

Barts Health NHS Trust

# The Royal London Hospital




## Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

### Ratings

Overall rating for this hospital	Good	
Maternity (inpatient services)	Good	
End of life care	Good	

# Maternity (inpatient services)

Safe	Good	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Outstanding	
Overall	Good	

## Information about the service

The maternity service at the Royal London Hospital consists of a 31-bed delivery suite, two obstetric theatres, a level 2 obstetric high dependency unit, a 31-bed postnatal ward, antenatal services, and the Lotus Birth Centre (a co-located midwifery led unit). The service is also responsible for The Barkantine Birth Centre on the Isle of Dogs (a stand-alone midwifery-led birth centre) and a midwifery-led home birth team.

The service provides community midwifery services for Tower Hamlets, delivered at home, in local children's centres and GP surgeries. The site is supported by a 37-cot, level 3 Neonatal Intensive Care Unit (NICU) which also supports the regional neonatal surgical unit. Around 5,000 babies a year are delivered across all areas. The Royal London Hospital is the tertiary referral centre for foetal and maternal medicine services within Barts Health NHS Trust and beyond, providing specialist multidisciplinary clinics for women with medical conditions who are pregnant, including specialist haematology, rheumatology, cardiology, renal, diabetes and neurology clinics.

Supported by the interventional radiology service, The Royal London Hospital also provides care for women referred with high risk of massive haemorrhage: for example, placenta accreta. The service also offers services such as the My Body Back clinic for survivors of sexual assault, Birth Options and Birth Reflections clinics and a pre-term labour clinic.

On this inspection we spoke to seven patients and around 40 members of staff, individually or as part of a focus group.

The staff that we spoke to included specialist doctors, midwives, matrons, departmental managers, ward clerks, specialist support staff and healthcare consultants. We observed care and treatment within the wards and the clinics, and reviewed ten care records. We also reviewed departmental and trust wide policies and procedures, together with a comprehensive number of further documents relating to performance, risk and governance.

From April 2017 to March 2018 there were 14,943 deliveries at the trust.

A comparison from the number of deliveries at the trust and the national totals during this period is shown below.

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.

From 1 April 2017 to 31 March 2018, the Royal London Hospital recorded 906 midwife led deliveries and 4,445 obstetric led deliveries. This was an increase from the previous year when there were 671 midwife led deliveries and 4,001 obstetric led deliveries. In this same time frame there were recorded a total of 47 still births.

From 1 April 2017 to 31 March 2018, the Royal London Hospital recorded 44 medical abortions and 497 surgical abortions. The hospital did not offer social terminations as these were carried out at a community hospital.

The birth centre service was midwife led with consultant cover. The Lotus Birth Suite located in the main hospital maternity unit was for the admission of low risk women in established labour. The obstetric unit based within the hospital was for admission of high risk women in

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established labour; transfer of care in labour from midwifery led units; admissions for high risk antenatal complications and postnatal admissions where there were complications post-delivery.

## Summary of findings

We rated the maternity services as good overall, with outstanding for well led.

Staff informed us that cultural issues that had been endemic in previous reports were now no longer a negative issue, and that staff morale and attendance had improved in the year 2017-2018.

- The system to report and manage risk had improved since that previous inspection and there was now an embedded and comprehensive system in place. In addition, there was some excellent work surrounding mitigation of risk and improving safety through staff skills and drills training.
- There were no outstanding serious incidents that were not being reviewed and managed.
- There was now an embedded and secure electronic tagging system to prevent infant abduction, which had been installed in 2017. There was also a clear and comprehensive enforced security policy where all staff and visitors had to display badges or lanyards and could only access the unit through swipe card doors or through a buzzer.
- There were clear improvements in governance and the maternity department was now part of the overall hospital site meetings and communication systems.
- Leadership was visible and the trust board now had a maternity champion to improve board involvement with the department.
- The department had increased the compliance with mandatory training and was now exceeding trust minimum requirements. There had also been an extension of training packages and an increase in proactive training as part of the risk management process.
- The clinical leads were involved in promoting an improved culture of staff satisfaction and increased knowledge and training.
- The department now actively sought out patient and stakeholder feedback. Patient satisfaction had increased and there was an improving picture for many indicators regarding care and treatment.

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- There were innovative strategies to implement further excellence in treatment, including 36-week screening for growth restriction and a dedicated breech clinic.
- The parent education team provided a service for antenatal advice. A Birth Reflections clinic for post-natal women was run by a consultant midwife and consultant obstetrician for emotional support. This support was also provided in other local languages other than English to ensure a more inclusive service.
- The department was undertaking a wide range of research projects and audit to further improve quality of service.
- There was a comprehensive and thorough complaints process, with the option of complaint resolution for the patients and staff involved.

