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Health & Wellbeing Board Supplementary Agenda

13. **CUH Update on improvement plan following CQC rating**
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This report provides an update on improvement actions taken by Croydon health services following the last two CQC inspections.

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LONDON BOROUGH OF CROYDON

REPORT:	Health & Wellbeing Board	
DATE OF DECISION	18 October 2023	
REPORT TITLE:	Croydon Health Services' update on improvement actions resulting from inspection by the Care Quality Commission (CQC)	
CORPORATE DIRECTOR / DIRECTOR:	Matthew Kershaw, Chief Executive Croydon health Services	
LEAD OFFICER:	Matthew Kershaw, Chief Executive Croydon health Services	
LEAD MEMBER:	Not applicable	
KEY DECISION? [Insert Ref. Number if a Key Decision] ***Guidance**: A Key Decision reference number will be allocated upon submission of a forward plan entry to Democratic Services.*	**[No]**	Not applicable
CONTAINS EXEMPT INFORMATION? ***(* See guidance)***	**[NO]**	**Not applicable**
WARDS AFFECTED:	**Croydon Health Service**	

1 SUMMARY OF REPORT

1.1 This report provides an update on improvement actions taken by Croydon health services following the last two CQC inspections. The report focuses on the inspection of the Urgent and Emergency Service in 2020 & the inspection of Maternity Services in 2022.

2 RECOMMENDATIONS

Not Applicable

2 REASONS FOR RECOMMENDATIONS

Not applicable

3 BACKGROUND AND DETAILS

3.1 Introduction

The last comprehensive CQC inspection of Croydon Health Services (CHS) took place in October 2019 and the report was published in February 2020. This inspection rated the trust as requires improvement in all CQC domains. In response to this rating, the trust developed an action plan to address areas for improvement. This action plan has since been merged to "business as usual".

In October 2020, the CQC returned and undertook an unannounced focused inspection of the Urgent and Emergency service. This inspection did not rate the service or the trust. The trust's CQC rating remained the same.

In December 2022, the CQC inspected CHS' Maternity services. This inspection was a short notice announced inspection; it was undertaken as part of the CQC's National Maternity Inspection Programme. Following this Inspection, CQC rated CHS' Maternity Services as "GOOD".

This report provides an update on improvement plans following the last two CQC inspections.

3.2 CQC inspection of the Urgent and Emergency Service

3.2.1 During the 2020 inspection, the CQC reported limited assurance about the safety of care provided to patients with mental health problems, on the urgent & emergency care pathway because;

- Record keeping were not compliant with trust policy
- There was limited documentary evidence of consistency in the effectiveness of the care, treatment and support that mental health patients received.
- Leadership & governance was not robust enough in relation to care for mental health patients & the risk to mental health patients increased with length of stay in the Emergency Department

3.2.2 As a result, the CQC issued a condition on the trust's registration. The trust was asked to:

- Commission an external review of the quality and safety of the care of mental health patients at the trust with immediate effect.

- Provide a report setting out the actions taken to ensure the emergency department mental health improvement plan is implemented and is effective.

3.3 Improvement actions

CHS commissioned an external review of the mental health service provision in the Emergency department. The external review made 27 recommendation.

The action plan to address the recommendations have since been completed. **A detailed action plan is presented at appendix A.**

3.3.1 Following completion of improvement actions, the trust applied for removal of the mentioned conditions and this application was accepted by the CQC and conditions were removed in July 2023

3.4 Maternity CQC Inspection

3.4.1 The CQC inspected Maternity Services in December 2022. The service was rated as “GOOD”. The CQC noted that the following

- The service had enough staff to care for women and keep them safe.
- Staff had training in key skills, worked well together for the benefit of women, understood how to protect women from abuse, and managed safety well.
- The service controlled infection risk well. Staff assessed risks to women, acted on them and kept good care records.
- The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills.
- Staff understood the service’s vision and values and how to apply them in their work. Managers monitored the effectiveness of the service and made sure staff were competent.
- Staff felt respected, supported and valued.
- Staff were focused on the needs of women receiving care and were clear about their roles and accountabilities.
- The service engaged well with women and the community to plan and manage services. People could access the service when they needed it and did not have to wait too long for treatment. All staff were committed to continually improving services.
- The CQC noted the “outstanding” work relating to the HEARD campaign. This campaign was launched during the COVID pandemic to raise awareness and have difficult conversation around health equity and racial disparity within maternity for the black, Asian or any other minority ethnic group with the aim to improve outcome were exemplary.

