entitled ‘Your stay at Croydon University Hospital’ which was a guide for inpatients, visitors and carers and provided information on what excellent care means, what privacy and dignity entails and information about food and mealtime support.

On Queens 2 Ward, the senior charge nurse had ‘office hours’ on Monday to Friday at 2pm to 3pm where families and relatives could come to talk to them about any concerns they had.

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

All the patients spoken with felt they had been involved in decisions about their care and treatment and many patients had commented on having seen the consultant every day. However, one patient commented on how the consultant seemed to be in a rush and another patient commented on the difficulty of their relative being able to speak to a doctor.

We attended a multidisciplinary meeting and observed evidence of staff highlighting patients that required assistance with eating, and pain relief and occupational therapists discussing patient’s choice when planning their discharge. A social worker was present and discussed the patient’s needs, where the consultant supported a decision for psychiatric referral.

In the pre-operative assessment area, the senior sister informed us that they would give family member’s their relatives ID numbers so that they could return to the main entrance restaurant area to wait. The ID number would appear on a screen, to update the family on what stage of surgery their relative was at, for example, in theatre, or recovery.

We spoke to a patient who said, “I have been visited by the Stoma Nurse and consultants and
have been very much involved in the decision making of my care and treatment”.

Is the service responsive?

Service delivery to meet the needs of local people

The trust worked collaboratively with commissioners and other trusts in south London, to ensure services were planned and delivered. The trust was part of and had contributed towards the South West London Five year Forward Plan, a collaboration of all parts of local NHS services. The aim to ensure services were sustainable in the years ahead. The plan looked at the increasing and aging population versus the services to deal with the increasing demands. The trust were also working hard to ensure those patients living in Croydon and had been referred to other NHS trusts outside of the area were seen by them. This involved working closely with relevant stakeholders.

Surgical wards had seen an increase in inpatients with mental health issues. Due to the lack of appropriate community services available, this placed an immense pressure on their resources. Staff told us, sometimes they felt they were unable to provide the best support possible, as treatment was outside the scope of their role, and required specialist care. There were dementia leads and learning disability link nurses available throughout surgical services and staff told us they were readily available to provide support.

An anaesthetic clinic had been introduced in Pre-Operative Assessment (on alternate Tuesdays and every Thursday). The clinic was run by anaesthetists to help to provide a seamless service for patients with existing health conditions or those who might be high-risk under anaesthetic. Staff told us the clinic worked well, but when an anaesthetist was on leave no cover was provided, so on some occasions the clinic did not run for several weeks.

Average length of stay

Between July 2016 and June 2017, the overall average length of stay for elective patients at the trust was 2.4 days, which was lower compared to the England average of 3.3 days.

The average length of stay for non-elective patients at the trust was 5.1 days, which was as expected compared to the England average of 5.1 days. Non-elective vascular surgery patients had a notably shorter length of stay, averaging 5.6 days compared to the England average of 11.1 days.

Elective Average Length of Stay – Croydon University Hospital

Non-Elective Average Length of Stay – Croydon University Hospital
Meeting people’s individual needs

Staff we spoke with were able to give examples of how they supported patients with specific needs such as patients living with dementia.

There was a hospital wide dementia specialist nurse from whom staff could seek advice on care for patients living with dementia. There was an acute liaison nurse for patients with a learning disability. The nurse would review each patient and visit them on wards.

Staff in pre-operative assessment told us that they could arrange for patients with a learning disability to be taken through the journey they could expect to take through theatres, prior to their procedure. There was a side room in day surgery that could be used for patients with a learning disability or living with dementia, to help reduce distress to the patient. In the discharge lounge, staff we spoke with told us that patients living with dementia or a learning disability would be brought down to the lounge as close as possible to when their transport arrived, to avoid a lengthy waiting time in an unfamiliar environment.

On the wards there were communication books containing words and pictures available to staff, which they could use to converse with patients with communication difficulties. Translation services were available for patients who did not speak English. Furthermore, staff told us they recently obtained a specialist interpreter to stay overnight in the hospital with a patient who was deaf and blind.

We saw booklets and posters on wards and in pre-operative assessment, which gave patients information on the care they could expect. On all surgical wards there were nutritional boards detailing the dietary requirements of each patient, and a yellow note above the bed to indicate such requirements. We saw that a range of options for specialist diets were available including vegetarian, gluten free and softer options.

Staff told us they referred to the mental health liaison team where they had concerns about the mental health of a patient. However, nursing and support staff we spoke with had not received any recent training themselves on supporting patients with mental health needs.

The trust were able to hire bariatric equipment for those patients requiring additional support. We observed a bed and chair had been hired for a bariatric patient and a side room had been used to accommodate the equipment.

Patients were provided with different coloured trays and beakers to distinguish their dietary requirements. For example, red trays and beakers indicated patients who needed assistance with eating, amber indicated those patients who required thickened fluid and blue was used for standard eating requirements.

Patients told us they enjoyed the food and variety but a few wished they could have a hot meal at lunchtimes.

Access and flow

Referral to treatment (percentage within 18 weeks) - admitted performance
Between August 2016 and July 2017, the trust’s referral to treatment time (RTT) for admitted
pathways for Surgery fell just below the England average for three of the five specialities.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty
A breakdown of referral to treatment rates for Surgery broken down by specialty is below. Of these, three of specialties were below the England average and two above.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>92.2%</td>
<td>77.5%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>83.3%</td>
<td>72.7%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>52.7%</td>
<td>66.4%</td>
</tr>
<tr>
<td>Trauma and Orthopaedics</td>
<td>40.8%</td>
<td>62.2%</td>
</tr>
<tr>
<td>ENT</td>
<td>34.8%</td>
<td>65.3%</td>
</tr>
</tbody>
</table>

The trust had oversight of RTT through monthly updates via the RTT performance update report, and action plans to address demand and capacity. Actions included the implementation of a live new patient tracking list (PTL) at the end of September, which had better functionality and usability. The trust planned to monitor the effectiveness of the new PTL through the NHSI data quality self-assessment, which was a way of monitoring RTT.

Cancelled operations
A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

The percentage of cancelled operations not treated within 28 days has generally been better than the England average. However, in the latest quarter (2017/18 Q1), there has been a sharp increase in this metric, and the trust was now at 9.4% compared to a national average of 7.2%.

It should be noted that the overall number of cancelled operations has reduced steadily since 2016/17 Q3 and the latest increase in the percentage not treated within 28 days was in part due to a smaller number of cancelled operations overall (3 of 29 cancelled operations were not treated in 28 days).

Percentage of patients whose operation was cancelled and were not treated within 28 days - Croydon Health Services NHS Trust
Over the two years, the percentage of cancelled operations at the trust showed a fluctuating trend, and was generally lower than the England average. Cancelled operations as a percentage of elective admissions includes only short notice cancellations.

Staff told us there had been an increase in cancellations for elective surgery as emergency surgery for patients admitted into the emergency department (ED) had increased. For September 2017, the performance report showed there had been 12 last minute cancellations for patient surgery.

(Source: NHS England)

The Surgical Assessment Unit (SAU) opened in December 2014, with the aim of reducing pressure on the Emergency Department (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. In our last report in 2015, we commented that the SAU was underused, not open 24 hours a day, seven days a week as was intended, and there was no dedicated medical, nursing, or support staff for the unit. On this occasion, during our inspection, we found that this was still the case. Staff told us that the SAU closed by 7pm each night. The unit did not have dedicated staffing, although staff told us that one nurse would be on standby to monitor the SAU and other staff could work flexibly to support them. We visited the SAU on two occasions during our inspection, and found it to be empty on both. Staff told us that the SAU was often used as an escalation area from ED and to create additional bed capacity in the hospital, rather than its intended purpose.

Throughout the surgical wards, there were outlier patients from other core services, mainly medicine. Patients were tracked through daily bed meetings between senior nursing staff from each ward and Matrons. We attended one of these bed ‘huddle’ meetings. The meeting was constructive and each ward was discussed, including highlighting numbers of patients with specific needs (such as cognitive impairments or mental health needs).
We observed a multidisciplinary meeting on a surgical ward. Nursing, medical, and therapy staff and a social worker contributed to discussion about potential dates by which a patient could be discharged, and there was clear consideration of additional needs of the patient upon leaving hospital.

There was a hospital-wide discharge lounge. We spoke with a member of the team who said that the primary challenge in discharging patients in a timely manner was delays in medical staff issuing discharge letters and seeing patients. Discharge lounge staff tracked the arrival and departure of patients from the discharge lounge through an electronic spreadsheet. Staff also recorded whether the patient had received a meal in the discharge lounge.

Staff within pre-assessment expressed concern that patient arrival times for surgery were not staggered. All patients required to arrive at pre-assessment at 7.30am on the day of their procedure, regardless of the time of their surgery. Staff were concerned this had a negative effect on the patient experience, especially if they had a long wait until their procedure, were delayed or had their procedure cancelled as they were all ‘nil by mouth’, which meant they had not eaten or drank since the evening before. The senior sister told us they had raised the issue several times with senior leaders, but the idea of a staggered list was met with resistance from the consultant surgeons.

### Learning from complaints and concerns

**Summary of complaints**

Between August 2016 and July 2017, there were 40 complaints about surgical care. The trust took an average of 28.5 days to investigate and close complaints.

The most common subjects of complaint were:

- Cause for concern - clinical or midwifery care, 24 complaints (60%)
- Communication/consent/information, four complaints (10%)
- Diagnosis problem, four complaints (10%)
- Staffing / Clinic related incidents, four complaints (10%)

Both junior and senior nursing staff told us they tried to resolve any complaints as soon as possible with the patient or their relatives. If this was unsuccessful, staff would refer the complainant to the Patient Advice and Liaison Service (PALS). Staff we spoke with were able to give examples of recent involvement in dealing with complaints. Complaints and outcomes from complaints were discussed in each clinical governance meetings as well as surgical ward meetings.

### Is the service well-led?

**Leadership**

Staff told us there had been an improvement in leadership across surgical services, since the last inspection. Staff had more confidence in the senior management team and said there was more stability. Most staff we spoke with from surgical wards and theatre felt the clinical director was supportive, present and doing their best to improve the service.

However, some consultants told us they felt there was a persistent widening gap in communication between themselves and the senior management team. There had been occasions when operational decisions were made without their input. Anaesthetists were particularly upset that the on call anaesthetist room was taken away without a replacement and discussion on the matter. It
took a senior anaesthetist to mediate and resolve the issue, where a different room was found at a different location. Staff told us the situation could have been handled more amenably, with better communication.

At a local level, a new theatre manager had recently joined the trust, but the position for theatre matron was still vacant. There was a positive reaction from theatre staff to the new theatre manager and the systems and processes they were following and wanted to introduce.

The trust had taken on board our comments from our last inspection, and many band 7 members of staff we spoke with had attended leadership courses. The courses involved empowering staff and those staff who had attended had found the course invaluable.

Ward staff said managers and leaders were approachable and responsive to them when they made contact. Nurse team leaders told us they felt well supported by the matron and colleagues.

Overall staff told us there had been improved e-mail communication from senior managers, but they wanted more personal interaction and the trust still had some way to go in ensuring a better communication flow within surgical services.

**Vision and strategy**

The trust had a clear vision and a set of values, with quality people-centre services integrated as a priority.

There was a strategy in place, with priority centred on theatre refurbishment, overseen by the strategic theatres user group and an equipment replacement programme in place.

We saw the trust visions and values displayed throughout the surgical wards we visited. We saw the values were displayed on the trusts intranet when staff signed in to use the system.

**Culture**

Overall, most staff we spoke with felt the trust supported them and were proud of their work and their colleagues. They generally found the culture was open, honest, and hardworking. Staff said they would speak up and challenge if required. However, staff felt frustrated and overworked, and were exhausted from the constant pressures and demands of the service.

Some ward staff felt overstretched due to staff shortages and felt this sometimes affected patient care. For example, they were unable to answer patient call bells as quickly as they would have liked.

Most nursing staff said they had seen an increase in patients with mental health issues. They said this placed incredible strain on their resources, and sometimes they did not feel they had the right training to help these patients. They understood that this was a wider national problem and not the fault of the trust. They told us they felt they were ‘firefighting’ these situations.

Within pre-assessment, some nurses commented that they had experienced bullying and harassment from anaesthetists, and this and made them demotivated. However, this had not been reported to senior management.

**Governance**

There was a much improved governance structure in place since our last inspection. The structure helped the delivery of good care. The integrated surgery, cancer, and clinical support directorate had oversight of governance structures and processes within surgery.
There were regular monthly and quarterly governance meetings held within each surgical speciality to monitor clinical performance and patient safety. Standardised terms of reference and agendas were used across all directorates and all surgical specialities used the same format for their clinical governance meetings. Attendees included consultants, clinical managers, matrons, and scheduling staff. However not all of the meeting minutes we reviewed had names of staff members who had attended. Agenda items included policy updates, training and outcomes to improve performance. We reviewed minutes from a selection of different surgical speciality meetings and found set agenda items were discussed, which included incidents, complaints, mortality, shared learning, clinical audit, RTT, training/appraisal, and safer staffing. There was good consultant input and we now saw ownership by consultants of the use of data used in the performance dashboard. Meetings we had with NHSI and Croydon Clinical Commissioning Group (CCG) prior to the inspection, acknowledged the improvements made with governance structures within surgery services.

There was a more robust system for oversight and close monitoring of mortality and morbidity. As well as being discussed as a set agenda item in each surgical division clinical governance meeting, there was also a Patient Safety and Mortality Committee. The purpose of the committee was to report on intelligence and investigations conducted following mortality alerts. From information we reviewed, we saw fractured neck of femur replacement deaths were discussed as well as all cases along with conclusions and recommendations. Consultants also held their own meetings and we saw mortality and morbidity cases were discussed within these meetings. At a senior level, we saw mortality was discussed at the Quality and Clinical Governance meetings. Attendees included senior executive managers and non-executive directors.

There were monthly scheduling meetings within the strategic theatres user group attended by the theatre manager and representation from each surgical division as well as the anaesthetic lead. Utilisation, staffing, equipment, and staff annual leave were discussed within each division as well as actions to be taken from the meeting.

A performance dashboard was used which tracked key performance indicators on capacity, utilisation, cancellations, length of stay and readmissions. Staff told us information was cascaded down through the management structure.

There were monthly ward meetings and the theatre team held a daily huddle, which was attended by the ward manager. Staff told us ward managers had an open door policy and kept them well informed of latest updates. On half a day, once a month, theatre staff attended clinical governance meetings; surgeons attended surgical governance meetings, which included representation from the anaesthetist lead.

Management of risk, issues and performance

Risks, issues, and performance were managed using strategies, including risk registers and monthly risk and departmental meetings.

There was a risk register covering the whole surgical care group. The risks identified were in line with what staff told us and acknowledged as their top risks. However, ward staff were not familiar with the risk register and were unable to tell us what was on the risk register.

The register included risks such as, the general state of repair of the resuscitation trolleys and mitigation actions staff should follow. During our inspection, we saw staff were following he recommended actions detailed in the risk register.

All risks showed there had been regular reviews over the past year with monthly dated reviews. All risks had current controls in place and named members of staff responsible for managing and completing the actions. Some of the higher risks were fed into the corporate risk register. Regular health and safety audits were completed and documented by ward sisters with actions taken to mitigate the risk.
Issues and performance were discussed during daily meetings, such as theatre staff meetings, major trauma, bed management, and staff handover meetings. Staffing, bed management, safety performance issues, patient concerns, and cancellation rates were usually discussed in these meetings.

**Information management**

There was a monthly performance dashboard, which gave details on operational performance. The trust's performance was rated to highlight where performance was not at target. For example, for the month of August 2017, the dashboard showed in red, there was one case of RTT over 52 weeks. The dashboard also showed positive performance, such as, 100% for four of the standard cancer treatment targets monitored.

**Engagement**

Patients were encouraged to provide feedback on the care and treatment they had received. We saw comment and feedback cards in all surgical wards, which could be easily accessed by patients.

Information on patient experience was reported on the monthly quality performance dashboard, alongside other performance data. This meant the senior management team and all hospital divisions had oversight of the patient experience and could identify whether there were concerns to be addressed.

Each year staff were invited to complete an NHS staff survey run by NHS England. This enabled the trust to engage with staff on how they felt and to ensure any issues were identified and acted upon. Results of the latest survey showed an improving trend. 74% of staff said service user care was the trust's top priority and 73% of staff said that the trust acted on concerns raised by patients or service users. However, some of the scores fell below the national average. This included ensuring staff had enough resources and immediate support from line managers. A third of all staff said they had received bullying or harassment from patients, relatives or the public in the last 12 months.

The trust held an annual awards ceremony called ‘Croydon stars’, which was a ceremony to recognise and celebrate staff for outstanding leadership, achievements, teamwork, and voluntary work. Colleagues were able to nominate individuals for this award.

**Learning, continuous improvement and innovation**

The trust had been accepted by The Royal College of Surgeons (RCOS) as one of two pilot sites in London to be involved in the Improving Surgical Training Pilot. This was a flagship project sponsored by Health Education England, to improve training in general surgery.

Surgical services had introduced an acute biliary/hot cholecystectomy service and from January 2018, the trust will be able to offer two slots per week, which will mean the trust will be able to meet NICE guidelines for acute gallstone disease. They will be the only hospital in South London to offer this service.

The colorectal department had three postgraduate research fellows who undertook a variety of research and innovation projects in conjunction with another hospital.

The trusts were one of a few centres to offer transanal total mesorectal excision service, which was a minimal invasive surgical treatment for rectal cancer.

The trust had a robust ambulatory pathway for abscesses; right iliac fossa pain, breast abscesses, non-specific abdominal pain and urology ambulatory pathway which meant patients avoided admissions and led to treatment being completed quickly and efficiently.
There was a theatre redevelopment programme 2020 and beyond, for the refurbishment of all theatres.

### Critical care

#### Facts and data about this service

The trust has 15 Critical Care beds. A breakdown of these beds by type is below.

**Breakdown of critical care beds by type, Croydon Health Services NHS Trust and England.**

<table>
<thead>
<tr>
<th>This trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Croydon University Hospital has one Critical Care ward: ICU/HDU.

(Source: Trust Provider Information Request)

There are eight adult intensive therapy unit (ICU) beds and seven adult high dependency unit (HDU) beds. Both units can be configured flexibly to provide care for patients with level one, level two and level three needs. The two units are connected and share a nursing and medical team. The intensive care society (ICS) classifies patients’ level of need by their medical dependency. Level three patients require clinical support of two or more organs; level two patients require support of one organ and level one patients require no organ support but need additional monitoring. During our inspection we included both adult units. We did not include neonatal or paediatric units.

Between November 2016 and October 2017, average bed occupancy was 85%. This reflected a range between 70% in October 2017 and 97% in January 2017.

In 2017/18, 70% of patients were admitted for non-surgical care, 40% were mechanically ventilated and 18% were admitted for emergency or urgent surgery. This was comparable to similar units nationally.

Is the service safe?