However;

- Some staff did state that, despite the improvements in security, there were no dedicated security guards for when there was a disruptive visitor or threatening behaviour.
- There were some record keeping concerns with paperwork not always secure and not all records completed – for example, modified early obstetric warning scores (MEOWS) and World Health Organisation (WHO) checklists.
- Outdated policies and draft policy/procedures were still available at the time of the inspection that were then reviewed and updated by the management team.
- Administrative staff cited some concerns regarding responsibility and career progression within the department and the trust.

## Are Maternity (inpatient services) safe?

Good



At our previous inspection in 2017 we had rated this service as requires improvement for safe. At this inspection we rated as good for safe because there had been significant improvements:

- In 2017, we had seen some improvements with the phasing in of swipe card access and increased receptionist cover, although there had still been issues with unauthorised access to the wards and delivery suites and receptionist cover had not been 24 hours. At this inspection there had been many more improvements in security for staff and visitors with the introduction of a robust electronic tagging system to prevent infant abduction, all doors to all areas now requiring swipe card access, and 24-hour receptionist cover. There was still some concern with some members of staff that there were no dedicated security guards for the maternity floors.
- At the inspection in 2017, there had been a backlog of reported incidents waiting for action to be completed. There was also some ambiguity regarding how these were to be completed as the processes were not clear. At this inspection, the incident reporting was now dealt with robustly with a clear process of shared learning from them and no backlog of incidents that did not have an action attached.
- The previous inspection in 2017 had highlighted that there was non-compliance when a bi-annual infection control policy had been undertaken. The issues had centred around the trust uniform policy and a lack of staff understanding regarding infection auditing. At this inspection all staff adhered to the uniform policy and the infection control process and audits showed that good processes were now in place, and that compliance was generally very good.
- Previously, in 2017, there had been concerns regarding mandatory training that was not being delivered in accordance with trust target levels. Mandatory training levels were now above trust minimum levels expected, and compliance was increasing and a continued focus for improvement.
- Previously we had found that records were not always securely stored, with some having been left unattended.

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At this inspection the records were all securely tracked and stored. Record keeping had improved since the previous inspection, although there were a few issues that should be addressed regarding loose papers and completed checklists.

- In 2017, the safeguarding adults training levels for staff did not reach the required standards and were below the trust target for completion. At this inspection there was now a dedicated safeguarding lead and safeguarding training completion had improved to be meeting the targets for the trust. There was also an increased improvement in management of vulnerable patients through the Gateway team.
- Staffing levels for midwives had improved in the last two years and were now established with a minimum use of agency staff. Previously, staffing levels had been on the risk register and had been highlighted as possible unsafe practice with a lack of skilled midwives and a higher incidence of sickness rates. Sickness rates had also now improved at this inspection.
- Previously, in 2017, the department had not met its target to ensure the provision of 98 hours per week of obstetric consultant cover on the labour ward. There was increased obstetrician consultant cover in 2018, with the department now meeting the 98 hour weekly target, and also increasing the cover provided by consultant anaesthetists from previously.
- At the previous inspection the delivery suite co-ordinator was not necessarily supernumerary to the staffing rota and did not therefore always have the capacity to ensure oversight. At this inspection the management of the delivery suite now accommodated the co-ordinators as dedicated roles and therefore there was a clear process of oversight.
- There was a new openness and transparency with staff and visitors to the risks and safety within the unit. There were specific noticeboards in all wards and delivery suites where these were clearly recorded for all to see. This openness had not always been observed at the previous inspection, as some information had only been displayed in staff only areas. The maternity performance data had been available on noticeboards at the previous inspection, but was now in a more accessible format for visitors to the ward to understand, with clear phraseology and pictorial guidance.
- There was a clear overall improvement in safety, driven by audits including the WHO safety checklist audit.

Safety, and incident recording levels, was also significantly improved by the outstanding work focusing on the skills and drills training for all potential scenarios in the unit and that were undertaken regularly.

## Mandatory training

At the previous inspection in 2017, the trust had in place a 90% trust target for completion of mandatory training. This had not been met in some areas, particularly with regard to infection control and basic life support. At this inspection there had been a significant improvement in completion rates. The trust had since set a target of 85% for completion of mandatory training and there was compliance in all but two of the 29 courses. For many courses the compliance was significantly above the trust target. Training was provided via e-learning and was also delivered in face to face sessions. Staff confirmed that their training days were now scheduled in advance and therefore were more accessible and hence, better attended. There had been a significant focus on enabling all staff to undertake mandatory training since the last inspection and all areas showed improvement from the previous inspection period.