3.5 Areas for improvement were as follows

Should Do Actions	Trust actions
The service did not always maintain and service equipment.	The service has standard operating procedures for management and maintenance of equipment. Staff

	reminded at the daily staff briefing. Ward Managers and Matrons carry out weekly spot checks.
They did not manage medicines well.	Staff reminded at the daily staff briefing. Medicine management are discussed at staff appraisal.
Policies and guidelines were not always reviewed in line with their review date.	A clinical audit midwife is now in post - guidelines prioritised for review and update
Not all staff had received their annual appraisal to make sure they were competent for their roles.	Time for undertaking staff appraisal included in Band 7s allocated time and staff are booked in to appraisals with bank/ agency for backfill or time
Some final year student midwives experienced delays in completing the required number of deliveries needed to complete their midwifery training programme	A recruitment retention plan is in place including engagement with clinical areas to support student Midwife.

Conclusion

CQC preparedness is part of trust's business as usual. The Executive team remain engaged with the relevant CQC team, sharing pertinent information regularly and meeting with them on a quarterly basis. The next routine engagement meeting with the CQC is scheduled for the 19th October 2023. The CQC is taking a risk based approach to their inspections and are currently testing their new strategy. At the point of writing this report, the trust is not aware of any upcoming CQC inspections of the trust.

4 ALTERNATIVE OPTIONS CONSIDERED

Not applicable

5 CONSULTATION

Not applicable

7. CONTRIBUTION TO COUNCIL PRIORITIES

Not applicable

8. IMPLICATIONS

8.1 FINANCIAL IMPLICATIONS

Not applicable

8.2 LEGAL IMPLICATIONS

Not applicable

8.3 EQUALITIES IMPLICATIONS

Not applicable

OTHER IMPLICATIONS

Not applicable

9. APPENDICES

Appendix 1: The mental health action plan (Now closed)

Recommendation	Update
• The Trust should consider further integrating and co-locating the MHLT into the emergency department.	The Psych Liaison Team are based with the Hospital above the Emergency Department. There is a monthly formal meeting known as the ED & SLAM Mental Health Interface meeting, which provides a forum for the MDT to review and discuss data, incidents and pathway. There is a twice-daily planned Mental Health Surge / Escalation Call. This is embedded into business as usual regardless of pressure, acuity and volume. If the trust is experiencing significant pressures such as long waits for beds and complex patients additional call maybe put in. The Psych Liaison Team, ED, Trust Leadership, SLAM Bed Management and Southwest London Surge attend. Additional stakeholders will join depending on the situation.
• The Trust should implement an audit to assure that patients who have stayed for 8 hours or more have had a mental health review completed by MHLT and their allocated nurse	SLAM colleagues undertake a review of patients in the Emergency Department every 8 hours or sooner if clinically required. They undertake an audit to monitor compliance by their clinicians and this is presented on a monthly basis. Feedback is shared with the Psych Liaison Team at supervision. Timely escalation occurs when review is needed based on dynamic need of the patient.
• The Trust should develop a roll out plan to train ED nursing staff in the use of the mental health matrix	The Mental Health Matrix is a well-established assessment tool used at the Trust, monitoring occurs through monthly audits by the Lead Link Nurse for Mental Health. The document is also captured at the point of Induction for new Nurses and revisiting when Nursing Staff undertake Triage Training and supervision.