Mandatory training

Mandatory training completion rates
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust did not allocate any medical staff to either the ICU/HDU or Critical Care Outreach Team. After our inspection we asked the trust to clarify this and were supplied with information for consultants only. As of December 2017, consultants had 90% overall compliance with mandatory training. This was an average figure and reflected 33% completion in equality and diversity, 67% in conflict resolution and 100% completion in the remaining nine subjects.

The trust set a target of 95% for completion of mandatory training. Following the inspection the trust told us the target was 90%.

A breakdown of compliance for mandatory courses as of July 2017 for nursing/midwifery staff is shown below. The table only includes courses delivered specifically to medical and nursing staff:
Both modules relating to resuscitation were below the trust target of 95%. Resuscitation – adult basic life support had the lowest completion rate at 43%, although it should be noted that this represented a small number of staff with seven eligible staff of which three had completed the training.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The trust provided additional training information, which indicated that 91% of critical care staff had up to date immediate life support training. This was better than the trust standard of 95%.

**Safeguarding**

**Safeguarding training completion rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust did not allocate any medical staff to either the ICU/HDU or Critical Care Outreach Team. We asked for this information after our inspection and found all consultants in the department had up to date safeguarding adults level 2 and safeguarding children levels 2 and 3 training.

The trust set a target of 95% for completion of safeguarding training. Following the inspection the trust told us the target was 90%.

A breakdown of compliance for safeguarding courses as of July 2017 for nursing/midwifery staff is shown below. The table only includes safeguarding courses at the appropriate level for medical and nursing staff, therefore level 1 and level 4 courses are not included in the tables:
All applicable safeguarding training modules met or were near to the trust target of 95% for training completion.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The lead nurse for critical care and lead consultant acted informally as the unit’s safeguarding leads and liaised directly with the trust safeguarding team for support and guidance.

As of October 2017 88% of the nursing team had up to date training in recognising and acting on female genital mutilation.

The trust told us that 100% of staff had completed level 1 safeguarding training.

Cleanliness, infection control and hygiene

A named nurse for infection prevention and control care was in post and disseminated learning from audits and training to the rest of the team.

In the year prior to our inspection critical care reported two instances of unit-acquired MRSA, three cases of MSSA and three instances of Clostridium difficile. Two cases of MSSA related to hospital-acquired pneumonia and one case related to arterial line sepsis. In the same period there was one case of a vancomycin-resistant Enterococcus bloodstream infection related to leukaemia and an acquired kidney injury.

The infection control named nurse carried out a weekly audit of 10 observations of hand washing compliance and techniques in addition to a hand hygiene audit. The most recent results were from October 2017 and indicated 100% compliance with hand hygiene policy and 95% compliance with handwashing techniques. However, during our observations over three days we observed inconsistent and sometimes low levels of adherence to good hand hygiene and infection control practices amongst clinical staff. For example during a ward round we noted the senior nurse had to prompt a number of colleagues to gel their hands between patient examinations. In addition we
saw that staff without patient responsibilities entered the unit and approached patient bed spaces without washing their hands or using antibacterial gel.

To protect patients and staff from the risks associated with Legionella. Legionella is a term for a particular bacterium which can contaminate water systems in buildings. Cleaning staff used a daily job list to ensure appropriate flushing of sinks. We saw cleaning staff signed daily checks for flushing showers and taps but these were not always dated. It was therefore not possible to confirm appropriate flushing took place daily.

There were inconsistencies in the use of personal protective equipment. For example we observed a nurse change a catheter bag without washing their hands or wearing gloves. We also observed a student nurse following the same practice. Staff in the vicinity did not challenge either practice.

There was evidence of damage to the floor in the HDU. Staff had tried to repair this with tape but the tape had frayed and there was a notable build-up of dirt in the damaged area. This presented an infection control risk to patients. In addition damage to the staff room presented a cross-infection risk for staff due to broken flooring and worktops and damaged furniture.

We saw variable compliance amongst staff with infection control and uniform policies. For example we observed one member of staff wearing a stoned ring and four clinical staff from other areas of the hospital not comply with the bare below the elbow or handwashing policy. Two visiting clinicians were also wearing wristwatches. We did not see unit staff challenge this in any instance. In addition, we saw it was common practice for staff to take bags, coats and jumpers into the clinical area.

Each bed space had an individual cleaning folder for nurses to complete twice daily when the bed was occupied. We looked at six cleaning records in the HDU for the month prior to our inspection. We found inconsistent recording of bedside cleaning. For example a nurse told us if there was no record of cleaning on a certain date this meant the bed was vacant. However this was not recorded in the folder and we saw a number of missing entries on dates that patients had been admitted. In addition where nurses had completed the cleaning record there were unexplained omissions. For example nurses routinely marked the cleaning of sharps bins as ‘N/A’ although each bed space had a sharps bin. We saw in the HDU one bed had been occupied for one week but had no recorded cleaning for the previous two days. In the most recent entry a member of staff had marked the sharps bin as ‘N/A’. However the sharps bin had dried blood on the exterior of it, which presented an infection control risk.

We asked a member of the contractor cleaning team about cleaning schedules and duties. They showed us the cleaning schedule they used daily, which we saw they worked through meticulously on each day of our inspection. However there was no documented evidence of this as they were not required to sign off any cleaning. In addition they did not know if their own cleaning schedule meant nurses did not need to use the bedside cleaning checklists. Overall this meant some elements of the cleaning and daily infection control processes lacked coherence and consistency.

Environment and equipment

The environment presented a significant challenge to staff in delivering safe care. This was because both the ICU and HDU were in very cramped areas with a lack of storage space and space for free movement. Neither unit was compliant with the Department of Health Health Building Note (HBN) 04/02 in relation to safe clearance space between patient beds. We saw this had an impact on patient care and on how staff worked. For example during a ward round in ICU, the attending staff had to line up four deep into the bed space to be able to see the patient. This
also presented a challenge with noise, which made it difficult for all members of the ward round to hear. Although the unit was in operation before the HBN guidance, there was no evidence of risk management that would address the challenges of an older building.

The ICU had two side rooms that staff could use for isolating patients with an infection control risk, one of which was equipped for negative pressure therapy.

Bed spaces were too close together to allow safe access for chairs or equipment for mobilising. The HDU was equipped with ceiling-mounted hoists which meant patients could be more safely transferred or supported to mobilise. However this also meant that when relatives or other health professionals visited patients there was limited safe space for them to sit. The nurse in charge told us even if they could fit a chair by each bedside, there was no safe space to store them as all storage space in the unit was full.

There was a lack of suitable storage space for equipment on the unit. A decommissioned bed space in HDU was used as storage, which reduced access to the adjacent beds and walkways.

Between November 2016 and October 2017, 5% of reported incidents related to the environment or equipment. We identified a theme of inconsistent planning and a lack of timely, coordinated support for staff when they needed this urgently. For example during a failure of the piped air supply system in March 2017, staff found that only three suitable masks were available for portable back-up oxygen although seven patients needed a continuous oxygen supply. This was because some of the valves were not compatible with the oxygen cylinders. There was no evidence there was a responsible team or policy that could have avoided this situation.

Staff submitted an incident report in April 2017 regarding an insect infestation in the unit. This included uncontrolled flies that landed on sterile equipment and on patients who were at risk of infection. Staff noted they had contacted the trust’s estates and facilities team who said pest controllers could only visit the unit if there were no patients undergoing treatment. There was no final outcome documented.

There was limited evidence of controlled access to the unit. For example during a ward round we observed a relative entered the unit unchallenged and interrupted the medical review. Staff dealt with the situation sensitively but, there was not a process in place to have interacted with the individual when they first arrived on the unit. Access to the HDU was through an inpatient medical ward. Access was not controlled and although signs asked visitors to ring a bell for staff to grant access, we did not see this happened in practice. The HDU and ICU were connected and this meant people could gain unrestricted access to the ICU if they entered through the ward.

There was room for improvement in the processes used to check emergency equipment. For example airway trolleys should be checked by a clinical member of staff who is airway trained. However on this unit staff nurses documented daily checks. In addition we found two items to be missing from the airway trolley but were later found in a resuscitation trolley. It was therefore not evident that daily safety checks were effective.

After our inspection we were provided with information about a two-stage action plan to address the immediate concerns we found with the environment. This included furniture, storage, decoration, fire safety and layout. The trust planned to complete the action plan by April 2018. This meant it was not evident the trust had the capacity or resources to address the immediate safety concerns we found.

**Assessing and responding to patient risk**
The team did not routinely use daily safety briefings but the lead nurse for critical care explained plans were in place to implement them.

Staff did not routinely use recognised tools such as the confusion assessment method for ICU (CAM-ICU) to assess delirium and instead reviewed this reactively.

All beds in the critical care unit could provide flexible care based on changing or deteriorating patient need. For example if a patient receiving level 2 care in the HDU deteriorated and needed level 3 care, including ventilation, staff could provide this without the need for a move of bed. This met the requirements of the ICS core standards.

All clinical staff in the unit were trained in the care of the deteriorating patient including using ventilator, tracheostomy and catheter care bundles to monitor status. During our inspection we observed staff monitored patients for deterioration appropriately using recognised clinical scores.

In addition the critical care team ensured this information was handed over to ward staff when they discharged the patient, for example through the use of a tracheostomy ‘passport’ to ensure continual monitoring.

An advanced nurse practitioner led a team of five senior nurses to provide the critical care outreach team (CCOT), which was available 24-hours, seven days a week. The team provided support for ward staff where patients’ early warning scores (EWS) observations indicated they were deteriorating in line with ICS core standards. The trust routinely audited the use of EWS. However, audits were not carried out in the critical care unit as patients in the unit had already been escalated via the EWS system and were under intensive or high dependency care.

The CCOT standard was to see patients within 30 minutes of referral and to repeat each patient’s observations within two hours. We spent time with the CCOT team as part of our inspection and saw evidence repeat observations were completed consistently.

All nurses in the CCOT team had completed training in advanced life support.

The trust’s emergency prevention, preparedness and response working group (EPPR) had completed a major incident simulation with a critical care nurse to update their processes and response. This occurred to highlight learning after a major incident involving public transport in the local area. Staff participating successfully evacuated in seven minutes, which was the trust target. This exercise led to updated major incident policies and action cards for key staff. Although the action cards and policies had been updated and were readily available on the unit, there were previous cards dated 2010 in both the ICU and HDU. This meant there was a risk staff would use out of date procedures in the event of an emergency. In addition the trust major incident plan had been ratified in draft form only. However the simulated exercise was video recorded and the EPPR and nurse planned to use this as a training resource for staff who had not taken part.

The technician conducted a daily fire check including ensuring fire exits were unobstructed and firefighting equipment was in critical care. However there was an overall inconsistent approach to fire safety in the unit. For example a vacuum cleaner and easel partially blocked one fire exit. The fire door had contradictory signage on it. One sign instructed staff to keep the area free from obstructions and the other indicated the exit was no longer in use. Staff we spoke with had varying knowledge of whether or not the exit could be used in an emergency. We escalated this to the trust senior team at the time of our inspection.

Emergency exits from the HDU to the adjacent ward were blocked to varying degrees during our inspection despite signs on both sides of the doors indicating they should be kept clear. A refreshment trolley on the ward blocked part of one exit on one day of our inspection. We asked a
nurse about this and noted it was moved afterwards. On another day of our inspection we noted another exit from the HDU was completely blocked by equipment, including a chair and computer terminal. This presented a significant risk in the event of a fire or evacuation and indicated staff were working within an environment that was too small for the work they were required to carry out.

Between May 2017 and October 2017 there were 51 days on which daily fire safety checks had not been documented. The store technician told us this most often occurred when they were not on shift as there was not a coordinated system between the fire wardens to always complete daily checks.

Staff adhered to the latest sepsis six policies, which were readily available electronically on the unit.

Two medical inpatient wards in the hospital were able to provide care for patients with non-invasive ventilation. To ensure patient safety, nurses from CCOT provided one-to-one support and observations of patients.

**Nurse staffing**

All critical care nurses were trained to work in both the ICU and the HDU. Of the nursing team, there were seven shift coordinators in addition to an administrator, an audit nurse, a practice development nurse, a store technician and a ward clerk.

The trust reported their staffing numbers below as of March 2017. It should be noted that the trust did not provided a breakdown at ward or unit level so the mapping was unable to be verified.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post at March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care</td>
<td>130.37</td>
<td>118.26</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

As part of our inspection we asked to see up to date staffing data. We found:

The unit met the requirements of the Intensive Care Society (ICS) core standards for intensive care. This was because there was a supernumerary coordinator and nurse in charge at all times and nurse to patient ratios met national standards. This was a ratio of 1:1 for patients who required level 3 care and a ratio of 1:2 for patients who required level 2 or level 1 care.

The senior team told us the trust restricted their ability to recruit to vacant posts unless the unit met the requirements of a 95% appraisal rate and a 90% mandatory training rate. However the executive team told us this would be waived if patient safety was at risk.

**Vacancy rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Between August 2016 and July 2017, the trust reported an average vacancy rate of 16.7% in
Critical Care. As of July 2017, the vacancy rate was 18.4%.

- ICU / HDU had an average vacancy rate of 18.1%
- Critical Care Outreach Team had an average vacancy rate of 2.7%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Between August 2016 and July 2017, the trust reported a turnover rate of 22% in Critical Care;

- ICU/HDU had a turnover rate of 20%
- Critical Care Outreach Team had a turnover rate of 33%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Between August 2016 and July 2017, the trust reported a sickness rate of 3.4% in Critical Care;

- ICU/HDU had a sickness rate of 3.7%
- Critical Care Outreach Team had a turnover rate of 1.6%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and agency staff usage**
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Information provided by the trust did not show any bank and agency usage for Critical Care.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

We looked at agency and bank staff usage data as part of our inspection. In the year prior to our inspection an average of 20% of shifts were filled by bank or agency staff and in September 2017 19% of shifts were filled by agency staff. The ICS national standard for staffing recommends a maximum of 20% of posts per shift be filled by agency nurses.

**Medical staffing**
The trust has reported their staffing numbers below as of March 2017. It should be noted that the trust did not provide a breakdown at ward or unit level so the mapping was unable to be verified.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post at March</th>
</tr>
</thead>
</table>

---

54
<table>
<thead>
<tr>
<th>Critical Care</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>56.85</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

**Vacancy rates**
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust did not allocate any medical staff to either the ICU/HDU or Critical Care Outreach Team. Following the inspection the trust told us consultants provided advisory support on a 24/7 basis and a registrar was available 24/2 via bleep and consultant support was available where required.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust did not allocate any medical staff to either the ICU/HDU or Critical Care Outreach Team.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and locum staff usage**
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Information provided by the trust did not show any bank and locum usage for Critical Care.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

A team of eight consultant intensivists led medical care. Consultant staffing levels meant there was a ratio of one consultant per 15 beds. Although this met the Faculty of Intensive Care Medicine (FICM) standards the consultant also provided support to the CCOT team, which meant consultant cover could be compromised at times. This was evident at weekends when clinical governance records indicated consultants did not always review patients within 12 hours of admission. This meant care was not always delivered in line with FICM standards.

Consultants led twice-daily ward rounds and a junior doctor reviewed each patient prior to this, which meant the ward round was based on the latest available test and observation results.

Core medical trainees dedicated to critical care led the service overnight with support from an on-call consultant and anaesthetist.

**Records**
Patient records and prescribing in critical care were electronic. Electronic patient records were accessible through computers based at central unit stations and at each bed space.
A nurse and the practice development nurse carried out an audit of patient records between May 2017 and September 2017. The audit found 84% compliance overall with 13 trust records standards. This was an average and reflected low compliance (71%) with oral hygiene documentation and more consistent compliance (98%) with the recording of intravenous fluid drips. The auditing nurses found there was inconsistent training for staff, including some who had not had any formal training in use of the records system. It was also identified that not all bank or agency nurses had competency checks and some staff did not know about the standard operating procedures for documentation. An action plan to address these issues was due to be completed by December 2017.

**Medicines**

Medicines in the critical care were stored with electronically-controlled access for security although staff removed all medicine planned for the day at the start of each shift. The electronic storage ensured medicines were ordered efficiently and discarded when they had expired. However where medicines were stored outside of this device, it was not evident an effective system was in place for safe disposal. For example we found three opened antibiotic ampules that should have been disposed of within 24 hours of being opened. We escalated this to a pharmacist at the time of our inspection who destroyed the items.

Between November 2016 and October 2017, 4% of reported incidents related to medicine errors. One incident related to staff administering a fentanyl patch to the wrong patient and nine incidents related to an incorrect dose or route of administration. One incident related to poor management and oversight of controlled drugs. Staff noted none of the incidents resulted in patient harm although there was no indication of how this was measured or what the learning outcomes were, despite significant initial impact. For example one patient experienced a delayed antibiotic infusion of 40 hours and another patient did not receive a dose of IV immunoglobulin due to a lack of appropriate nurse handover communication.

We saw evidence staff consistently recorded the temperatures of refrigerators used to store medicines. We looked at records for the three months prior to our inspection and found there were no gaps in recording and no instances where temperatures had exceeded the daily maximum advised by medicine manufacturers.

Controlled drugs (CDs) were stored in line with national guidance and we saw documented evidence that staff carried out daily checks on stock levels and storage. All of the CDs in the unit at the time of our inspection were within their expiry date. A senior nurse carried out a quarterly CD audit and highlighted results during staff briefings.

A pharmacist audited omitted doses of prescribed medicine but there was no clear evidence that this information was shared with the critical care team immediately or that it led to improvements in practice. At the time of our inspection we found that between August 2017 and October 2017 the average rate of omitted doses was 20%. Staff had not always documented reasons for missed doses and due to a lack of resources in the pharmacy team; there was a lack of capacity to monitor this more consistently. Staff had not always completed incident reports for cases of missed doses. We spoke with the pharmacist about this who had identified a need for more training in the use of electronic codes staff used to indicate why doses had been missed. After our inspection the trust provided different data that noted omitted doses as 3-4% for this period.

Medicines were not always stored securely. We found two ampules of sodium chloride left on a nurse’s station unattended. On our weekend unannounced inspection we found all three secure
medicine storage cabinets in the HDU were unlocked. We spoke with a nurse about this who told us the team had been too busy to complete a security check and they should normally be locked at all times. However when we left the unit two of the medicine cabinets remained unlocked. We also found three oxygen cylinders which were out of date and intravenous fluids were stored in an area without ambient temperature monitoring.

Incidents

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Between September 2016 and August 2017, the trust reported no incidents classified as never events for Critical Care.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 2 serious incidents (SIs) in Critical Care which met the reporting criteria set by NHS England between September 2016 and August 2017.

The types of incident reported were:

- Diagnostic incident including delay meeting SI criteria (including failure to act on test results): one incident.
- Sub-optimal care of the deteriorating patient meeting SI criteria: one incident.