A breakdown of compliance for mandatory courses as of the 4 June 2018 for nursing staff/ maternity staff in maternity services was provided. Training was comprehensive and included moving and handling, equality and diversity, dementia awareness, 4 Harms; VTE and pressure ulcer prevention and catheter acquired infections, emergency planning, conflict resolution, complaints and clinical infection control and prevention.

Midwifery staff exceeded the 85% completion target for 27 out of 29 mandatory training modules; the lowest scoring module was medical gas safety with 81% and highest were the moving and handling modules at 100%.

At the previous inspection it was found that the resuscitation policy had not been updated and referred to outdated guidelines. At this inspection this policy was in date and referred to current standards. All staff had received current guidance on resuscitation and there was an 88% compliance of training for the department.

As reported at the last inspection, there was mandatory multi-professional team training for Cardiocotography (CTG) assessment, bereavement training and annual rehearsals for obstetric emergency drills. Staff had all been given a copy of the Practical Obstetric Multi-Professional Training (PROMPT) manual. This was an aid to the

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continued multi-disciplinary training undertaken for all staff including consultants, staff grade doctors, doctors in training, and all grades of midwives in dealing with obstetric emergencies. The trust had recently changed the CTG training package for a perceived more user-friendly training package, and the trust now had compliance for midwives of 98% and for doctors it was 93%.

The lead midwifery team acknowledged that there were still two areas that they considered an 'amber' issue for training, where compliance was not yet attained. These were regarded as a priority going forwards by the leadership, and training dates were being scheduled. There was an internal focus on in-house training sessions for staff and some 'ad hoc' training clinics to be scheduled.

Staff could now access their training records electronically to see if they were up to date with their training and when updates were required.

There were annual fire drills on site and staff were demonstrably aware of the fire safety policy and training. Fire training and Basic Life Support were two areas that the departmental management were working on further improving compliance towards 100%.

The Royal London Hospital provided mandatory training data for medical staff in the maternity and gynaecology services. This showed that in all areas of mandatory training that there was an overall compliance level of 96% for general completion. The trust target for mandatory training completion was 85%. In particular there was 100% compliance in some training modules, including dementia training, early warning systems and emergency planning. When medical staff were asked regarding mandatory training they stated that they considered that they were up to date with their mandatory training and were all regularly involved in drills and skills training for obstetric emergencies.

## Safeguarding

The systems to keep vulnerable women and babies safe were good and took account of best practice and national guidance.

There was a comprehensive pathway in place on site for all staff to access regarding vulnerable patients. The pathway gave an example schedule but also clearly reiterated the need for it to not be prescriptive with consideration given for each individual case to assess the frequency of contact. All information logged in the patient notes covered issues

from physical and mental health through to social circumstances and any relevant history to indicate vulnerability. At a minimum on a full-term pregnancy the patient was seen ten times for monitoring (including a home visit) before a postnatal check schedule was put in place. All antenatal notes had to be attached to the postnatal notes to ensure continuity of care.

There was a dedicated vulnerable patient team (Gateway Team) in place that was well established in the maternity department. The team of nine whole time equivalent staff was headed by the dedicated safeguarding lead midwife. This team offered specialist midwifery support in the hospital and the community. This included young mothers, mothers at risk of domestic abuse, female genital mutilation (FGM), severe and enduring mental health illness, substance abuse, child protection concerns, women with learning difficulties and asylum seekers and refugees. This specialist team had support from specialist safeguarding lead midwives and a midwife specialising in substance misuse. There was a clear process of team leader and on call midwives to support. A member of the midwife team with responsibility for safeguarding was always either available on site or on call at weekends. The hospital followed multi agency guidelines on FGM and the issues surrounding it. The Gateway team currently provided antenatal and post-partum continuity, but there were also plans to extend into intrapartum care as well for those patients in both the high risk and low risk birth centres. There was an active pursuance of gaining funding for perinatal mental health midwife case loading for those with significant or critical mental health issues.

The appointment for a full time safeguarding lead midwife had taken place since the last inspection. The safeguarding lead midwife had overseen further improvements in the checking and monitoring of all safeguarding concerns, spending 60% of the role dedicated to the safeguarding role only, and 40% of the role as line management within the Gateway team. There was good line management support for this role and communication with all staff in the service. Safeguarding training involved mandatory updates delivered in house for perinatal health, domestic abuse, writing reports and social service correspondence for reports.

There were trust guidelines in place for safeguarding women and reducing harm to the mother, the unborn or new born baby and any other children if applicable.