• The Trust should review the triage pathway and use of the Urgent Treatment Centre for those presenting with self-harm to ensure the Trust remains compliant with NICE guidance on managing self-harm.	All patients regardless of how they present are assessed in the same way, they are Streamed. Those with a Mental Health presentation including self-harm, will be Triaged based on MTS supported by the Mental Health Matrix to assess the risk and highlight supervision needs. A referral will happen with the Psych Liaison Team and promotion of parallel working will be encouraged. Those who come via Police, undergo the activation of the Code 10 process. This means a member of the Psych Liaison Team, Security the ED Nurse in Charge and the Doctor in Charge will attend an MDT handover, the patient then undergoes the above process. The concept is to identify an early exit strategy for the patient. This is mainly aimed at those on a Section 136, but have found benefit if doing this for all patients who arrive by Police as an MDT can promote safe detention of the patient. Any feedback will be given at an either directly to the police Bi-Monthly meeting formally to the Police and addressed live directly as the need arises.
• The Trust should review the support and training available for the RMNs including induction of agency staff on shifts	An induction package is in place and clear expectations are set with our agency/bank staff. Work has been done to look at how we can ensure a consistent workforce for patients who require enhance care, and look at how we can do this with substantive staff, a plan has been pulled together to develop workforce model.
• The Trust should review the role of joint management of people in distress between ED staff and the MHLT	Review of those who are distressed is undertaken dynamically, whilst the patient is in the Department. Needs are action in the live environment. This is no different to physical health patients. There are frameworks in place for learning from situations. This is managed through the patient safety incident processes and case-based discussions.
• The Trust should review the Band 5 Registered Mental Health Nurse roles to understand what makes the roles difficult to fill such as access to career progression, banding and the support structure	As an acute Trust, there is limited scope to provide the carer pathway for Nurses or other Health Care Professionals who wish to undertake a focused carer working in mental health. The trust has pulled together the plan for delivering enhanced care differently. The concept will be to utilise Band 3 (Senior HCA roles) and Nursing Associates along with the Band 5 RMN role to support this. Plans are in place introduce a Band 6 role to support this workforce and provide supervision which also links with the Trust wide Enhanced Care Team.

• The Trust should include recognising transition as a risk factor into the ED training plan	Processes for 8hr and 12 hour reviews are in place within ED & confirmed within SLAM's new Operational Policy.
The MHLT and Trust should undertake a review/listening event with ED staff to determine if they understand the care and risk information documented and their role in managing patients risks.	Listening events occur on every team day; this is led by the ED Matron and input from the Head of Nursing overseeing the Emergency Department.
• The Trust must review the environment with regard to ease of access to exits which enable absconding and consider improvements to the waiting area to create a more dignified environment for the treatment of people in distress.	Based on an estates review and available of space within the footprint of the Department, Mental Health Rooms have been moved further away from the main Sub-Wait area. These rooms will be suitable to support those who need enhanced care and are high-risk mental health patients. They will continue to be ligature free. Work is also being done to increase the number of ligature free toilets across the ED department. This work is ongoing. By moving the rooms to a slightly different location in an environment that is not as stimulating, it will help support behavioural aspects as well as maintaining the privacy & dignity of patients.
• The Trust should undertake an audit to ensure that all staff working in the Majors Department are aware of the glasses symbols, their meaning and what their role is toward a patient being cared for in this space.	The symbol is to highlight Cubicles where those needing enhanced care can be placed, if our dedicated Mental Health Cubicles are in use. They are in line of sight of staff and are closely located to the staff base. This is now part of the Induction checklist to ensure that all staff are aware of these rooms and what they can be used for.
• The Trust should review the rationale for patients who are 16 year or older using the adult space for their mental health crisis and the impact this may have on the young person's mental health crisis	This is a dynamic decision, and on a case-by-case basis. The factors that affect the decision is what is going on in the adult facilities, what is going on the paediatric facilitates, staffing models and the risk that associates with placing a 16-year-old in the clinical area that is appropriate for them.