(Source: Strategic Executive Information System (STEIS))

As part of our inspection we asked for the unit’s information on serious incidents (SIs) during the above period. The unit reported four SIs; three of which had been de-escalated to incidents and one was in the investigation phase. The investigation details provided to us were not evidence of detailed investigations or outcomes. For example one patient had developed epilepsy that required ventilation and a critical care admission. Although staff had identified a possibility of harm, there was no conclusive outcome or identification of risk.

However in some cases there was evidence of improved practice as a result of SI investigations.
For example the senior team reviewed sedation guidelines for patients experiencing alcohol withdrawal and issued a new policy to stop the administration of a specific opioid to patients who were not ventilated. In addition nurses were trained to be more observant with changes in patient behaviour and complete more thorough observations to identify what a patient’s disposition could reveal about their condition.

Between November 2016 and October 2017 staff reported 377 incidents of which 74% resulted in no harm, 25% in low harm and 1% in moderate harm.

A consultant led monthly morbidity and mortality (M&M) meetings and reviewed all patients as part of this process. Critical care, medical and surgical consultants attended this meeting along with the trust risk manager and senior divisional managers. However where the planned lead for the M&M discussion was unavailable, the review did not go ahead. This was the case in September 2017.

We reviewed the records of M&M meetings between July 2017 and October 2017. There was no clear identification of patient needs in any of the records and the majority of reviews looked at the actions of other units in the hospital. Ongoing challenges were identified such as “a problem with out of hours echo” but there were no recorded solution or attempts to improve outcomes. In addition there was no evidence of an embedded multidisciplinary approach to investigating mortality. For example in one case the minutes of an M&M meeting noted a patient had “slipped through the net.” This meant there was no consistent, documented evidence of a multifaceted approach to learning from patient deaths. In one set of minutes, out of the 12 patient deaths discussed, the team identified five as being inappropriately referred to critical care or lacking specialist input from other clinical teams. For example two patient reviews noted a lack of discussion with the gastro team and one patient was admitted due to a “difficult family.” There were no documented outcomes or learning from the reviews and instead the notes indicated questions such as whether treatment could have been implemented earlier.

Following the inspection the trust provided information about the patient listing report where all the mortality cases are listed along with admission events, cause of death issues of concern etc.

Safety Thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 5 new pressure ulcers, no falls with harm and no new catheter urinary tract infections between August 2016 and August 2017.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Croydon Health Services NHS Trust
Total Pressure ulcers (5)

Total Falls (0)

Total CUTIs (0)

(Source: NHS Digital)

- Staff used urinary catheter care plans to care for patients with a catheter in place.

**Is the service effective?**

**Evidence-based care and treatment**

Critical care was part of the South London Critical Care network. However the latest peer review had been cancelled due to unforeseeable circumstances. Although the network manager and lead assessor visited the unit, there were no documented outcomes from this. In addition an audit nurse was in post but there was no local audit programme. This meant the clinical team were not auditing practice and outcomes at a local level or benchmarking their work against national standards.

The unit was compliant with 35 of the 41 guidelines for the provision of intensive care standards as identified by FICM and the ICS. Areas of non-compliance related to a lack of specialist resources such as full pharmacy cover and a psychologist for the follow-up service.

Consultants supported trainee doctors to participate in clinical audits but the doctors we spoke with said they did not have time to take this up.

Physiotherapists supported critical care staff in planning for patients to step-down from the unit using National Institute for Health and Care Excellence (NICE) guidelines, formal handovers, multisystem assessments and by establishing step-down goals with each patient. The multidisciplinary (MDT) team also used this approach to support patients who were transferred between hospitals.

Trust and unit policies were readily available on the intranet, including to temporary staff. Although the trust had a process for reviewing and updating policies we found some policies had not been updated in line with the policy. For example the bowel management policy had last been updated
in 2011. The unit had a link nurse for colorectal conditions who was developing an up to date bowel management programme.

The trust did not maintain an up to date organ donation policy. The organ and tissue donation policy had been ratified in 2012 and had been due for review in 2015. However this had not been reviewed until October 2017 and as of December 2017 was still in draft form. This meant organ donation work in the hospital took place without up to date policy and guidance.

**Nutrition and hydration**

Staff calculated each patient’s Waterlow score on admission but we did not see consistent monitoring of this through a patient’s inpatient stay.

A nutrition support team met weekly, which enabled dieticians and speech and language therapists to review individual patients.

Dieticians were dedicated to ICU and reviewed each patient. Critical care staff referred patients in the HDU to dieticians on an individual basis.

We did not see evidence staff had training in supporting the nutrition and hydration of patients with complex social or psychological needs, such as a learning disability. For example we saw one patient had a cooked breakfast next to them that was cold and untouched. A member of staff took this away without speaking to them and there was no record that staff had tried to encourage the individual to eat or offered to find an alternative.

**Pain relief**

Critical care sedation guidelines included directions for assessing and managing pain and this policy had been updated in 2016. Although we saw evidence staff scored pain for one hour each day, documentation did not indicate they used the unit’s pain assessment framework. This meant the unit did not have assurance pain scores were consistently calculated.

There was limited specialist pain cover for the hospital. In the six weeks prior to our inspection, a dedicated acute or chronic pain doctor was available on only three days. This represented availability of 5%. Following our inspection, we were made aware that the intensivists on the unit have specialist pain knowledge and lead and support the trust on pain management and that across the trust had increases the numbers of the pain specialist team. However, we found access to pain management and utilisation of the measures in place was limited.

**Patient outcomes**

**ICNARC Participation**

The trust has one unit which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. We used data from the 2015/16 Annual Report. Any available quarterly data should be considered alongside this annual data.

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

**Hospital mortality (all patients)**

For the critical care unit at Croydon University Hospital, the risk adjusted hospital mortality ratio was 1.3. This was worse than expected. The figure in the 2014/15 annual report was 1.2.

*(Source: Intensive Care National Audit Research Centre (ICNARC))*. 
Hospital mortality (for low risk patients)
For the critical care unit at Croydon University Hospital, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 1.4. This was within expected limits. The figure in the 2014/15 annual report was 1.5.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Following the inspection the trust informed us that the information was based on ICNARC data. Risk adjusted mortality is ‘green’ for Q1 Apr- June. The end of year report for 2016/17 exposed inadequate coding and thus giving a lower mortality risk per patient. Before the inspection this had already been highlighted and addressed. ICNARC2017 Data demonstrates that quarter 1 and 2 mortality rates are within 25D comparator and are comparable to similar units and have demonstrated improvement.

Staff used visual infusion phlebitis (VIP) scores to monitor patients with an arterial line in place. These were calculated once during the day and once during the night.

We found inconsistencies in the care documented for patients with pressure ulcers. For example where staff found a patient had developed a pressure ulcer they completed an incident report and a tissue viability care plan and also photographed the areas of concern. They also referred the patient to a tissue viability nurse. However position changes were not always documented. We found staff had documented position changes every three to four hours for one patient in line with their care plan. For another patient repositioning occurred between twice daily and 13 times daily in a seven day period although tissue viability notes stated they should be repositioned every two hours.

There were inconsistencies in how staff graded pressure ulcers. For example for one patient in November 2017 we saw three different nurses had marked the same pressure ulcer variably as grade 2 or 3 on three days. In addition staff had completed a daily pressure ulcer checklist on only two dates in the previous three weeks. There was no documented explanation for this and a tissue viability nurse we spoke with said they would only review the patient again if the critical care team re-referred them.

Critical care achieved a 100% brain stem death testing rate in the four years prior to our inspection.

CCOT provided follow-up for patients after they were discharged to an inpatient ward for up to four days.

Competent staff

Appraisal rates
Between April 2017 and July 2017, 74.1% of staff within Critical Care at the trust had received an appraisal compared to a trust target of 95%. Information provided by the trust did not allocate any medical or dental staff to either ICU/HDU or the Critical Care Outreach Team.

A split by staff group can be seen in the graph below:
In the nursing team, 70% had completed a post-registration qualification in intensive care nursing. This was better than the national ICS guidance of 50%.

All agency nurses who worked in the unit had a post-registration qualification in intensive care medicine and were required to have a minimum of three years’ experience. Although we saw agency nurse induction forms were completed and stored on the unit, they were not audited against the number of agency staff who had worked shifts there. This meant it was not possible to confirm that every agency nurse had completed an appropriate induction. For example on one night during our inspection four agency nurses were on shift but a documented induction was available for only three of them.

Trainee doctors had weekly protected teaching time and an education supervisor. However not all trainee doctors we spoke with had completed an induction. They told us this meant they had to adapt to the electronic patient records system themselves and that there had been no formal instruction in ordering tests.

The pharmacist produced a quarterly newsletter for critical care staff that was held in the team folder.

Two nurses from CCOT worked regular bank shifts on the ICU to ensure they maintained critical care competencies. In addition this team completed training in the Sepsis 6 pathway and each member of the team was trained in providing tracheostomy care.

The hospital had a simulation centre and had recently appointed a centre manager who worked with the CCOT team to provide respiratory and acute life threatening events recognition and treatment (ALERT) courses as well as competency assessments for staff in tracheostomy care and non-invasive ventilation.

Consultants used wards rounds as teaching and learning opportunities for more junior doctors, which we saw in practice.
Dieticians did not have formal training to care for patients who received critical care. However new members of the team spent time shadowing more experienced colleagues to help them apply their practice to the needs of patients with complex needs.

A learning disability liaison nurse provided on-demand training and support to clinical staff when patients were referred to them.

The senior team were not able to demonstrate the overall level of clinical competency training and achievement of staff due to inconsistent recording. It was also not possible to identify the competency training of long-serving staff. The senior nursing team had identified this as an area for improvement in training and competency.

Staff spoke positively about their opportunities for training and development, including a student nurse who said they felt staff had gone out of their way to make them feel part of the team. Staff had access to learning facilitated by their colleagues elsewhere in the trust who were involved with research and audits. For example the falls improvement collaborative had presented their work to understand falls risks in older people with delirium and confusion to help the critical care team reduce risks.

**Multidisciplinary working**

We saw that members of the MDT team responded in a timely manner to referrals from the unit. For example we found where one patient had been referred to a dietician; they were seen the same day.

A pharmacist was dedicated to critical care on a 0.5 whole time equivalent (WTE) basis. This meant there was pharmacy presence on ward rounds two days per week; although a business case was being prepared to increase cover to one WTE post.

Although there was a system in place for nurses to take on link or champion roles, there was limited evidence this worked in practice. For example there was no evidence of recent identification of roles locally.

We observed during ward rounds that surgeons routinely attended to discuss individual patients with the rest of the MDT team. However there was no other routine MDT attendance or input during ward rounds including physiotherapists and dieticians.

A microbiologist met daily with the critical care consultant to review each patient although clinical governance documentation indicated some difficulties in ensuring a microbiologist was available for patient review in a timely manner. In addition staff noted they were not able to obtain a consultant haematologist review following a change in practice meaning a registrar took over this role. After our inspection the trust told us there had been no change in cover and that a senior registrar or consultant continued to provide support 24-hours, seven days a week. We were unable to confirm why this difference in understanding occurred.

Although there was evidence of MDT working this was on an individual basis and there was no coordinated or formal approach that enabled the MDT team to meet and review patients. After our inspection the trust told us they had worked with the critical care network lead to identify other models of MDT working. This was to reduce the size of the ward round team in a small space and to reduce infection control risks.

The learning disability liaison nurse had joined ward rounds to support the medical team on request to help coordinate the care for specific patients.
Seven-day services

Consultants provided cover 24-hours, seven days a week between 8am and 8pm. Overnight a consultant was always on call. An anaesthetist was also available on call at all times. This met the requirements of FICM and the ICS core standards for intensive care units.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

The trust did not include information for either Mental Capacity Act (MCA) training or Deprivation of Liberty training.

(Source: Trust Provider Information Return)

During our inspection we observed a patient being restrained with mittens to prevent injury. However the patient had a learning disability and there was no documented evidence that staff had completed an appropriate risk assessment for their use or that a restraint care plan was in place. After our inspection the trust confirmed the safeguarding lead had carried out an appropriate assessment to ensure this was appropriate care for the patient.

Staff used the Richmond Agitation-Sedation Scale (RASS) to identity each person’s level of sedation.

Where a patient had reduced mental capacity and a suitable family member was not available, staff referred them to an independent mental capacity advocate (IMCA) to ensure their best interests were taken into account. We saw evidence of this from looking at patient records but our conversations with staff indicated there were inconsistencies in awareness in relation to mental capacity. For example a nurse told us they would only ask for a mental capacity assessment if, “[The patient’s] family don’t want you to do something.” In another instance the relative of a patient told us they did not know if they had undergone a capacity assessment and were concerned some decisions around their therapy were against their wishes. We spoke with an occupational therapist about this who said they did not know if the patient had a mental capacity assessment in place and they would look at implementing a plan if needed.

During our main inspection we found that some of the critical care team did not have a well-defined understanding of the Deprivation of Liberty Safeguards (DoLS) or how it applied to patients who were restrained for their own safety. For example staff had restrained two patients in the HDU with mittens. The senior nurse in charge and patient A’s allocated nurse believed they had a DoLS authorisation in place, which they used along with a mental capacity assessment to ensure they used mittens appropriately. However we found patient A did not have a DoLS authorisation and the critical care team had believed this was the case due to a verbal handover from a medical inpatient ward. The mental capacity assessment did not include a review date. This meant staff could not be assured of the patient’s level of capacity.

There was a DoLS policy available to staff on the intranet from 2016 although this did not reflect the latest guidance for DoLS in critical care settings. We spoke with senior nurses about the use of DoLS and during our unannounced weekend inspection we found new posters based on trust and national policy were on display to support staff in the process.
A learning disability liaison nurse carried out mental health and best interest assessments for patients admitted with a learning disability.

After our inspection we asked the trust to provide evidence of the ICU care and treatment policy on DoLS. Although the trust sent details of the latest FICM guidance on DoLS, there was no evidence staff on the unit adhered to this.

Is the service caring?

Compassionate care

The unit participated in the NHS Friends and Family Test (FFT). This provides monthly data on how patients and the people close to them feel about their experiences. Between July 2017 and September 2017, 91% of respondents said they would recommend critical care. This was an average figure and represented a wide variation between 83% recommendation in August 2017 and 100% in July 2017.

We observed a nurse attending to a patient with kindness and making a demonstrable effort to explain their care and treatment clearly. In addition we observed all members of the critical care team were consistently compassionate and encouraging when delivering care to patients with complex needs. For example when a patient was distressed while receiving tracheostomy care from a nurse, a colleague intervened and tried a different approach using humour and familiarity. We saw this had an immediate calming effect on the patient and staff subsequently completed the care task. After the procedure both nurses congratulated and reassured the patient.

One patient we spoke with said, “The consultant was very patronising. I don’t have that much confidence in the doctors; they keep telling me different things.”

Maintaining privacy and dignity was challenging because the environment was very cramped and patient beds close together. We observed this meant private conversations could easily be heard by other patients, relatives and visitors around the unit. Although some staff demonstrably maintained the dignity of patients they cared for we did not see that this practice was consistent. For example in the HDU we saw a nurse emptied one patient’s urine bag without drawing the curtains. In another instance a patient sat exposed to visitors and another patient opposite them unnoticed for over 30 minutes before a member of staff intervened. However two patients we spoke with said staff had respected their dignity.

We did not see that staff from other units always spoke kindly or respectfully with staff, patients or relatives. For example a doctor from another unit found they could not review a patient with a learning disability because they did not have a relative present. The nurse explained when a relative would be available and the doctor said, “I have ten referrals and [patient] is least of my worries because [they’re] actually sorted out.” This took place in hearing range of the patient the doctor referred to as well as other visitors and patients. This was a demonstrable instance of a lack of respect and dignity and other staff present did not challenge it.

Emotional support

Staff provided patients and their relatives with emotional support during end of life care. Although this practice was not consistent, we found examples of individualised practice. For example the
criticall care time had prepared a memory box for the relative of a patient who had died in the unit.

A chaplaincy service was available 24-hours, seven days a week. However there was a lack of other structured bereavement support in critical care as there was no dedicated bereavement telephone follow-up or end of life care champion or link nurse.

Understanding and involvement of patients and those close to them

We observed during ward rounds that the team discussed how to include patients and their relatives in decision-making about their care.

During all of our observations we saw staff introduced themselves to patients, explained who they were and asked for consent to continue before conducting an examination.

A relative we spoke with said they did not feel involved in the care of their family member. They told us they were confused by the number of different doctors involved and said no-one had explained the care and treatment plan to them until they met a consultant after requesting this several times over the course of a week. This did not reflect the majority of our observations, during which staff made a clear effort to engage with patients. For example during a nurse bedside handover we noted nurses woke a patient to include them in the discussion and to introduce the nurse taking over. This resulted from a previous discussion in which the patient had asked to be more involved. In addition two patients and two relatives told us they had felt informed about their care and treatment.

The unit philosophy embedded patient involvement. For example staff recognised that patients had the right to participate in discussions relating to their care and to have questions answered honestly.

Is the service responsive?

Service delivery to meet the needs of local people

A visitor’s booklet was available in critical care for those visiting patients. However this was stored in a staff-only area and was not readily available to people. It was also not available in large-print or in any language other than English. Although the national ICU Steps programme was advertised in a visitor area, there were no leaflets available to take away. We found a laminated copy in a rack on the floor of the relative’s room but it was evident this had not been accessed recently and it was not readily available for people. Information leaflets for patients and relatives on the care and treatment provided in critical care were available for staff to give out but none of the people we spoke with said they had been offered this.

Three relative’s rooms were available and two could be used for overnight stays with sleeping chairs and blankets. A coffee machine, cold drinks and a shower room were available and relatives were offered discounted catering vouchers.

Between April 2017 and November 2017, a specialist nurse in organ donation and a consultant worked collaboratively in 100% of cases when approaching family members to discuss organ donation. In this period three potential donors were consented and the trust facilitated two actual solid organ donors, which resulted in four patients receiving a life-saving or life-changing transplant according to the criteria set by NHS Blood and Transplant. A dedicated clinical lead for
organ donation was assigned to critical care and attended organ donation committee meetings three times a year to identify successes and strategies to improve rates of successful organ donation. NHS Blood and Transplant found no instances in 2017/18 where potential organ donors were not referred.

All of the staff we spoke with said they were unaware of future expansion plans for the unit.

**Meeting people’s individual needs**

The HDU did not have any facilities for patients such as a toilet or shower. When patients needed to use these, staff had to arrange support to access the adjacent inpatient ward.

We found one patient with a learning disability did not have a communication care plan in place and there was not a learning disability link nurse or champion in the unit. However a liaison nurse was available from another NHS trust and provided on-call support. In addition, where patients were admitted with a hospital passport we saw staff used this as part of their care planning. However communication between staff around care plans was inconsistent and we did not see well-coordinated care when patients had additional needs such as around tissue viability.

Staff used behavioural charts to track patients with fluctuating capacity and delirium. This helped them to identify conditions that preceded a violent or aggressive outburst and meant they could tailor their care and communication to ensure the patient remained calm and free from anxiety or stress. We saw this was an effective strategy to support patient recovery and to protect staff from avoidable harm.

A physician provided a follow-up clinic for patients after they were discharged. A patient-directed forum was held weekly and all patients who were discharged from the unit were invited to attend this. Between August 2016 and August 2017 130 patients were seen in the follow-up clinic. Although a follow-up clinic reflects best practice as recommended by FICM and the ICS, a psychologist was not available and this service was limited in scope.

We saw doctors routinely included patients’ social history and needs in handovers and ward rounds.

A team of three physiotherapists and a physiotherapy intern provided care to critical care patients. However the lead physiotherapist was also responsible for patients on the cardiology ward and the team was not sufficiently resourced to attend ward rounds.

Physiotherapists provided tracheostomy and mechanical weaning plans for patients. Although members of the team reported positive MDT working with dieticians, speech and language therapists (SaLT) and nurses, there was limited opportunity for working with consultants to coordinate care. Members of the SaLT and physiotherapy teams conducted joint weekly reviews of patients for weaning and swallowing.

We saw nurses who spoke languages other than English provided dedicated support to patients. This provided a more dedicated alternative to translators and the telephone translation service. For example during our inspection a nurse who spoke Italian had been allocated to provide care to a patient who was demonstrably comforted because they could more easily communicate. This also enabled the nurse to support the rest of the clinical team by offering cultural insight into the patient’s needs and behaviours. However we saw where a patient spoke a language not represented amongst the clinical team there was limited evidence efforts were made to establish communication. For example staff had been unable to speak with one patient due to a language barrier and there was no documented evidence a translator had been found. We spoke with a
nurse about this who told us they believed the patient understood what was happening because they had been “compliant with care.”

Each patient had an information board behind their bed that included the names of their consultant and named nurse. The boards could also be used for important allergy or dietary information. We saw inconsistent use of the boards, including occasions when there was no information on them at all but a patient was being cared for in that bed space.

**Access and flow**

**Bed occupancy**
Between September 2016 and August 2017, Croydon Health Services NHS Trust has seen adult bed occupancy which has fluctuated but been largely similar to the England average.

**Adult Critical Care Bed occupancy rates, Croydon Health Services NHS Trust.**

![Graph showing bed occupancy rates](image)

Please note that data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

*(Source: NHS England)*

**Delayed discharges**
For the critical care unit at Croydon University Hospital, there were 5490 available bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 5.9%. This compares to the national aggregate of 5.3%. This meant that the unit was not in the worst 5% of units nationally. The figure in the 2014/15 annual report was 6.8%.

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

Senior clinical staff told us the trust prioritised the national standards set for the emergency unit, which meant patients were often delayed in critical care awaiting a bed. Although the hospital bed manager ensured there was always one inpatient bed per day for patients this was often insufficient for the number of patients ready to be discharged.

**Non-clinical transfers**
For the critical care unit at Croydon University Hospital, there were 641 admissions, of which 0.8% had a non-clinical transfer out of the unit. Compared with other units this unit was within expected limits. The figure in the 2014/15 annual report was 1%.

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

**Non-delayed out of hours discharges to the ward**
For the critical care unit at Croydon University Hospital, 2.4% of admissions were non delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. Compared with other units, this unit was within expected limits. The figure in the 2014/15 annual report was 4.3%.

(Source: Intensive Care National Audit Research Centre (ICNARC))

All decisions to admit were consultant-led, which was in line with ICS national guidance. Nurses in the critical care outreach team were able to refer patients directly to a critical care consultant for admission.

Where discharges were delayed or occurred between 10pm and 7am, staff submitted an incident report. This occurred on six occasions between November 2016 and October 2017, which meant reports were not consistently submitted. There was no evidence of learning or improvements to access and flow procedures as a result of incident reports. For example a report from November 2016 indicated a patient had been discharged home directly from critical care after waiting six days for a ward bed. Staff submitting the incident noted this had placed the patient at risk because critical care staff were not equipped or trained to provide the same dedicated care patients would receive on an inpatient medical ward.

Between April 2017 and October 2017, 79% of patients were discharged to a ward within 24 hours of admission. This was similar to the trust target of 80%.

The senior team had recently implemented an audit of the time from decision to admit to the patient arriving in the unit against the national standard of four hours. This was a new unit and there were no data available to us at the time of our inspection.

The team maintained one staffed level three bed space for emergency admissions.

Patients who underwent planned elective surgery in the trust were usually booked a bed in the HDU for monitoring. However, a lack of bed capacity meant these patients were sometimes cared for in theatre recovery. Although this meant their safety was maintained, theatre recovery did not have comparable facilities to meet patient needs.

Learning from complaints and concerns

Summary of complaints
Between August 2016 and July 2017 there were no recorded complaints about Critical Care.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

We spoke with the clinical team about handling minor issues raised by patients or relatives. The nurse in charge of each shift was able to respond to concerns that arose and also ensured the lead nurse for critical care was told about these. Learning from feedback and minor issues was shared across the whole team. For example a relative had raised an informal concern about communication they had misunderstood from a consultant. In response the lead nurse for critical care identified how this could be improved and shared it in a team meeting.

Printed information about how to complain was available on request but this was not on general display in the unit.

Is the service well-led?
Leadership

The lead nurse for critical care acted as the critical care manager and was supported by a team of senior nurses. The clinical lead was also the lead consultant. The lead nurse for critical care worked part time and was on site three days per week. A practice development nurse, nurse practitioner and a team of seven sisters provided leadership support at all other times.

The lead nurse for critical care led monthly ‘in touch’ meetings with the critical care team although meetings with senior nurses were on an ad-hoc basis. Senior nurses met together once or twice per year.

Staff described different experiences with the trust senior leadership team. For example one individual said there was no routine contact between the senior clinical team in the unit and the trust senior team, such as the medical director, unless there was a problem to address. However another individual said the senior team visited the unit every Wednesday and the chief executive officer regularly visited.

Overall there was a lack of consistent, effective leadership. This was evident in the wide range of areas in which we found improvement was needed. From our conversations with staff a sense of apathy was evident in the unit and staff did not feel they were a priority for the trust.

Vision and strategy

Staff described the trust’s values as, “Respect, being cared for, introducing yourself, openness and the Duty of Candour” although they said they had not been offered training in the Duty of Candour. Three members of staff we spoke with were unable to fully articulate the trust values and said they did not know if the critical care team demonstrated these behaviours. After our inspection the trust told us duty of candour training was included in all staff inductions, was available through the staff intranet and all staff had been given an explanatory guide which was attached to their payslips in 2015 and 2017. They also told us the duty of candour was also included in the quality guides given to all staff in 2015 and in 2017.

The immediate plans for critical care focused on improving the clinical environment. The senior team had completed a scoping exercise for space and had submitted a business case for a rebuild of the unit. The senior trust team demonstrated an understanding of the need for significantly environmental improvements but staff in the unit told us they felt they were not a priority for the trust. One member of staff said, “They know about how hard it is to work in here with so little space but the only thing they ever talk about is the rebuild of the A&E.”

A service philosophy was on display in the unit and noted that staff provided care without prejudice to age, gender, sexual orientation, religion, political persuasion or illness.

Although the senior trust team identified the challenges resulting from the environment, there was a lack of structured sustainability planning. For example the hospital’s emergency unit was increasing significantly in size but there was no immediate plan to increase the number of critical care beds available.

Culture

One member of staff said they felt there was a more positive working culture in the unit and in the trust in the past nine months. They also said the feedback forms received from ward staff when critical care nurses were deployed there helped them to improve their work. All of the ward staff
and members of the multidisciplinary team we spoke with were positive about the care provided in critical care.

A specialist nurse in organ donation was based on the unit up to three days per week. They had supported the introduction of future planning and provided nurses with bedside training as a strategy to change the working culture around organ donation.

We did not find staff were always empowered or confident to challenge inappropriate behaviour as described with the trust staff pledges. For example on one day of our inspection we observed a medical consultant speak rudely and disrespectfully to an HDU nurse in front of patients and relatives. We spoke with the nurse afterwards who did not feel they could challenge the behaviour.

All of the staff we spoke with said the unit was a good place to work. Each person also noted teamwork was one of the most positive elements of working there. For example one nurse said, “I’d recommend this as a place to work. Everyone knows what’s going on and there’s a huge back-up of people to help you if your patient [deteriorates].”

**Governance**

The lead nurse for critical care led a bimonthly multidisciplinary governance meeting and structured this in line with the Critical Care Network service specification standards (D16). In addition the clinical lead and the lead nurse for critical care or a senior nurse attended a bimonthly multidisciplinary governance meeting that included a review of incident reports and recruitment.

Handovers between senior staff were not sufficiently robust to maintain effective oversight of patients, as evidenced by the patient not receiving a dose of IV immunoglobulin due to a lack of appropriate nurse handover communication and the confusion over whether a patient from a medical ward had a DoLS in place.

From looking at the outcomes of incident reports we saw that staff were not always able to obtain urgent non-clinical support when they needed it. For example in July 2017 staff had contacted the trust’s central switchboard for urgent support when the electronic patient record system failed. There was evidence of a lack of timely and substantive support from the on-site leadership team, the IT team and the central switchboard. It was not clear from the incident report that the trust had implemented learning or improved risk support procedures as a result. Another incident report related to the delivery of new equipment that had been ordered by another unit from the critical care budget. The senior team were unaware of the equipment until it was delivered in the unit. This meant the team had not approved the budget spend, ensured the equipment would meet patients’ needs or arranged training for staff.

A consultant met bimonthly with the audit nurse and senior nurses and managers to review ICNARC data.

**Management of risk, issues and performance**

The lead nurse for critical care maintained a monthly activity report and presented this at divisional performance meetings.

The lead nurse for critical care attended a monthly performance board with the senior trust team. This was not attended by the clinical lead due to existing duties.
The pharmacist planned to set up separate medicine safety meetings in the unit to reduce the rate of omitted doses. Although the pharmacist regularly attended governance meetings, these had not proved to be an effective forum in which to understand or reduce the problem.

The advanced nurse practitioner who led the critical care outreach team attended governance, sepsis and morbidity and mortality meetings.

The senior team used a risk register to identify and monitor risks to the service. The lead nurse for critical care identified the main risks as relating to the environment, the skill mix of the nursing team and water safety. This reflected the lack of space to safely provide care, a nursing team in which 10% had less than one years’ critical care experience and inconsistent monitoring of the water supply.

Elsewhere in this report we note that access to the unit was not always securely monitored and we saw uncontrolled access on a number of occasions. In addition we saw staff did not always securely control access to data or devices. For example we found a staff IT access card discarded on an unattended nurse’s station in the ICU. We found the nurse was working in the HDU next door, which meant they did not have constant control of who could use their ID to sign in to secure and confidential systems. We asked a nurse about this who said it was normal practice to not always carry their IT card when they were ‘floating’ or coordinating.

It was not evident that risks associated with the environment around the unit were identified by the senior trust team. For example on one day of our inspection fumes from equipment used in construction works outside of the HDU were apparent in the unit. Staff said they could not close a window because they had no control over radiators and so the unit would become too hot. However the smell of fumes was very strong and there were patients in the unit with significant vulnerabilities relating to breathing and infection control. We raised this was the senior trust team. When we returned for a weekend unannounced inspection the window was still open but staff said construction works did not take place on a weekend and so they did not know if the issue of fumes had been resolved. In addition, we noted an area outside of the temporary pre-fabricated building used to stored medical gases was used as a smoking area. We escalated this at the time of our main inspection and noted there was no further evidence of smoking when we returned. In addition the trust had met with contracted staff working on site to enforce the no smoking policy and new signage had been installed.

The senior team were unable to verify the clinical competency levels of all members of the team. This was evident from incomplete training records and a clinical records system audit that identified inconsistent staff training.

It was evident from the minutes of clinical governance meetings that the clinical team effectively identified risks to the service and include staff feedback in this. However it was not evident that the senior team had the resources or capacity to address the issues and risks. For example risks identified in September 2017 reflected a junior medical team and relatively new nursing staff overnight. This was compounded by the loss of experienced nurses on shifts when the service was overstaffed and nurses were sent to the inpatient wards.

Information management
The lead nurse for critical care and clinical lead managed a staff intranet page that included real-time information on key performance indicators, shared learning and other information of importance to the service.

A critical care shared learning board was available in the unit entrance and included information from incident investigations and feedback from relatives and patients.

There were inconsistent standards of data and information management on the unit. For example we found the personal medical details of one patient discarded in a bedside cleaning folder. The patient this related to was no longer in the unit. In addition a member of the SaLT team had displayed a poster above a patient’s bed that included their full name and details of a special diet prescribed. This information was readily visible to anyone in the unit, including visitors, and the patient was unable to give their consent for this.

**Engagement**

Each consultant took lead roles in specific areas such as trainee doctor supervision, research trials, morbidity and mortality and the electronic patient record system. Additional lead areas included medicines, advanced life support, transplant and anaesthetics.

An information board at the entrance to the ICU provided relatives and visitors with information to help them understand the care provided in critical care. For example staff had noted that patients might not have a good memory and included suggestions for relatives to help. The information also suggested the use of patient diaries, although this was not a strategy routinely used on the unit.

Staff told us there was no formal counselling service provided for those affected by patient bereavement. Although a senior nurse told us this was planned there was no formal timeframe or framework for this. However after our inspection the trust provided details of the counselling arrangements available for staff, such as through the occupational health team, chaplaincy team and Schwartz rounds. We could not establish why staff we spoke with were not aware of this.

**Learning, continuous improvement and innovation**

To support sustainable nursing, band five nurses had access to a critical care competency development framework that acted as an access programme to band six nursing. A practice development nurse led this programme and ensured nurses were ready for leadership development at band six before they progressed.

Business continuity plans were in place for staff to ensure the safe care of patients in the event of situations such as pandemic flu, severe weather and major transport disruption. Appropriate senior staff in the trust had ratified the plans and policies were valid until at least 2018.

Although most staff were not active in research, there was evidence previous research had contributed to good or improved practice. This included research to identify the mental health needs of patients who had been admitted as a result of a drug overdose and a project to improve continuous renal replacement therapy.
End of life care

Facts and data about this service

End of life care is provided on the wards across the hospital and was everyone’s responsibility. The specialist palliative care team (SPCT) supports patients and staff, reviewing patients and giving advice for example with symptoms such as pain control, sickness and poor appetite.

The specialist palliative care team (SPCT) at the trust was led by a part time consultant in palliative care and consisted of 5.7WTE (whole time equivalent) clinical nurse specialists, one social worker and one administrator.

The trust provides end of life care at Croydon University Hospital. End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

The trust had 923 deaths between July 2016 and June 2017.
(Source: Hospital Episode Statistics (HES))

The SPCT delivers a service seven days a week between 9.00am and 5.00pm with medical advice and support available 24 hours via a telephone line.
(Source: Routine Provider Information Request (RPIR) – Context Acute)

The Care Quality Commission (CQC) carried out a comprehensive inspection between 16 and 19 June 2015, which rated end of life care overall as requires improvement. We returned to inspect the service on 31 October 2017 and 1 November 2017.

During this inspection we visited wards - Queens 1,2 and 3, Purley 1 and 2, Heathfield 2, Fairfield1, Wandle 1,2 and 3, accident and emergency department, acute medical unit, Edgecombe unit (acute elderly care unit), the mortuary, the chapel, the bereavement office, Macmillan cancer centre and patient advice and liaison (PALs) office.
We spoke with four patients and four relatives. We also spoke with 31 members of staff, including senior managers, the specialist palliative care team, doctors, nurses, porters, chaplain and bereavement staff and cancer support service staff.

Is the service safe?

Mandatory training

Overall mandatory training rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 95% for completion of mandatory training. Following the inspection the trust told us the target was 90%.

A breakdown of compliance for mandatory courses as of July 2017 for medical/dental and nursing/midwifery staff in end of life care is shown below:

All staff took part in mandatory and statutory training to ensure they were trained in safety systems, process and practices such as moving and handling, safeguarding, health, safety and welfare, infection control and dementia awareness. Monthly study days relating to EOLC were held covering recognising the dying patient, discharging palliative care patients, palliative care in long term conditions and medications used for patients at end of life.

There was also a short section relating to EOLC in the trust induction for new staff. The SPCT covered key EOLC areas and the chaplaincy team also trained new staff in the basics of pastoral and psychological care.

Portering staff completed mandatory training on their induction and yearly thereafter. Areas covered included privacy and dignity, moving and handling, mortuary procedures and safety processes.

The majority of training modules were above the 95% trust target although it should be noted that...
there was only one staff member in the medical staff group.

All training modules were 100% and above the trust target.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The SPCT provided nurses on the wards with training in the use of syringe drivers and were available to provide ongoing support.

Major incident training completion rates
The trust did not report on major incident training courses.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
Staff in the mortuary attended yearly major incident training and simulations.

Safeguarding

Safeguarding training completion rates
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 95% for completion of safeguarding training. Following the inspection the trust told us the target was 90%.

A breakdown of compliance for safeguarding courses as of July 2017 for medical/dental and nursing/midwifery staff in end of life care is shown below:
Completion rates for both required courses were 100% for medical and dental staff, although it should be noted that there was one member of staff in this group.

The table only includes safeguarding courses at the appropriate level for medical and nursing staff, therefore level 1 and level 4 courses are not included in the tables.

Safeguarding children level 2 training was slightly below the trust target of 95%, although this represented six staff out of a cohort of seven.
The table only includes safeguarding courses at the appropriate level for medical and nursing staff, therefore level 1 and level 4 courses are not included in the tables. The trust told us that 100% of staff had completed level 1 safeguarding training.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff understood their role with regards to protecting patients’ from harm or abuse and reporting any issues. This included identifying any risks to patient’s family such as children or vulnerable adults whose main carer may be a patient.

Staff had access to the trust safeguarding policy and procedures on the trust’s intranet. The staff we spoke to were able to describe what constituted a safeguarding concern and were aware of their role and responsibilities to safeguard vulnerable adults from abuse.

Cleanliness, infection control and hygiene

The wards we visited were visibly clean, bright and well maintained. In all clinical areas the surfaces and floors were covered in easy to clean materials allowing hygiene to be maintained.

We saw staff had access to personal protective equipment (PPE), such as gloves and aprons and were seen to be using the equipment and hand hygiene facilities. Each ward had a daily and weekly cleaning regime carried out by domestic services, the wards own housekeepers and clinical staff.

Staff were bare below the elbow, sanitised their hands between patient contacts and wore aprons and gloves when they delivered personal care to patients.

We saw on all wards visited there were hand gels available at entrances and notices reminding staff and visitors to use them.

The mortuary was visibly clean and had a cleaning schedule and records.

Environment and equipment

Staff we spoke with told us they had no problems accessing equipment for patients receiving palliative or end of life care in the hospital.

All staff were trained to use the syringe driver. We were told syringe drivers were available and obtained from the equipment library in hours and out of hours.