• The Trust should consider a review to clarify the factors and causes of increased lengths of stay in the department, including external barriers, particularly for those patients who are not admitted.	There is a meeting twice a day with a line-by-line plan for each mental health patient in ED. The Associate Director of Operations responsible for the Emergency Department has a weekly huddle with the SWL ICB, SLAM and CAMHS Execs to discuss locks to process and any pressing issues. This is an informal meeting but a good escalation point. Executive-to-Executive conversations happen regularly when the length of stay is challenged. While access to MH beds remains challenged frequently, our MH partners continue to progress their own plans around capacity and demand. The trust has put in place on site Clinical Assessment Unit which is run and led by SLaM . The Unit can take 4 patients from ED as appropriate. A SOP is in place for this
• SLaM should consider maintaining operational responses to the Covid-19 pandemic which have improved the management of flow and bed requests post pandemic.	The operational responses to the COVID 19 pandemic were very specific to that situation however as a trust, SLaM has learned many lessons from this and the aspects that they are able to take forward have been included in their OPEL Framework and in a new Full Capacity Protocol that is currently in draft stage within the organisation.
• SLAM should continue to work with surrounding Counties to develop and implement a London Compact style bed management agreement	The actions around HTT pathway, the London compact with surrounding counties and the maintaining covid 19 actions have been confirmed as complete by SLAM with evidence of their escalation plans
• SLAM should review the referral pathways to Home Treatment Teams, including those for older age adults	Please see above
• SLAM should review the use of a trusted assessments and follow up by the Community Mental Health Teams	This action is complete & Trusted assessments are covered by the SLAM's Operations policy.

• The Trust should review the membership of the surge meetings to routinely include social care partners, if a number of delays to discharge are as a result of social care issues	Twice daily, there is an escalation call with SLAM, CHS and Surge around MH patients. There is a variety of stakeholders who attend Including representatives from Site Ops, ED Ops team, OOH by the On-Call meeting. When there are significant issues, a Senior Nurse from ED will join. Monitoring of MH patients occurs in ED and through our Site Meetings, these occur at 08:30, 12:00, 15:00, 17:00 22:00 and dynamically depending on what is going. When there is an escalation CHS can and will hold and MDT / Best Interest meeting.
• The Trust should clarify the purpose of the surge meetings through the review/development of Terms of Reference circulated to staff	All stakeholders are aware of the call, as this is part of Business-as-Usual practice. This call is chaired by the Surge Team. The objective of the forum is to do a line-by-line review as mentioned above to discuss all MH patients, their needs, their plan/exit strategy.
• The Trust and SLAM should jointly review escalation processes (including on-call management/directors) to ensure they are consistent and effective.	Joint escalation process are in place
• Update policy to reflect the current practice and share the process with staff groups	SLAM's operations policy was updated and this action is complete
• The Trust and SLAM should consider embedding the band 5 RMNs into the general team/MHLT	CUH has clinical and line management responsibility for the band 5s RMN & SLaM continue to support the development of the MH Team.
• The Trust should consider using the PLAN standards for training needs for ED as a guide on training packages	The Trust delivers Mental Health Training across 3 days. The structure delivered meets the PLAN standards and includes areas relating health behaviours, culture, ethnicity and inequalities in care. This training is delivered by Head of Nursing for Mental Health and colleagues from SLaM.

• The Trust should clarify the purpose of the monthly ED & MHLT governance meetings through the review/development of Terms of Reference circulated to staff	The Head of Nursing for Mental Health owns and chairs this forum and TOR are used to ensure meeting objectives/expectations.
• The Trust should ensure there is a process in place for the management of action plans to provide assurance as to the completeness and effectiveness of actions.	This is now in place and managed by the compliance team
• The Trust and SLAM should ensure there are processes and systems in place to ensure the sharing of incidents to increase organisational oversight	Incidents and processes are formally discussed at The ED & SLAM Mental Health Interface meeting. The Trust have an Incident Review Group where the Patient Safety Team monitor the Datix's that have been submitted, depending on the incident, risk and harm level are discussed at this group. The outcome could be formal process implement e.g. 72 Hour Report/Route Cause Analysis are completed. If directly affects both organisations we will review with SLAM Leadership. Bi-monthly we hold a multi-agency group, this involves the Police, Security, SLAM and ourselves, some of the topics discussed is 136 patients, pathways and incidents. As demonstrated in evidence you can see the Trust and Croydon Psych Liaison Team and ourselves have presented at Summer Schools on how we work and what we do.
• The Trust and SLAM should consider the use of regular reflective practice for ED staff to support them	All staff are supportive with supervision and reflection. The attached evidence demonstrates what is available for people. Staff are monitored every 6-8 weeks at the Nursing Leadership meeting, this is where all staff are discussed and action plan implemented. Dynamically staff are monitored by the ED Nurse in Charge who will put a management plan in place depending on the situation / need.

10. BACKGROUND DOCUMENTS

Not applicable

11. URGENCY

Not applicable