Access to the mortuary was restricted due to building works relating to the new emergency department. Staff ensured there were parking spaces available for families viewing the deceased. The environment was visibly clean and very well organised. Plans were in place to build 18 more spaces. Protocols were in place to ensure that deceased with similar names were recognised and highlighted. The mortuary staff has rapid access to additional body storage should they require it. Temporary refrigeration units were in storage and could be built rapidly or local undertakers could store bodies if required.

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. The registers were monitored by the equipment services team.

Assessing and responding to patient risk
Patients that were recognised as deteriorating or dying were started on the end of life care plan. We were told by staff this was commenced following discussions with the SPCT. Early warning system (EWS) were used by staff to identify if escalation of care was required. The system was used to identify patients who were deteriorating and may have required specialist team involvement. Ceilings of care were also used to ensure that the dying patient was exposed to unnecessary treatments.

Care plans were developed in line with the “Five Priorities of Care for the Dying Person”. Care plans were completed on the electronic patient records and the three patient records we reviewed were completed to a satisfactory standard.

Ward staff told us the SPCT team had a visible presence on the wards. Any changes to patient’s conditions generally instigated a visit by the SPCT. We saw patient’s daily notes by nursing, medical and therapy staff with updates on any changes recorded clearly.

We observed a ‘safety huddle’ in Wandle 2 ward. Staff on this ward supported patients receiving end of life care. This safety huddle was held every morning and included all of the staff on the ward, including cleaning and catering staff. Staff described patients by bed number to preserve confidentiality as the meeting was held in the middle of the ward to accommodate everybody. This meeting discussed patients’ health and risk levels at the moment; this included which patients were not sleeping at night, which patients were not mobilising well, change in presentation, emotional health and risks of absconding. This meeting was done in ten minutes, but gave staff the basic up to date information needed to keep patients safe and well.

**Nurse staffing**

**Overall staffing rates**

The trust has reported their staffing numbers below as of March 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon University Hospital</td>
<td>4.73</td>
<td>6</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

**Vacancy rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Between August 2016 and July 2017, the trust reported an average vacancy rate of 11.5% in end of life care. As of July 2017, there was a vacancy rate of 0%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.
Between August 2016 and July 2017, the trust reported a turnover rate of 0% in end of life care.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Between August 2016 and July 2017, the trust reported an average sickness rate of 0.8% in end of life care.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. Between August 2016 and July 2017 the trust did not report any bank and agency usage for end of life care.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing
The trust has reported their staffing numbers below as of March 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon University Hospital</td>
<td>1.89</td>
<td>1.00</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Between August 2016 and July 2017, the trust reported a vacancy rate of 54.5% in end of life care (1.7 WTE vacant out of an establishment of 2.2 WTE)

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Between August 2016 and July 2017, the trust reported a turnover rate of 0% in end of life care.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.
Between August 2016 and July 2017, the trust reported an average sickness rate of 0% in end of life care.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. Between August 2016 and July 2017 the trust did not report any bank and locum usage for end of life care.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

There was one palliative care consultant on the SPCT. The role was a 0.5 WTE. The consultant worked at the hospital for two and half days per week and the other two and a half days were worked at a local hospice. Telephone cover was available during this time at the local hospice. This had not changed since our previous inspection in 2015. The consultant staffing levels were not in line with the ‘Commissioning Guidance for Specialist Palliative Care 2012’. This recommends that there should be two WTE consultants in EOLC per 250,000 population. There is a population of 380,000 in the London Borough of Croydon. The only mitigation the trust had regarding the low level of consultant cover was that the part time consultant was available by telephone to the team in the other two and half days per week and there was a service level agreement with a local hospice for out of ours telephone support. The trust board papers for July 2017 noted they had submitted a business case for additional consultants.

Records
There was a trust wide electronic record system in place which enabled sharing of patient information within the team and with other health care professionals.

During our inspection, we examined three sets of EOLC patient records on the electronic records system (EPR). All the records we looked at were concise, signed and dated, easy to follow and gave clear details of people’s care and treatment.

We saw that when patients had a Do Not Attempt Resuscitation (DNACPR) order in place ward staff were not able to easily access as it was stored in the EPR.

Discussions about DNACPR with patients and relatives were not easily accessible within the EPR. Patients that were DNACPR were identified clearly within the EPR but staff on the wards were unable to show us the notes of the discussion with the patient/families and who had completed the DNACPR. The SPCT team were able to access the DNACPR forms and show us they had been completed fully.

Medicines
Anticipatory medicines had been prescribed in three drug charts we reviewed. Anticipatory medicines were prescribed for patients, including those discharged to their own home or a hospice. The SPCT were involved when these medicines were prescribed, as indicated by three nurses we spoke with. Three of the SPCT Clinical Nurse Specialists were prescribers.
We requested information about anticipatory prescribing audits, including the most recent audit, however the trust were in the middle of an audit which would not be completed in time for this report.

Medicine administration records were completed accurately in the patient records we reviewed.

Where syringe drivers were being used, we found them to be locked as per guidelines.

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 the wards we visited, a compliant CD register was in place. We found no discrepancies between the stock, controlled drugs in the cupboard, and the CD register.

We viewed four prescription charts. Whilst it was clear that staff knew their patients well and were responsive to their needs in terms of pain assessment and management, this was not always documented well. We also found an example of prescribing that had not yet taken account of a person’s declining body weight since admission.

**Incidents**

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Between September 2016 and August 2017, the trust reported no incidents classified as never events within end of life care.

*(Source: NHS Improvement - STEIS (01/09/2016 - 31/08/2017))*

Each member of staff we spoke with told us they were encouraged to report incidents, near misses and any incidents that had caused actual harm via the trust electronic incident reporting system. They confirmed they received feedback from incidents that were reported in other areas of the hospital.

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident (SI) Framework 2015, the trust reported no serious incidents (SIs) in end of life care which met the reporting criteria set by NHS England between September 2016 and August 2017.

*(Source: NHS Improvement - STEIS (01/09/2016 - 31/08/2017))*

There were no incidents reported which specifically related to the care of patients at the end of their life.

There were examples of learning from incidents being applied and evaluated. We saw evidence that SIs had been investigated using root cause analysis and a report of the investigation shared with staff.

Each member of staff that we spoke with told us they were encouraged to report incidents, near misses and any incidents that had caused actual harm via the trust electronic incident reporting system. The SPCT had a close working relationship with the wards they served and we were confident that they would be aware of any incident which may have affected an EOLC patient.
**Safety thermometer**

Safety thermometers were displayed on the wards we wished. They contained information regarding Meticillin resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C.diff) rates, hand hygiene audit results and safe staffing levels.

---

**Is the service effective?**

**Evidence-based care and treatment**

All staff in the SPCT undertook within their role, the responsibility for training and the development of staff.

The hospital had not used the Liverpool Care Pathway (LCP) since its withdrawal. They had developed an individualised care plan for the last days of life to replace the LCP.

Palliative care and end of life guidance developed included treatment protocols for pain, respiratory tract secretions, nausea and vomiting, terminal restlessness and agitation, and breathlessness.

We saw evidence in the policies and within our observations that the palliative care was managed in accordance with national guidelines, including National Institute of Health and Care Excellence (NICE) CG140 August 2016 Palliative care for adults “strong opioids for pain relief”, NICE QS13 November 2013 “End of life care for adults”, Five priorities for care of the dying person June 2014 and NICE NG31 December 2015 “care of the dying adult in the last days of life (includes anticipatory prescribing).

**Nutrition and hydration**

The trust told us they did not usually undertake a comprehensive MUST assessment of someone who was imminently dying or on the EOLC plan. In the EOLC plan separate questions were asked about hydration and nutrition and whether the patient/ carer/staff/ next of kin were concerned about each area, and if they were what could the trust do about it. This was documented and provided an individualised plan for each patient.

Patients’ nutrition and hydration had been audited by the SPCT as part of National Care of the Dying Audit 2016. The trust scored higher than the national average in both nutrition and hydration. For example documenting patient’s ability to drink in the last 24 hours and documentation of the patient’s assessment of ability to eat at the end of life.

The SPCT and ward staff worked closely with the speech and language team (SALT), to gain support for people who were experiencing difficulties swallowing. We saw patients receiving assistance to feed themselves and we saw patients that had thickening agents added to fluids to assist with swallowing.

Oral care was provided by the ward staff. We saw evidence of this happening during the inspection. The SPCT trained staff on how to provide oral care for patients.

All but one patient that we spoke with told us that the food was good and drinks were readily available throughout the day.
We saw the meals times were protected and patients who required assistance were identified by the red tray system. We saw staff assisting and encouraging patients to eat their meal.

**Pain relief**

Patients we saw appeared to be comfortable and pain free. We spoke with family members who confirmed their relatives were comfortable. We saw anticipatory medications were prescribed for most palliative care patients, in regard to National Institute for care and health excellence guidance (NICE QS13, CG140).

Staff told us there were adequate stocks of appropriate medicines for end of life care available including controlled drugs. We saw these were stored and managed appropriately in line with NICE guidelines (NICE NG31).

The SPCT liaised with medical and ward staff to ensure that pro ne nata (PRN) (as needed) medication was prescribed, to ensure any breakthrough pain could be managed whilst patients adjusted to their pain control.

We saw pain scores were assessed using a numerical scale and noted on patient records. Omitted doses were reviewed quarterly with learning and actions. We did not see evidence of pain audits being completed.

Syringe drivers were in use for patients at the end of their life. Staff on all wards we visited told us that they were readily available and they had been trained in using them by the SPCT team.

**Patient outcomes**

**End of life care Audit: Dying in Hospital**

The trust participated in the End of life care Audit: Dying in Hospital 2016 and performed better than the England aggregate for two of the three agreed metrics and similar to the England aggregate for the remaining measure.

(Source: Royal College of Physicians)

The area that the service scored lower than the England aggregate was in access to specialist palliative care services seven days per week. Whilst the service provided a seven day nursing service, the consultant cover was only for two and half days per week, with telephone cover outside of this time. A business case had been developed with regards to acquiring funding for the additional consultant cover; no information was available as to whether this business case had been approved or not.

**Competent staff**

**Appraisal rates**

Between April 2017 and July 2017, 42.9% of staff within end of life care at the trust had received an appraisal compared to a trust target of 95%. During 2016/17, 85.7% of staff received an appraisal.

A split by staff group can be seen in the graph below:
It should be noted that staff numbers are small and completion rates may be skewed as a result.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Nursing staff told us they had received training from the SPCT to use the end of life care pathway and found the care pathway easier to use as a result of the training.

In 2016 and 2017 nine nurses attended and completed the Quality End of Life Care for All course provided by a local hospice.

The SPCT were just completing the development of a specialised EoLC E-learning programme. This system will be available for use by all start within the one month of our inspection.

**Multidisciplinary working**

The multi-disciplinary team (MDT) worked well together to coordinate and plan the care for patients at the end of life. The MDT included physiotherapy and occupational therapy input, this meeting was held weekly and was well attended.

Staff had access to specialist physiotherapy and occupational therapy services at the hospital for end of life care patients.

Nurses, porters and mortuary staff had a good collaborative working relationship. We were told trained porters were always available to convey the body to the mortuary whenever they were needed to do so.

Each of the clinical nurse specialists on the SPCT had specific wards they were responsible for and caseload of patients; however the team held a briefing each morning to have formal discussions about each patient.

The clinical nurse specialists attended MDT meetings for specific conditions including lung cancers and breast cancer.
An out of hours telephone advice service was provided by an on call consultant from a local hospice.

There was effective multi-disciplinary (MDT) meetings on the wards caring for patients who were critically ill or receiving end of life care. The MDT included the consultant, junior doctors, nurses, occupational therapist and a social worker. MDT meetings covered the wishes and feelings of carers, necessary assessments for a safe discharge, discussions of the mental and emotional health of patients, and risks on the wards. We observed a MDT meeting and observed that all disciplines were treated equally and had their views heard.

The SPCT team sensitively and professionally promoted organ donation amongst the patients and families of EOLC patients. The team worked closely with the tissue donation teams to provide this service.

**Seven-day services**

The palliative care service operated a face to face visiting service seven days per week 365 days per year from 9am to 5pm. The service on Monday to Fridays consisted of palliative care clinical nurse specialists, palliative medicine consultants, social worker and an administrator. On weekends and public holidays, one clinical nurse specialist was on site from 9am to 5pm. Outside of these hours, an on call telephone advice services was provided by a local hospice.

The chaplaincy service was available every day of the year, 24 hours a day. The team had arrangements with local faith leaders to provide an on-call out-of-hours service. There was a large team of over 50 volunteers from many faiths who were available to attend and speak to and provide comfort for patients.

The SPCT team were available seven days a week from 8am to 5pm with cover out of hours by a consultant from the local hospice under a service level agreement. Staff told us that they did not have any problem contacting consultant cover out of hours.

**Health promotion**

There were leaflets on smoking cessation, alcohol consumption and healthy living on all the wards we visited.

The Macmillan cancer centre had many leaflets regarding the diagnoses and treatment of many types of cancer, they also provided support to cancer patients and their carers though yoga classes, reflexology and medication classes. The classes were available for carers prior to and for several months post the death of their family members.

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

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported did not report training for either the Mental Capacity Act (2005) or Deprivation of Liberty Safeguards (DoLS) training.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff told us they undertook Mental Capacity Act 2005 and DoLS training as part of their mandatory training. Staff we spoke with were able to describe accurately the process they would follow should someone be found to be unable to make a decision in relation to their care or give consent to agree to treatment. Staff on the wards told us they completed DoLS applications for
patients. All of the staff we spoke with understood the application process. However we asked for and the trust was unable to provide evidence that staff completed or documented mental capacity assessments before applying for a DoLS authorisation. Section 13.42 of the MHA Code of Practice states that when considering whether to apply for a DoLS authorisation, decision-makers should first assess the capacity of the person to consent to the arrangements for their care or treatment, in accordance with the MCA.

Staff did not demonstrate understanding of the Mental Capacity Act (2005). Staff accepted the diagnosis of dementia as a sign of lack of capacity. Staff were not proactive in ensuring patients had their capacity formally assessed and recorded.

Staff told us that they applied for a DoLS if the patient lacked capacity and was trying to leave the ward. On Wandle 2 ward, staff said that all of the patients lacked capacity, however only two of the 12 patients were on DoLS authorisations. Section 13.45 of the MHA Code of Practice states that a person’s compliance or lack of objection is not relevant in determining whether there is a deprivation of liberty.

The trust policy on DNACPR does not emphasis doing a capacity assessment before assuming a patient lacks capacity. However, section 13.21 MHA code of practice states that capacity should be reassessed as appropriate over time and in respect of specific treatment decisions. Section 13.22 states that where a capacity assessment is undertaken, this is recorded in the individuals’ care and treatment record. The capacity assessment should record the specific decision, for which capacity was assessed, the points that the individual needs to understand, the steps taken to promote the individual’s ability, and how the diagnostic test was assessed. Staff did not always fill out mental capacity assessments fully. We saw three mental capacity assessments. Staff filled out two of the mental capacity assessments prior to referring a patient to an Independent Mental Capacity Act Advocate. Staff filled out the third mental capacity assessment in relation to a patient’s will. Staff used a trust assessment template, but in two of the assessments, staff had not filled in the comments box to demonstrate the options that they had presented to the patient, the different ways they had tried to communicate with the patient, or the reason why the staff member came to the conclusion that the patient lacked capacity.

We saw evidence of consent being asked for and given by patients during ward rounds, we also saw evidence of consent in the EPRs we reviewed.

Is the service caring?

Compassionate care

Staff consistently treated patients with dignity and respect. Staff introduced themselves, sought permission to enter the bed space and drew curtains around bed bays when privacy was needed.

Staff were caring, compassionate and sensitive to patients needs. Staff asked permission to commence treatment and explained what they were going to do to the patient.
Patients who remained on the ward in their final stages of life were moved to side rooms where possible.

Patients were spoken to empathetically about their worries and fears.

Patients and families told us they were happy with the care they had received. They told us call bells were answered promptly and staff were kind.

Porter and mortuary staff said the bodies of deceased patients were handled with dignity and respect. The porters who collected the bodies from the wards performed their role with caring and concern for the deceased and their family members.

The mortuary staff provided a kind a caring service to the families and friends of the deceased. They were aware they were the often the last point of contact families and friends had with the trust and were sensitive to the grief they may have been experiencing. They tried to make the process as stress free as possible for families and friends by being as flexible as they could be with regards to viewing times and by developing and maintaining a strong working relationship with the local mosque so that families would be able to perform religious washing rituals.

The bereaved family members made an appointment at the bereavement office to collect the forms needed to register the death.

Staff gave examples of supporting carers; for example, sending a carer to the emergency department if they were very distressed or alerting police to do a welfare check if carers were very unwell at home.

**Emotional support**

The chaplaincy service provided spiritual and emotional support to patients and their family members during their stay in hospital and were available for bereaved family members.

The chaplaincy service and the bereavement and Macmillan offices provided information and contact details for local support groups and bereavement counselling services for family members to contact.

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

We found the SPCT had a good understanding of their patients. They spoke about them in a personable and caring way. Care was planned and delivered in a way which involved the patient and their family.

The patients we observed had a named nurse, which allowed patients and family members to know who was caring for them on that day.

Family members were able to stay overnight, if the patient was in a side room. Concessionary parking fees were offered to family members staying extended periods of time.

The bereavement officers supported bereaved families and friends after a patient’s death by explaining all the legal process and what to expect when someone had died. An information pack which included contact details for support and counselling groups was provided.

The chaplaincy service held a number memorial of services which family and friends could attend during the year in order to remember their relative or friend who had died at the hospital.
Symptoms were discussed and treatment options were explained to each patient, before a final decision was reached. Agreed changes were then made to patient records and these were shared with the wider team.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The mortuary staff operated an on call out of hours telephone service which ensured that they were responsive to urgent calls. The mortuary has space for 81 bodies, four of which were for obese bodies. There were plans in place to build additional storage space for another 18 bodies, two of which would be for obese bodies.

The hospital had a ‘Forget me not’ scheme. Staff supported carers to fill in a personal profile of patients with dementia, from the view of the patient themselves as if they had capacity.

The hospital had introduced the Enhanced Care Project training for staff who cared for patients with dementia. This training emphasised different ways of communication and trying different ways to reassure patients who might be frightened of the unfamiliar environment of the hospital. This training also included safeguarding and mental capacity act assessments.

There were no dedicated facilities for relatives however there were quiet rooms which relatives could use, there were recliner chairs for relatives who were staying overnight.

Information for families about end of life care was not readily available when visiting some of the wards; however leaflets were available from the chaplaincy service, the bereavement office and the Macmillan cancer support service.

The bereavement suite had recently been renovated to provide a tranquil private place for families and friends to come to terms with their bereavement. Funding for the renovations had been provided by an international humanitarian foundation and the friends of Croydon Hospital.

**Meeting people’s individual needs**

There were flexible visiting hours to allow family to visit their relatives at the time that was suitable to them. Where possible, patients were nursed in side rooms and family members were able to stay with the patient if they wished too. Reclining chairs were provided for relatives to sleep in. Parking fee concessions were also available and some refreshments would be provided for families staying with dying patients.

We saw patient care was individualised and we observed discussions around care and treatment decisions that demonstrated this during the onsite visits to the wards.

Staff told us translation and interpreting services were available for patients who didn’t speak English and for those who had other communication difficulties.

The hospital ensured the faith needs of its patients were met. The chaplaincy team provided spiritual support for different faiths.
The hospital had access to translation services via a telephone translation service.

The wards had been assessed as being dementia friendly wards, which meant they had been assessed by trained staff to ensure the environment was not distressing for people living with dementia needs. Walls and flooring were different colours and there were neutral coloured fabrics used.

Community services could provide equipment for patients who were returning home.

Staff could explain the procedure followed a death of a patient to us. We were shown the information that staff used.

The staff at the mortuary service demonstrated a very caring, compassionate attitude towards the care of the deceased and their family and friends. They understood the requirements of all faiths with regards to care of the deceased.

The chaplaincy service was available and very responsive to requests for support.

For those suffering from cancer the Macmillan service provided free therapies including yoga, reflexology and massage. They also provided art classes, financial support; carers support groups and meditation classes.

Menus were varied and provided choice for spiritual/religious and cultural preferences.

The SPCT and ward staff told us were possible patients were moved to their preferred place of care rapidly. In a preferred place of care audit conducted between September 2016 and end of February 2017 288 patients out of 358 achieved their preferred place of care.

**Access and flow**

Any member of staff on the wards could refer a patient to the SPCT.

We observed discussions about a patient’s progress, discharge plans and referral back to the community. Pre populated handover sheets were available for use at the MDT meetings to cover prognosis, progress, referrals and discharges.

Staff told us they worked closely with the discharge liaison nurse and SPCT, who attended the ward MDT meetings to enhance early discharge where possible.

Nursing staff we spoke with told us they knew how to access the specialist palliative care team and the team were responsive to the needs of patients to whom they had been referred to.

Staff we spoke with on the wards told us the specialist palliative care nurses would respond very quickly to concerns. The standard was that the referred patient would be seen within three working days, from April 2016 to March 2017, 93% of referred patients were seen within three working days.

We saw the SPCT visited patient’s at the end of life and provided specialist advice and support to ward staff, patients and relatives.

Rapid discharge protocols and processes were seen to be effective in getting patients to their preferred place of care prior to dying.

**Learning from complaints and concerns**

**Summary of complaints**
Between August 2016 and July 2017 there were no recorded complaints about end of life care.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

We visited the patient advice and liaison service (PALS) during our inspection and we were informed there had not been any complaints regarding end of life care in the last year.

Staff on the wards told us any concerns raised with them were discussed and rectified as soon as possible. Learning from complaints was disseminated to staff at team/ward meetings.

The bereavement office staff told us during their meetings with family members after the death of a patient, if any issue arose around the care of the patient, they contacted the ward to resolve the matter for the family.

---

**Is the service well-led?**

**Leadership**

The service had a non-executive lead for end of life care, as well as a part time specialist palliative care consultant, who was the clinical lead and led the service. The specialist palliative care nurses were managed by a newly recruited band 8 nurse. The medical director was the board level senior responsible officer for EOLC.

The SPCT consultant demonstrated effective leadership, knowledge and understood the current challenges to provide good quality palliative and end of life care services across the trust. The palliative care lead chaired the EoLC steering group meetings and told us they had attended board meetings and had presented to the members of the board in early 2017.

All the ward staff we spoke with knew who the lead was for the SPCT.

There were clear lines of accountability within the SPCT. The team worked in a well-organised way and were all well-led. They knew what was expected of their role and respected the roles of the manager.

**Vision and strategy**

The vision for Croydon Health Services NHS Trust was to provide excellent integrated care for you and your family, when and where you need it.

Staff at all levels of the service understood how their work assisted the trust to fulfil its vision. Staff we spoke with believed the vision reflected the priorities of end of life care. They agreed they wanted to provide patients with excellent care in the place where the patient most wanted at the time they needed it.

The manager was passionate about the service their team provided. They were proud of the achievements that had been made and there was a clear wish to continue to improve the service for the benefit of patients.

The trust’s palliative care operations policy was fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership.
We did not feel the board were committed to increasing the consultant numbers to be in line with national guidelines. A business case had been presented to the board in January 2017 and there has been no development beyond this point. This was an area of concern that we raised during the previous inspection in 2015.

**Culture**

Staff within the SPCT were motivated and positive about their work and felt supported and valued by their peers within the team and by the palliative care lead. Staff felt they could be open and honest and raised any issues they had and were generally motivated and positive about their work.

Daily discussions about patients’ needs and staff skill mix ensured patients received the best possible response and staff were supported to provide it.

Some of the SPCT felt the non-executive director with responsibility for EOLC was not working with the board effectively to secure the additional consultant posts needed to meet national guidelines.

Relationships between the SPCT and the local hospice enabled staff to share ideas, best practice. The shadowing opportunities for hospital and hospice staff will provide increased understanding of end of life care in both settings.

All staff we spoke with told us they felt the SPCT was a supportive team. Staff interacted in a supportive way within the team to ensure safety and efficiency for patient care.

**Governance**

The SPCT were based within the Integrated Surgery, Cancer and Clinical Support division. The service had a clear management structure at both divisional and departmental level. The managers knew about the quality issues, priorities and challenges.

Clinical Governance meetings were held monthly and were attended by the palliative care lead. During each meeting, there was a review of clinical incidents, complaints, risks, clinical audit, effectiveness and mortality. Actions and those responsible for them were identified; however no expected timelines were included.

We saw minutes from the palliative and end of life care steering group and saw discussions had taken place around syringe driver pumps, EOLC complaints, e-learning, annual report, preferred place of care audit and chaplain’s annual report.

We saw clear clinical oversight and involvement with patients throughout their care. Systems were in place which ensured the manager understood the workforce and their workload. Clinical supervisions took place in addition to regular one to one meetings and staff meetings.

Staff were clear about their role within the trust and how the team integrated within wards and other providers. Staff had individual roles in the provision of end of life care services.

The Do Not Resuscitate policy did not specify the importance of professionals carrying out and documenting a mental capacity act assessment on patients who are assumed to lack capacity. It states in section 9.2 “in some circumstances it may be necessary to undertake a formal assessment of capacity where such lack of capacity may not be clear cut”. This is in contradiction
to the MCA (2005) which states that lack of capacity should not be assumed and states that a mental capacity assessment should be carried out in regards to specific treatment.

The trust did not ensure that staff implemented its policy on DoLS. The policy states that DoLS applies to patients who lack capacity and who are not free to leave, whether or not they are asking to leave or showing by their actions that they want to leave. However, we saw that patients who staff said lacked capacity, but who were not trying to leave, did not have a DoLS authorisation in place. The DoLS policy states that first of all, staff must ensure that a mental capacity test is carried out to establish if the person can make their own decisions in relation to care and treatment. However, we did not see mental capacity assessments recorded in patients’ notes before staff applied for a DoLS authorisation. The policy is unclear regarding the extensions of urgent DoLS authorisations. The DoLS Code of Practice states that it is the local authority which can extend the urgent DoLS authorisation. In the hospital policy, it states that an extension can be granted at ‘trust level’. However, in practice, all the extensions made at ward level and signed by the senior nurse. We saw nine extensions, and they were all signed at ward level.

The safeguarding lead, who has overall responsibility for monitoring the DoLS, said they rely on the local authority to tell the hospital how many DoLS authorisations were granted during the past year, for patients within the hospital. The tracking of DoLS authorisations was missing a great deal of data; it suggested that patients without capacity were regularly on wards for periods of time without a DoLS authorisation in place. In the last quarter, of 32 patients for whom DoLS were authorised, 24 patients spent periods of time in hospital after the DoLS had lapsed and a standard authorisation had not been signed in time, if at all. We saw staff preventing one patient from leaving the ward. Staff told us that this patient was under a DoLS authorisation. The urgent DoLS authorisation for this patient had expired at the beginning of September 2017 and there was no other DoLS authorisation in place. This meant that staff may have been unlawfully depriving this patient of their rights. We raised this with the trust at the time of the inspection.

Management of risk, issues and performance

Staff and SPCT lead were clear about the challenges the service faced. They could explain the risks to the service and the plans to deal with them.

Data provided showed the end of life risk register had one risk on it, which related to the shortage of palliative care consultants was not in line with national guidance. There was a description of the risk, action to be taken, risk score, a named responsible person for dealing with the risk, however there was no review date and this risk was entered on to the log on 1 December 2015. The board papers for July 2017 show that a business case for more consultants was submitted and the service had extended to a nurse led seven day service. There were no risks relating to end of life care on the integrated surgery, cancer and clinical support divisional risk register.

Senior leaders were aware of priorities for EOLC in the trust, including staff training, individualised care planning and meeting patients’ preferred place of care and death.

Information management

The SPCT team participated in local audits as part of clear and robust service performance measures reported to the trust board. Audits included patient discharge, preferred place of care vs achieved place of care amongst others.
The trust used an electronic patient record system accessible to staff via electronic workstations on wheels and from fixed desktop computers on all wards and offices. Staff used the system effectively to monitor and improve the quality of care to patients. All staff we spoke with during the inspection said the system was beneficial to patients and staff.

**Engagement**

All the wards had a named member of the SPCT identified, who assisted with sharing information on EOLC and engaged the wider staff team in new developments.

The Macmillan support staff member carried out health promotion in relation to end of life in the local community by attending various health fairs and events and raising awareness sessions at the local further education college.

The chaplaincy service sent Christmas cards to families of people who died in the service during the year. They held regular memorial services which families were invited to attend.

Staff engagement was primarily through team meetings, email and intranet services. All staff we spoke with described the service as inclusive and supportive.

**Learning, continuous improvement and innovation**

The service had moved to seven day service since our last inspection. Nursing staff were available seven days per week from 9am to 5pm.
Facts and data about this service

Total number of appointments compared to the England average

The trust had 398,586 first and follow-up outpatient appointments between July 2016 and June 2017. The graph below represents how this compares to other trusts.

The outpatients department (OPD) at Croydon University Hospital (CUH) and Purley War Memorial Hospital (PWMH) are open 8.30am to 5pm, Monday to Friday.

Patients present to the departments by appointment. Clinics are mostly held in the general OPD at both CUH and PWMH. Many clinics are coordinated within the main OPD and others are managed by clinical specialties in other parts of the hospital.

We visited the OPD over two days during our announced inspection. We visited a variety of clinics including: gastroenterology, ear nose and throat (ENT), fracture, orthopaedic, endocrine, phlebotomy, elderly care, cardiology and rheumatology. We observed care and treatment being delivered. We looked at 12 sets of patient records. We spoke with over 25 members of staff, including nurses, doctors, allied health professionals, managers, and support staff. We spoke with 10 patients who were using the service at the time of our inspection. We also used information provided by the organisation.

The trust had 398,586 first and follow-up outpatient appointments between July 2016 and June 2017. The graph below represents how this compares to other trusts.
The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, between July 2016 and June 2017.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of Spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon University Hospital</td>
<td>523,118</td>
</tr>
<tr>
<td>Purley War Memorial Hospital</td>
<td>32,686</td>
</tr>
<tr>
<td>This Trust</td>
<td>555,804</td>
</tr>
<tr>
<td>England</td>
<td>104,275,113</td>
</tr>
</tbody>
</table>

Type of appointments
The chart below shows the percentage breakdown of the type of outpatient appointments between July 2016 and June 2017. The percentage of these appointments by type can be found in the chart below:

Number of appointments at Croydon Health Services NHS Trust between July 2016 - June 2017 by site and type of appointment.
Is the service safe?

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, and conflict resolution every three years. Nurses and healthcare assistants were also required to undertake yearly basic life support (BLS) training. The target for completion was 95%. Following the inspection the trust told us the target was 90%.

We viewed the mandatory training spreadsheet for OPD dated October 2017. We found all mandatory training courses had met the trust 90% target for staff completion. For example, the lowest completion rate was 91% for information governance, the highest completion rate excluding safeguarding was 97% for equality and diversity, fire safety and health, safety, and welfare. The overall average completion rate for all mandatory training was 97%. However, the mandatory training spreadsheet did not differentiate medical and nursing staff. We were therefore unable to comment on whether mandatory training figures for medical and dental staff had improved from the data the trust submitted in July 2017.

Staff told us they received email prompts to remind them when mandatory training was due.

Mandatory training completion rates

The trust set a target of 95% for completion of mandatory training. Following the inspection the trust told us the target was 90%.

A breakdown of compliance for mandatory courses as of July 2017 for medical/dental and nursing/midwifery staff in outpatients is shown below. The table only includes courses delivered specifically to medical and nursing staff: (Please note the diagram below relates to data returned by the trust in July 2017. The mandatory training compliance rate at the time of inspection had improved. Please see above).
None of the training modules met the trust target of 95% for medical and dental staff. Manual handling people and conflict resolution had the lowest completion rates at 62% each (both having 18 out of 29 eligible staff trained). It should be noted that this data is based on performance in July 2017. The mandatory training compliance rate at the time of inspection had improved.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Major incident training completion rates
The trust did not report on major incident training courses. However, staff were aware of the trust’s business continuity policy. Senior staff understood their roles and responsibilities in the event of an interruption to normal business. For example, in the event of flood or chemical spills.

Plans were in place for staff to respond to a major incident. Staff had worked with the site management team to assess current risks.

**Safeguarding**

Staff we spoke with working within outpatients in both sites had relevant knowledge of the safeguarding procedures and were able to access the trust’s policies and procedures in relation to safeguarding.

The main outpatients waiting areas displayed information on safeguarding children and had contact details for the local authority safeguarding team.

All staff were required to complete level 2 safeguarding training for children and adults every three years. Band 7 and above nursing staff and medical staff were required to complete level 3 children’s safeguarding training. The outpatients’ mandatory training spreadsheet for October 2017 showed there was 100% compliance with adults safeguarding and 95% compliance with children’s safeguarding training level 3 and 100% compliance with children’s level 2 safeguarding training at the time of our inspection.

Staff we spoke with could identify the different types of abuse and knew how to report safeguarding concerns to the trust’s safeguarding team.

**Safeguarding training completion rates**

The trust set a target of 95% for completion of safeguarding training. A breakdown of compliance for safeguarding courses as of July 2017 for medical/dental and nursing/midwifery staff in outpatients is shown below. The table only includes safeguarding courses at the appropriate level for medical and nursing staff, therefore level 1 and level 4 courses are not included in the tables. (Please note the diagram below relates to data returned by the trust in July 2017. The safeguarding training compliance rate at the time of inspection had improved. Please see above).
All safeguarding modules were at or near the trust target of 95% for nursing staff with the exception of safeguarding children level 3, which had the lowest compliance rate at 67% (two trained staff out of a required group of three). However, at the time of inspection the compliance rate had improved. The trust told us that all staff had completed level 1 safeguarding training.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Cleanliness, infection control and hygiene
Cleaning was outsourced to a private cleaning services provider. In both hospitals most of the clinical areas we visited appeared clean, and all the waiting areas and toilet facilities were clean.

Cleaning records were displayed in the main outpatients waiting area, we found some gaps, but most records were up to date. Staff told us the cleaning supervisor visited every afternoon and did a walk about of the department to ensure standards of cleaning were up to standard.

Cleaning schedules and records were available in the consulting and treatment rooms at both sites. Staff told us that cleaners were available throughout the day to clean if necessary.

Personal protective equipment (PPE), such as gloves and aprons, were available for staff in all areas where it was necessary. We saw staff using PPE appropriately.

Outpatients collected infection prevention and control (IPC) data in the form of hand hygiene audits and infection control audits. The matron was the lead for IPC. The hand hygiene audit for September 2017 demonstrated 100% compliance with trust hand hygiene standards.

Outpatients were compliant with the trust policy in their disposal of clinical and domestic waste. Staff had infection prevention training as part of their mandatory training. We viewed the staff training spreadsheet and saw 100% of staff had completed level 1 infection control training and 95% of staff had completed level 2.

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 OPD at CUH and PWMH had been checked regularly and serviced in line with published guidance.

Staff at PWMH said the trust had a security guard at night, but there was no security guard during the day and this left staff feeling vulnerable. Staff in PWMH told us there had been two episodes of unauthorised people entering the hospital. The trust had taken action and installed panic alarms in some clinical rooms. However, staff said they sometimes had to work in a room without a panic alarm. The matron told us a meeting was arranged for November 2017 with the trust’s head of security to review security arrangements at PWMH.

Assessing and responding to patient risk

There was a rapid access chest pain clinic. This provided early specialist cardiology assessment for patients with the onset of chest pain due to coronary heart disease, who were referred by their GP.

Patient referrals were immediately logged onto the patient’s electronic record, which identified patients who were at risk of deteriorating.

Pressure ulcers of grade three or above were referred for investigation to the trust’s patient safety team.
Staff used the national early warning score (NEWS). This is an observation chart that determines the degree of illness in a patient using six observations of patients’ vital signs, for example, blood pressure, pulse, respirations. Staff were aware of the escalation protocol for recognition and response to a patient whose condition was deteriorating.

Emergency equipment was available to respond in the event of an emergency and staff told us they were trained to use it.

All staff working in the OPD had completed basic life support (BLS) training.

Nursing and medical staff told us they had received training on Sepsis. Staff had been provided with ‘Think Sepsis’ cards. These outlined the symptoms of sepsis, what actions staff should take in the event of a patient displaying sepsis symptoms, for example, ‘blood cultures and then broad spectrum antibiotics within one hour,’ and who to escalate concerns to, for example, ‘specialist registrar or consultant within 30 minutes.’

If a patient became unwell in outpatients, the service had a clear protocol to follow. Staff would treat the patient within the department and call the medical emergency team. If a patient required hospital admission following review and treatment by the medical emergency team, transfer was arranged either to a ward or to the accident and emergency department depending on the nature of the patients’ illness.

All staff we spoke with were clear of the procedure to follow if a patient deteriorated while visiting outpatient clinics.

**Nurse staffing**

A matron had been appointed to post since our last inspection. Staffing establishment was based on the needs of specific clinics.

Nursing services in the OPD were provided by the outpatient nurses and clinical nurse specialists (CNS). For example, rheumatology and cancer care.

Staff told us there were sufficient nursing staff to ensure shifts were filled in line with their agreed staffing numbers. The matron told us outpatients were fully staffed to established levels with no vacancies.

We viewed nursing establishment figures provided by the trust. The spreadsheet recorded that the established whole time equivalent (WTE) staffing level for qualified nursing staff was 6.89; the actual staffing figure was 6.43.

The established whole time equivalent (WTE) for health care assistants (HCA) was 11.37. The actual number of HCA was 12.32 which were above the establishment.

A safe staffing dashboard was displayed in the OPD. This showed details of the required levels of staffing, and actual level on each day. Staffing levels were adequate, as was the required skill mix at the time of our visit. The matron demonstrated an online acuity tool which was used to assess the required staffing levels for each day. The matron explained that staffing was assessed daily, dependent upon the nursing requirements for each clinic. The department also received additional nursing input with a band 4 health care assistant (HCA) and band 5 qualified nurse working three days a week.
Clinical specialities such as rheumatology, and cancer care had nurses with specialist skills, who were assigned to those clinics. Nurses and healthcare assistants in outpatients could be asked to rotate between CUH and PWMH. However, staff we spoke with at PWMH told us they were rarely asked to rotate at CUH and were mostly based at PWMH.

The overall rate of nursing and HCA staff leaving outpatients in the previous twelve months had been stable at 0%.

Staff told us if a staff post had not been filled in 12 months the trust would review whether the post was required at a ‘vacancy panel’. However, staff we spoke with told us they were not aware of any posts that had been removed as a result of not having successfully recruited staff within 12 months.

Between August 2016 and July 2017, the trust reported a sickness rate of 1.4% in Outpatients. Between August 2016 and July 2017, the trust reported an average of nine shifts per month for bank staff and no agency staff usage.

The trust has reported their staffing numbers for outpatients as of March 2017. Please note that the trust did not provide a ward or department level breakdown for this information.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>20.59</td>
<td>20.94</td>
</tr>
</tbody>
</table>

**Medical staffing**

Staff told us there were a sufficient number of doctors to run all scheduled outpatient clinics. We looked at rotas and clinic schedules which confirmed this.

A rheumatology consultant told us the OPD had improved over the previous 12 months. This consultant said the department had struggled due to the retirement of a speciality doctor and band 7 nurse. This was on the risk register. However, the trust had responded with improved funding and a re-design of the staffing model. The department received 4.7 WTE consultants, with one of these being a recent appointment.

The trust reported their staffing numbers for outpatients below as of March 2017. Please note that the trust did not provide a ward or department level breakdown for this information.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>21.08</td>
<td>18.41</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

**Vacancy rates**

Between August 2016 and July 2017, the trust reported a vacancy rate of 18.1% in outpatients.  
(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

Between August 2016 and July 2017, the trust reported a turnover rate of 8.7% in outpatients.  
(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

Between August 2016 and July 2017, the trust reported a sickness rate of 0.1% in outpatients.  
(Source: Routine Provider Information Request (RPIR) P19 Sickness)
Bank and locum staff usage
None of the bank and locum usage provided by the trust was able to be mapped to outpatient services.
(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Records
The clinical records in the outpatients at both PWMH and CUH were paper based 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. However, from November 2017 some specialities were moving to a paper light records system.

Staff told us patients paper based records were available for clinics and it was rare for a patient to have a temporary record created due to the unavailability of records. Patient records were available for clinics 72 hours in advance to enable staff in identifying any missing patients’ records.

Staff in the administration 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.

There was a patient electronic management system which provided staff with access to letters, reports, imaging and test results. However, most patient records were paper based, including risk assessments. Staff told us a new paper light electronic record system was being rolled out in November 2017.

Doctors could dictate notes directly onto the patient electronic records system. However, some doctors reported shortages of dictation machines in outpatients.

We viewed nine patients care records. For example, patients discharge summaries and referral letters were in their care records, together with risk assessments that included a record of patients’ allergies, activities of daily living (ADL), whether they were at risk of venous thromboembolism (VTE), and whether they had an assessment of mental capacity.

The staff training system recorded that most staff mandatory training in information governance was up to date.

The trust’s website carried information on people’s rights to access their health records under the Freedom of Information Act 2000.

Medicines
Overall, we found medicines were stored securely in the main outpatients at CUH and PWMH. The pharmacy provided a weekly medicines top up service at CUH and PWMH. Overall, we found medicines in both CUH and PWMH were in date. However, we found some medicines and irrigation solutions were out of date in the dermatology clinic. Staff removed these immediately when we drew this to their attention.

Medicines requiring refrigeration were stored at the correct temperature at CUH and PWMH. However, on 31 October 2017, we found containers with an unidentified substance in the medicines fridge; these were labelled “keep frozen.” Staff removed these on 1 November 2017. The resuscitation trolley in the main outpatients was tamper proof. However, on the 31 October 2017 we found the oxygen cylinder attached to the resuscitation trolley to be out of date. We found this had been rectified immediately by staff and the out of date oxygen cylinder was replaced with an in-date cylinder on 1 November 2017.
We also found the resuscitation trolley in the dermatology clinic was tagged for tamper proofing, but one of the drawers was broken. Staff told us they had already reported this and were awaiting repairs or replacement.

Medicines waste was handled appropriately at PWMH and CUH.

Incidents

We viewed an incident spreadsheet provided by the trust. There had been 910 reported incidents in the period November 2016 to October 2017. The category of most incidents was appointments with 770 reported incidents. This was followed by staffing with 89 reported incidents.

The service had not reported any never events in the previous 12 months. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

There had been one serious incident reported for the outpatients through the Strategic Executive Information System (STEIS) from March to October 2017 for both CUH and PWMH. The incident related to the wrong diagnosis. The incident took place in dermatology where the patient gave consent for a lesion to be removed and the incorrect lesion was removed. The trust informed us the incident was discussed at an executive incident review and also with the clinical commissioning group (CCG) who supported the Trust’s serious incident investigation approach. It was agreed locally not to report the incident as a ‘never event’ on the following basis: The patient had given consent for the same lesion to be removed. The clinician removed the lesion of most concern, based on the clinical evaluation at the time of the patient presentation. The patient was subsequently recalled to review the lesion that was for removal, which was no longer present when reviewed. However, the incident would meet the criteria for a ‘never event’ for wrong site surgery, as defined by the NHS England, ‘Never Events List 2015/16.’

Serious incidents were reviewed by the trust’s serious incident review group. The group met weekly to review any serious incidents at the trust. There was also an annual review of serious incidents by the trust’s board.

Staff had access to an electronic incident reporting form, and staff in both CUH and PWMH knew and felt confident in using the system.

Incidents were escalated to the matron. If incidents related to ear, nose and throat (ENT) the matron would redirect these to the ENT service lead.

We saw in formal minutes that incident handling was discussed in the monthly clinical governance meetings held by the main outpatients’ staff who worked across the two hospitals.

We observed that in all cases reported through the system (incidents related to outpatients); there were clear records of actions taken in response. For example, an incident in March 2017 identified a shortage of specimen pots. Pots were sourced from other departments in CUH, and the materials management team ordering was addressed by staff in the OPD.

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. We viewed the duty of candour correspondence for an incident at the dermatology clinic. We saw that the trust had followed its procedures for duty of candour and had offered the patient a written apology.
Staff we spoke with in CUH and PWMH 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 applied to their work. However, the clinical governance lead for the ISCCS directorate told us the directorate sometimes struggled to meet duty of candour timescales, although the directorate were up to date at the time of inspection.

Is the service effective
Evidence-based care and treatment

Staff in outpatients demonstrated how they could access trust policies and guidelines on the trust intranet.

We viewed a range of policies on the trust’s intranet and found they were up to date. For example, the chaperone policy had been ratified by the risk assurance group on the 10 July 2017 and was due for review in July 2020.

The trust had developed a clinical audit plan for 2017 to 2018 to ensure safe and effective care in line with the trust priorities stipulated in its 2016 to 2017 quality account. The plan consisted of national and local clinical audits. The national clinical audits benchmarked the quality of the trust’s services compared with other NHS trusts, and to highlight both best and substandard practices to drive continuous improvement across services. The national audit list was published by Healthcare Quality Improvement Partnership (HQIP).

Pain relief

Staff were able access appropriate pain relief for patients within outpatients’ clinics. Patients’ pain was assessed and monitored. Staff in outpatients could give patients paracetamol if they experienced pain, but if patients needed other analgesia these would be prescribed by a medical practitioner.

There were pain clinics at both Croydon University Hospital (CUH) and Purley War Memorial Hospital (PWMH) for patients experiencing pain. Patients’ pain was assessed and planned at the clinic. Patients’ pain was monitored and reviewed, and changes made in response to patient need or pain relief not having the desired effect for the patient.

Records confirmed that patients’ pain needs were assessed before undertaking any tests in the majority of cases.

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 OPD were involved in a range of national audits. For example, the National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA). We requested but did not receive audit outcomes or action plans from the trust. However, the trust informed us they had, “developed their clinical audit plan for 2017/18 to help ensure that care was safe and effective in line with the trust’s priorities. The plan consisted of national and local clinical audits. The national clinical audits help the trust to benchmark the quality of services provided against other NHS trusts, and to highlight best practices and drive continuous improvement across the service. The national audit list was published by Healthcare Quality Improvement Partnership (HQIP).”
The OPD used a dashboard to benchmark services. The dashboard was monitored by the governance lead for outpatients and circulated monthly to department managers. The dashboard provided information on referral to treatment time, ‘did not attend’ rates and follow up to new rates. (RTT and DNA rates are commented on in the Responsive section of this report).

**Follow-up to new rate**
Between July 2016 and June 2017, the follow-up to new rate for CUH was higher than the England average; the follow-up to new rate for PWM was lower than the England average.

**Follow-up to new rate, Croydon Health Services NHS Trust**

(SOURCE: Hospital Episode Statistics)

**Competent staff**

Nursing staff were supported with revalidation ensuring they maintained their continuing professional development and required hours of practice. However, staff in outpatients told us there was no clinical supervision in place for nursing staff. There were supervision teams where a band 5 nurse had a non-clinical supervision meeting weekly with their team of healthcare assistants (HCA). 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.

There was an induction programme for new members of staff and staff told us they felt well prepared for their role.

Staff told us that they had training opportunities to develop professionally.

In main outpatients at CUH there was a daily team huddle where all administrative staff and supervisors met with the nurses and healthcare assistants before clinics commenced. The purpose of this meeting was to share information to facilitate the running of the clinic. Staff told us the daily huddles were helpful to know any issues that may present for clinics so that they could minimise the impact on patients.

Administrative staff and staff working with records, appointments and data collection for services told us they received team meetings and felt equipped to do their roles. However, staff felt there had been insufficient liaison with staff in regards to the introduction of a new model of working.
We spoke with three junior doctors who told us they worked to their job plans and were well supported by the trust’s consultants. They also said the consultants were approachable and responsive to any requests for advice.

**Appraisal rates**

Between April 2017 and July 2017, 78.3% of staff within outpatients at the trust had received an appraisal compared to a trust target of 95%. While only one staff group met the trust’s target, most had improved compared to the previous financial year. A split by staff group can be seen in the graph below:

![Appraisal Completion Chart](image)

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

**Multidisciplinary working**

Staff in cardiology had a weekly MDT with visiting cardiac surgeons from another London NHS trust.

Staff in outpatients told us they worked well with staff in diagnostic imaging. Some outpatient staff had specialist interest and attended speciality meetings, for example, accident and emergency.

There were regular multidisciplinary team (MDT) meetings in outpatients.

Therapists including OT and physiotherapists were part of the OPD MDT. The cardiology clinic provided patients with MDT assessments involving nursing and physiotherapy assessment, cardiac risk factors identification and modification, education, support, counselling and prescribed exercise, as well as medical evaluation.

Patient information was shared with GP’s following hospital attendance to ensure continuity of care.

Meetings were held twice a month with the local clinical commissioning group (CCG) to monitor patient pathways, there were also weekly reports to National Health Service Improvement (NHSI) to look at breaches in performance.
Seven-day services

At CUH and PWMH most of the outpatient clinics ran from Monday to Friday between 8am 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.

There were extended evening clinics at CUH on Wednesdays in the main OPD.

There were no weekend clinics in OPD at either CUH or PWMH. Staff said the OPD had reviewed offering weekend clinics, but there was a lack of demand from patients for weekend clinics. However, weekend clinics could be offered on an ad hoc basis where there was demand and nursing staff were available.

Health promotion

Staff we spoke with told us there was a lot of focus in the OPD on how services could meet the needs of patients with a learning disability or patients with dementia. For example, staff at both CUH and PWMH said letters could be provided in ‘easy read’ formats or large print.

The CUH main reception had a falls prevention poster, this advised patients who were frail to ask for assistance from staff.

There range of printed information available to patients and their families and carers, including a range of information leaflets and literature for patients to read about a variety of conditions and support services. For example, patient information on: venous thromboembolism (VTE), information on smoking cessation, and information on mental health and wellbeing, and substance misuse.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff across both sites were clear about their responsibilities in accordance with the Mental Capacity Act 2005.

Staff told us outpatients worked on a principle of implied consent; this meant that patients arrived for appointments of their own free will and as a result the relationship with the hospital was consensual. However, staff told us it was the trust policy that patients should always be asked for verbal or should be asked to give a signal of their consent at every clinical appointment. Staff told us patients with a learning disability or cognitive impairment would be supported by their family or carers. Patients who required support could also access independent advocacy services. Staff told us they could access independent mental capacity advocates (IMCA) by referral. IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person.

Patients told us that they were asked for consent to procedures prior to receiving any care or treatment.

Staff showed us a range of consent forms and told us what actions they would take in the event of a patient being unable to consent to an investigation or treatment, for example, they would undertake an assessment of the patients’ capacity and assess whether the investigation or
treatment was in the patient’s best interests. Staff also told us they would involve the patient’s family or others close to the patient in any decisions about care or treatment.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust did not report on Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training.

**Is the service caring?**

**Compassionate care**

Staff were seen to be caring and compassionate. We observed communication between staff and patients and their relatives and saw that staff were caring and respectful.

Patients in the OPD spoke positively about the staff that supported them with their care and treatment and considered them knowledgeable and professional. We did not receive any negative comments from patients, their relatives or carers about staff attitudes or behaviour towards them in the OPD. We saw good patient interactions in the phlebotomy clinic. Staff members took time to patiently explain and reassure patients. We saw patients being greeted by a volunteer in the outpatients’ main reception, and the volunteer explaining the procedure for booking in. We saw reception staff signposting patients to the waiting area for their clinic.

We spoke with 10 patients during our inspection. Patients and relatives were positive about their experience of care. We heard that staff were kind and caring and that communication with patients and relatives was clear, open and empathetic.

Overall patients’ privacy and dignity was respected. For example, we saw curtains being drawn in the phlebotomy clinic to protect patients’ privacy when blood was being taken.

The trust used the friends and family test (FFT). The FFT is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. We viewed the FFT results for the OPD between July to September 2017. This recorded 94% of respondents would recommend outpatient services to their friends or family.

**Emotional support**

We saw that counselling and complimentary therapies were available from the trust’s cancer help centre were advertised in outpatients, together with details of how patients could contact the centre.

CUH had a multi-faith chaplaincy that could provide listening and emotional support if requested to all patients.

The hospital had a chapel which provided a multi-faith prayer room that was open 24 hours a day. Staff told us people of all faiths could use the room and all were welcome to the regular services.

The hospital's psychological service provided psychological and psychiatric consultation, assessment and therapeutic intervention to patients and their families and carers where required.

**Understanding and involvement of patients and those close to them**
Overall, patients and relatives told us they were involved in decisions about their care and treatment. A patient told us, "They do explain things to you."

We saw nursing staff seeking consent before carrying out tasks. We also saw staff providing directions to patients in corridors when they were looking for a clinic.

Managers and staff told us actions were being taken to address patients missing appointments, including sending texts to patients’ mobile phones, where patients were in agreement, to remind them of appointments.

We saw reception staff in the main outpatients at CUH being friendly and informative when booking patients in and explaining what would happen next.

There was a range of printed information available to patients and their families and carers, including a range of information leaflets and literature for patients to read about a variety of conditions and support services. For example, leaflets on the trust’s messaging service for outpatients appointments.

Most patients we spoke with told us they were informed about their care including any investigations.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

During this inspection we visited main outpatient areas and the cardiology department in CUH. The main outpatients was on the ground floor of the hospital in the Woodcroft Wing. The outpatients’ main waiting area had been the subject of an upgrade and environmental improvements in 2015. There were two waiting areas in the department. Clinical and treatment rooms were adjacent to the main waiting areas. We also visited the main outpatients at PWM hospital.

During our previous inspection we noted the distance from the orthopaedic clinic to the fracture clinic and the size of the plaster room were unsuitable for their use. Work was in progress for the orthopaedic clinic and fracture clinic to be relocated to the site of the current emergency department. The relocation was part of the trust’s transformation agenda. The relocation would take place once the emergency department had moved into its new building. This had been scheduled for 2017. However, due to delays with the new build emergency department the relocation would take place in 2018.

The fracture clinic waiting room had been remodelled. Two clinical rooms had been converted into a patient waiting area, with a reception desk at the entrance.

Staff told us they would try to keep children in a bay in the corner of the plaster room where the plaster room machinery was less visible. However, there were no posters or décor in the bay that would have made the bay child friendly.

In our previous inspection we found that within the cardiology department the rooms were small making access for wheelchairs and resuscitation trolleys difficult. However, during this inspection we found a new dedicated cardiology department had been opened. Staff described the new cardiology department as, "state of the art" and “the jewel in the crown.” The cardiology department was comprised of clinic rooms, investigation rooms, and a cardiac laboratory. Staff told us the department could offer the full spectrum of cardiology, including rapid access clinics to
diagnose patients presenting with the most common conditions and symptoms, for example, chest pain and arrhythmia, (this is a disturbance of a normal heart rhythm).

All the staff we spoke with told us there had been continuous improvement in the planning and delivery of outpatient services. Staff told us there was a new director of transformation in post to implement the trust’s transformation agenda. For example, the new cardiology department and the remodelling of the outpatients patient waiting area.

Medical staff told us there had been significant investment in the previous three years with the appointment of extra consultants in several specialties including but not limited to rheumatology, diabetes, cardiology and neurology. Staff told us further appointments were not planned due to limitations on the clinic space available for new or extra clinics.

Plans were in place for appointment letters to patients being outsourced to a private provider. Staff told us this meant patients would have a choice of receiving their appointment letters by email or through the post. Staff told us the text reminder service for patient appointments was also being tendered to another provider and the trust was looking at the possibility of text reminders being linked to patient letters electronically. However, this was a work in progress.

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 finished at 7pm on two days a week.

The utilisation rate of clinical rooms in outpatients was 95%. In response the OPD had introduced ‘virtual clinics’, these involved telephone consultations with patients who did not require a visit to the OPD. Virtual clinics replaced actual clinic time. Patients were booked into a virtual clinic and the clinician ensured that all the information required to make a clinical decision was available at the virtual appointment. This included requesting case notes from medical records, finding test results and information on shared care protocols with primary care on IT systems. The clinician attended the virtual clinic in the same way that they would attend an actual outpatient clinic. Typically, approximately 25 patients could be reviewed in a one-hour session. Staff we spoke with were positive about virtual clinics saying that it meant patients did not have to travel to the hospital to attend an appointment.

Did not attend rate
The trust had introduced a telephone text reminder service to prompt patients prior to attending their appointment. The texts would also ask patients to inform the service if they could not attend their appointment, so that the appointment slot could be allocated to another patient and avoid appointment slots not being utilised.

Between July 2016 and June 2017, the ‘did not attend’ (DNA) rate for Croydon University Hospital was similar to the England average the DNA rate for Purley War Memorial Hospital was similar to the England average. The chart below shows the ‘did not attend’ rate over time.

Proportion of patients who did not attend appointment, Croydon Health Services NHS Trust.
Meeting people's individual needs

The OPD had access to a range of support to meet patients' individual needs including: physiotherapy, speech and language therapists for voice, ear nose and throat (ENT) and respiratory disorders.

Staff said if they were aware of a vulnerable adult attending an appointment they would provide assistance. There was a learning disability notice in the OPD reception in easy read format explaining how people with a learning disability could access the local authority learning disability team. Reception staff told us they would be aware of anyone attending an appointment with a learning disability. Staff said they would be made aware that more time was needed to undertake the examination and would not interrupt.

Work was in progress on the trust's electronic system to flag patients with specific needs. This would improve staff awareness of patient's individual needs and enable staff to provide specific help and assistance.

Staff told us they would use an empty clinical room if a patient had an identified need and could not wait in the main reception area.

There was provision for bariatric patients in the form of a bariatric treatment table in the treatment room.

We did not see information in a range of languages available in either CUH or PWM hospitals. However, staff told us the trust's accessible communications team could provide printed information in a range of languages upon request. Patients with hearing loss had access to British sign language (BSL) support.

Interpreters offering both face to face and telephone interpreting could be pre-booked for patients who did not have English as a first language. Staff told us some members of staff also spoke other languages and could be approached to act as an interpreter. Staff we spoke with were aware that there was a list of staff members who were able to offer translation services for patients.
The main reception area at CUH outpatients and PWMH reception provided disabled toilet facilities. We saw these were clean and well maintained. Both of the reception areas provided baby changing facilities for parents and carers.

There was a water dispenser in the main reception area to ensure patients and visitors to the department had access to drinking water.

The main reception area at CUH had televisions that were subtitled. Patients told us this gave them something to focus on whilst waiting for their appointments.

**Access and flow**

The trust had introduced text messages to remind patients of their appointment times in March 2015. In rheumatology this had resulted in 95% clinic utilisation and a 5% ‘did not attend’ (DNA) rate.

A rheumatology consultant told us there was no pressure on the service to provide extra clinics, as there were no pressures on patient referral to treatment times (RTT).

There were some typing backlogs, this included clinic letters, patient and GP letters. The service manager told us the trust had employed bank administrators to assist with the backlog. The backlog was scheduled to be cleared by December 2017. The service were on schedule in terms of clearing the backlog of letters.

The main outpatients at CUH had introduced a ticket machine where patients took a ticket and sat down prior to being called to reception to be booked in. At reception their details would be checked, they would be informed of estimated waiting times for their clinics. The patient would then be called into clinic by the nurse running the clinic. At PWMH there was more than one receptionist who directed patients to the outpatients waiting area. There were no queues at PWM hospital.

The main OPD at CUH had a volunteer to direct patients upon arrival at the department. We saw the volunteer advising patients on taking tickets and to take a seat until they were called to reception.

Outpatients waiting areas at both CUH and PWMH had noticeboards to update patients on the current waiting times in the department. 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. However, we found recorded times were often less than the actual times patients were waiting and there were delays in the noticeboards being updated. Some patients told us this was a source of frustration as they were waiting longer than the time displayed. For example, in the main outpatients at CUH we monitored one patients waiting time, they had an appointment at 11.30 but were not called to clinic until 12.15. However, the noticeboard in the main outpatients waiting area recorded a 15 minute wait for their clinic. We noted that a member of staff changed the waiting time at 11.45 to inform patients that the wait in clinic was 30 minutes. However, this still did not reflect the times patients were actually waiting in clinics.

Three patients showed us appointment letters they had received. These demonstrated that patients received instructions with their appointment letters and were given written information as required.

We also monitored waiting times in the fracture clinic. We found at 10.20am on 31 October 2017 patients were waiting for 40 minutes in the fracture clinic, whilst on 1 November 2017 at the same
time 10.20am we found patient waits were 10 minutes. Managers told us it was difficult to assess staffing in the fracture clinic due to variances in the demand on the service.

We visited the phlebotomy clinic between 9.20am on 1 November 2017. We found 40 patients in the waiting area. Patients took a ticket and waited to be called for their blood test. However, there was no waiting time display. Staff and patients told us waiting times in phlebotomy varied from five to 40 minutes, depending on how busy the department was. We returned to the clinic at 11.00am and found the waiting room was empty and all patients from earlier in the day had received a blood test.

The service manager told us patients were prioritised for appointments on the basis of clinical needs.

Staff told us doctors’ turning up late for clinics was rare, and clinics usually started on time. OPD opening times were usually from 8.30am to 5.00pm Monday to Friday. Staff told us late clinics were offered on Wednesday evening and ad hoc clinics could be accommodated on Friday afternoons.

Staff informed us there had been two patients in the previous 12 months where the patients had been struck off waiting lists as DNA being incorrectly recorded. Staff said these had been investigated as incidents and one was due to a patient taking their clinical outcome sheet, this is the sheet that records a patient’s attendance at a clinic. As a result outpatients had introduced a procedure whereby all patients’ outcome sheets were checked on the system prior to the patient being discharged. If an outcome sheet was not present, the patient would be telephoned before they were recorded as not attending an appointment.

The OPD had tracking lists for patients waiting for appointments. Tracking lists were monitored by service managers and reviewed at weekly planning meetings.

We found a mixed picture in regards to referral to treatment times (RTT).

**Referral to treatment (percentage within 18 weeks) – non-admitted pathways**

Between September 2016 and August 2017 the trust’s referral to treatment time (RTT) for non-admitted pathways had been generally worse than the England overall performance. The figures for August 2017 showed 89.3% of this group of patients were treated within 18 weeks versus the England average of 89.6%. However, the trend was improving.

**Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Croydon Health Services NHS Trust.**

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty**

Eight specialties were above the England average for non-admitted RTT (percentage within 18 weeks).
### Referral to treatment (percentage within 18 weeks) – incomplete pathways

Between September 2016 and August 2017 the trust’s referral to treatment time (RTT) for incomplete pathways was consistently better than the England overall performance by around 2% and similar to the national standard of 92%.

### Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Croydon Health Services NHS Trust.

(Source: NHS England)
Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

All 13 specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic Surgery</td>
<td>100.0%</td>
<td>88.5%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>99.4%</td>
<td>94.5%</td>
</tr>
<tr>
<td>Neurology</td>
<td>98.8%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>98.7%</td>
<td>92.3%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>98.7%</td>
<td>96.4%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>98.5%</td>
<td>86.4%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>97.8%</td>
<td>91.7%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>97.7%</td>
<td>94.7%</td>
</tr>
<tr>
<td>Other</td>
<td>97.0%</td>
<td>91.4%</td>
</tr>
<tr>
<td>Urology</td>
<td>97.0%</td>
<td>88.6%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>96.6%</td>
<td>91.3%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>95.9%</td>
<td>92.3%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>95.4%</td>
<td>86.8%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust was performing consistently better than both the 93% operational standard and England average for people being seen within two weeks of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Croydon Health Services NHS Trust

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

The trust was performing generally better than both the 96% operational standard and England average for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The performance over time is shown in the graph below.

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), Croydon Health Services NHS Trust
Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust was performing consistently better than both the 85% operational standard and England average for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Croydon Health Services NHS Trust

(Source: NHS England – Cancer Waits)

Learning from complaints and concerns

Information on how to complain was available in waiting areas and on the outpatient information sheet, which was sent with every appointment together with information on the Patient Advice and Liaison Service (PALS).

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 complaints were mostly about clinical care (37%).

We viewed the complaints log for the previous 12 months. There had been a total of 58 complaints logged in outpatients in the period. The main categories for complaint were cancellations and patient dissatisfaction with treatment or outcomes, which each had nine complaints in the period.

We saw in governance meeting minutes provided that individual complaints were discussed and learnt from.

Staff told us they spoke with patients regularly to prevent any concerns that patients or families had from escalating. There was a formal complaints process for people to use with investigation, and response to the complainant. Complaints information, as well as patient experience information was fed into the trust governance processes and trust board with formal reporting.
mechanisms. Staff told us most complaints related to waiting in the waiting room and waiting times for appointments.

On the OPD at CUH and PWMH general information boards displayed the complaints procedure. Information regarding the Patient Advice and Liaison Service (PALS) and how to contact them was displayed in prominent areas in all the departments we visited. We also saw leaflets on PALS services in the main reception, patients could take these away to read at home. Staff had access to an easy read complaints policy for people who required information in this format.

Staff in the OPD told us they always tried to address complaints or concerns immediately to see if they could be addressed by the team. If it could not be resolved by the team, staff told us people would be given the contact details of the patient advice and liaison service (PALS).

Summary of complaints
Between August 2016 and July 2017 there were 178 complaints about outpatients. The trust took an average of 27 days to investigate and close complaints. The most common subjects for complaint were: cause for concern - clinical or midwifery care, 66 complaints (37.1%); access, admission, administration, appointments, discharge, and transfer, 55 complaints (30.9%); staffing / clinic related incidents, 14 complaints (7.9%)

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Is the service well-led?
Leadership

Outpatients were in the directorate of integrated cancer, surgery and clinical support services (ICCS). We viewed a flowchart for the directorate which demonstrated lines of accountability from the ward level matron to the trust’s board via the clinical director.

There were clinical business units which sat within the ISCCSs. Outpatients and ambulatory care was a business unit within the ISCCS directorate. The service manager for orthopaedics told us they straddled two business units, ISCCS and the cancer and performance directorate. A number of new service managers had taken up posts with the trust since our previous inspection. However, we found that some service managers were not fully aware of the transformation agenda proposals. For example, the orthopaedic service manager was not aware of proposals to relocate the fracture clinic and orthopaedic clinic.

A matron had been appointed since our previous inspection. The matron was responsible for overseeing the day to day running and management of the main OPD at both Purley War Memorial Hospital (PWMH) and Croydon University Hospital (CUH). This included organising the rota and supervising and assessing staff.

The OPD matron was covering three inpatient wards on an interim basis as well as the OPD. The matron said the arrangement was temporary and had been at short notice due to a band 7 nurse being on gardening leave. The matron told us they had a lot of support from the trust and the inpatient wards had “very competent band 7 nurses.” However, we noted that the matron was sometimes not available in outpatients and had to be called to the department in the event of any issues or visitors to the department asking to speak with them.
Staff at PWMH told us the matron visited weekly and was accessible via email and telephone. However, the outpatients’ deputy general manager told us they had not visited PWM as often as they would like due to competing priorities at CUH.

Staff at CUH told us that the chief executive officer (CEO) was visible and did walkabouts every Wednesday within the various departments. Staff in PWMH told us the CEO visited the hospital regularly and spoke with staff. Staff also received a weekly CEO newsletter with updates on trust strategy and the executive team.

**Vision and strategy**

All of the staff we spoke with were aware of the trust’s vision and values were related to this. The trust vision was, “Excellent integrated care for you and your family, when and where you need it.’ There was also a promise, ‘here for you’, which promised to ensure patients would feel valued and safe.

Outpatients had a monthly strategy board. We viewed the terms of reference (TOR) for the board. The purpose of the board was to give strategic focus and direction to improve the use of the areas used for outpatient activities, with the objective of using trust resources as efficiently as possible.

The trust also had a transformation agenda with a focus on utilisation of outpatients clinical rooms and facilities and a reduction in ‘did not attend’ (DNA) rates. In response the trust was targeting DNA with patients and GPs, improving communications with patients, improvements to the booking processes and access, working with point of delivery (PODs) model, changes to the delivery of care to the most appropriate health professional, and introduction of nurse led clinics where appropriate. Managers told us part of the strategic plan was the relocation of the fracture clinic and orthopaedics into the accident and emergency department footprint.

Staff in outpatients were positive about the introduction of the POD model. The POD model had a clear structure for each POD. This included a service manager, team leader, medical staff, patient pathway coordinator and patient pathway support. Administration of each POD was designed around the needs of the consultant group.

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.

**Culture**

Most staff in outpatients told us morale had improved with the appointment of a matron and the POD system. However, administrative staff told us the POD model had placed administrative staff under stress and this had a negative effect on the morale with this staff group.

Most staff told us they felt valued. Staff told us that the trust encouraged openness and honesty. The clinical governance lead told us staff had to be encouraged to report incidents and that some doctors would record incidents on the trust’s electronic record system rather than the electronic incident reporting system. However, this was being addressed by the directorate at governance meetings and the clinical director had raised this with medical staff.

The trust had introduced Schwartz Rounds, these were meetings which provided staff from all disciplines an opportunity to reflect on the emotional aspects of work. Staff told us they were encouraged to attend Schwartz Rounds.

**Governance**
The directorate had a dashboard to monitor key performance indicators (KPI). This was summarised and sent monthly to service leads. We viewed the dashboard for October 2017. We saw that the directorate was meeting most KPIs, with the exception of the cancellation rate, which across all outpatient services was above the trust’s target, with an average of 21%, and the ‘did not attend’ (DNA) rate which was above the trust’s target at 12%. The dashboard was red, amber, green (RAG) rated and did not provide the trust’s target rate, but, both the cancellation and DNA rate were rated as ‘red’ on the dashboard, to indicate that these targets were not being met in October 2017.

There were monthly clinical governance meetings and we viewed a range of minutes from these. The meetings reviewed complaints, incidents, learning from these, looking at the flow of clinics, staffing and performance.

The main outpatient nursing team met weekly with the matron to look at clinical issues or had a short training session, while the outpatient supervisors and administrative staff met with the outpatient’s deputy general manager.

The clinical director told us staffing was reviewed weekly at the staffing review meeting. The meeting was attended by the chief executive, medical director, director of HR, and clinical director. The matron told us all directorate managers and business unit managers attended the surgical board meeting. This meeting fed into the trust board meeting.

**Management of risk, issues and performance**

In February 2017 the trust introduced POD teams. The POD teams brought together the administrative support teams and clinical teams for specialist services. PODs were open from 8.30 to 17.30, Monday to Friday. The PODs had dedicated teams to track of patients care from start to finish, enabling the trust to improve the monitoring of patient waiting times.

Outpatients did not have a dedicated POD. Staff told us this was because outpatients covered a number of specialisms. Staff in outpatients said the POD system had improved communication as each specialism had dedicated teams OPD’ staff could approach with specific enquiries about patients. However, a few administrative staff told us they felt they had not been fully consulted prior to the service reconfiguration. Administrative staff said medical secretary roles had been replaced with a pathway coordinator role and there were differences in the tasks staff were expected to do. Some staff told us a result of the reconfiguration some medical secretaries had resigned.

Some staff told us the trust had introduced dictation machines for doctors to dictate directly onto patient records. However, some staff said there was a shortage of the dictation devices.

The directorate governance lead told us the directorate risk register sat with the chief pharmacist, who had oversight of the register. Individual risks on the risk register sat with the manager who would be most affected by the risk. The manager was responsible for updating and reviewing risks.

The governance lead told us the matron in outpatients would be responsible for any identified risks on the risk register relating to outpatients. We found there were two clinical risks on the risk register relating to outpatients. However, the matron did not have the correct permissions on the trust’s electronic system to access the risk register. The matron was also unaware of their responsibility in regards to adding risks to the risk register.
The matron said if they identified a risk the head of nursing would review the risk and make a decision as to whether the risk should be added to the risk register. This meant the outpatients’ matron could not review risks on the register and could not regularly monitor risks in the OPD.

The risk register contained two risks relating to outpatients. Both risks were categorised as ‘access, admission, administration, appointments, discharge, transfer’ risks. One risk was that of patients with long waits potentially being hidden in queues for appointments. In mitigation the service were sending reports to the outpatients group and chief operating officer (COO) on a monthly basis to monitor patients waiting in queues. Another risk related to a backlog of patient letters. The deputy general manager told us action had been taken to address the risk with the recruitment of extra bank staff to clear the backlog. However, we found that the risk register had not been updated to reflect this.

Risks on the risk register were overseen by the governance lead. The governance lead collated a monthly quality performance report. This was forwarded to service leads.

**Information management**

The OPD were in transition to a paperless system. Staff told us this was being phased in. Staff told us some outpatients specialities were going live with a paper light system in November 2017. This meant patients records would be accessible to all staff irrespective of whether they were working at CUH or PWMH.

The service had introduced electronic referrals. Staff told us from March 2018 all GP referrals would be via a shared electronic referral system. From November 2017 all paper based or faxed GP referrals would be scanned onto the trust’s electronic referrals system. This meant staff would be able to access patients’ referrals on the system.

The OPD were using a spreadsheet to manually book rooms and monitor room bookings. Staff told us the OPD were looking at electronic room booking systems. Staff said the department had not yet received the board’s agreement to fund an electronic room booking system.

**Engagement**

The OPD had a ‘Listening into Action’ (LiA) champion. This was a member of staff who collected patient’s views on services through LiA events such as workshops. We saw patients being given feedback cards at their clinic appointments. The department had been remodelled and had a decorative facelift as a result of LiA.

There was a ‘you said – we did’ board in the main outpatients waiting room. The matron told us this was used to inform patients of actions the service had taken in response to patient feedback. For example, one comment recorded, in response to patients raising waiting in clinics as an issue, “ensure we have enough staff on reception to reduce waiting times. We also liaise with consultants and registrars to see if patients can be seen sooner.”

Outpatients used the friends and family test (FFT), this gathers information on whether patients or their families or carers would recommend the service to their friends or family. The department’s FFT results from July 2017 to September 2017 demonstrated that on average 94% of patients responded that they would recommend the service to their friends or family.

Staff had access to a confidential ‘whistleblowing’ helpline. This was a helpline where employees could raise concerns about the trust or its employees. We saw information leaflets in the staff room informing staff how they could contact the helpline.
We viewed the trustwide staff survey results for 2017. There was an action plan in place to address the survey findings; this included the cardiology department moving to new premises, which had been completed.

Administrators told us they felt they had not been fully consulted about the introduction of the POD system.

The trust has a number of user groups in outpatient services. For example, cardiac rehab had a self-run patients group, sickle cell and anaemia support group, and work was in progress on the introduction of and equality, diversity and inclusion forum.

Learning, continuous improvement and innovation

The transformation programme for the OPD was still in progress. As an aspect of this the trust had introduced in February 2017 ‘point of delivery’ (POD) teams. The POD teams brought together the administrative support teams and clinical teams for specialist services. The PODs had dedicated teams to track of patients care from start to finish, enabling the trust to improve the monitoring of patient waiting times.

Work was in progress for the orthopaedic clinic and fracture clinic to be relocated to the site of the current emergency department. The relocation was part of the trust’s transformation agenda. The relocation would take place once the emergency department had moved into its new building. This was scheduled for 2017. However, due to delays with the new build emergency department the relocation would take place in 2018.

CUH had a new dedicated cardiology department. The cardiology department was comprised of clinic rooms, investigation rooms, and a cardiac laboratory. Staff told us the department could offer the full spectrum of cardiology, including rapid access clinics to diagnose patients presenting with the most common conditions and symptoms.