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A breakdown of compliance for safeguarding courses as of the 4 June 2018 for midwifery staff in maternity services was provided. It showed that midwifery staff exceeded the 85% completion target for all five safeguarding training modules. This was a marked improvement from the previous inspection in 2017 when there were found to be only 55% of midwives on the postnatal ward having had training to Safeguarding Adults Level 2. At this inspection 88% of all staff were trained appropriately. All staff had been trained in Safeguarding Children level 1 and 98% trained in the level 2. In addition, 86% of all staff were now trained in Safeguarding Children level 3 which was above the trust target of 85%. At the previous inspection there had not been protected training time for staff to achieve the training targets, particularly in safeguarding. With the increase in staffing levels and a focus on training completion targets by management, staff now had time to fulfil their training without being taken away to perform other duties instead. At this inspection we were told that safeguarding for doctors based in maternity to Safeguarding Children level 3 was now around 92%. This was following a large push for safeguarding training completion. The hospital provided further data for obstetrics and gynaecology medical staff combined that showed that there was an 89% completion for all medical staff for Safeguarding Children level 3, and a 98% completion for all medical staff for Safeguarding Adults level 2.

Staff were clear to the safeguarding process in place and would use the signposted contact numbers to progress a concern. All staff knew that the safeguarding guidelines were on the intranet and were confident in the process. Staff had been trained appropriately and were able to articulate the safeguarding process to inspectors. Capacity issues were discussed with staff who were confident regarding steps to take if there was a doubt to a patient's capacity to consent to care. The safeguarding team were empowering individual midwives to address issues and make referrals for vulnerable women as part of the ongoing culture of positive changes within the department. This was following on from improved safeguarding training compliance and better staff communications within the unit.

There was a continuing initiative that was being followed through since the previous inspection to comprehensively follow up all women who may have booked late in pregnancy or missed appointments. Midwives felt that they were well supported in this initiative.

Attention was paid to the local community needs about safeguarding and there were adaptations and skilled people in place to ensure that language and cultural diversity was not a barrier to effective safeguarding procedure. An example of this was an increasing number of advocates being used by the unit to converse with the large local Bengali population.

The patient journey through the department was comprehensively managed with easily accessible guidance on the intranet and the various staff noticeboards. There were clear signposted processes that gave directions on when to contact other agencies or to escalate a concern.

There was a clear and accessible pathway for staff to follow with regard to safeguarding when a patient presented in labour and had not been booked into the labour unit.

Going forwards there were initiatives to improve and roll out case loading between staff. This would mean an emphasis on continuity of care and a more personal relationship between midwives and mothers, and would therefore have a positive impact on safeguarding management. Midwives were involved in the child protection meetings and had support from site based social workers. There was a dedicated safeguarding folder on each ward for staff to access.

## **Cleanliness, infection control and hygiene**

All the clinical areas were visibly clean and clutter free. Domestic staff in the maternity areas followed cleaning schedules on required cleaning standards, practices and frequency of cleaning.

Arrangements were in place for safe disposal of waste and clinical specimens. Waste management was compliant with national guidance, and staff could demonstrate good practice regarding sharps boxes and clinical waste management. Staff adhered to the 'bare below the elbows' national guidance. All signs were laminated which were displayed on the walls and were visibly clean. The 'I am Clean' stickers were in place on equipment and correctly dated to indicate that they were ready to be used again.

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The Patient Led Assessment of the Care Environment (PLACE) survey showed that the Royal London site scored 99.8% for cleanliness, which was better than the acute hospital average of 98.5%.

A band 8 matron was the lead for infection control within the maternity department. The role necessitated attending an infection and prevention control meeting once a month alongside all the other departments at the Royal London Hospital. These formal meetings promoted communication and encouraged feedback and shared learning for best practice. The infection control leads would benchmark against each other to ensure they were up to date with all processes and audits including hand hygiene, swabs and medical devices. Maternity had only recently been invited to these as a matter of routine. We attended one of these formal meetings where there were five maternity attendees in attendance from each ward. Maternity performance was good compared to the other departments in the hospital, with the infection risk as 'green' generally overall, compared to other areas that had more amber risk flags. These risks were assessed on compliance to the infection prevention control policy. These were also in relation to the audits undertaken - for example, the hand hygiene compliance. The hand hygiene audits from July 2018 to December 2018 showed 95-100% compliance for each week for staff observations.

We saw shared learning of the effectiveness of all visitors to the hospital being challenged to stop and use hand sanitiser or wash their hands. There was also feedback from the 'Perfect Ward' audit programme where infection control was seen to be good at that time.

There was a confirmation that all staff inductions to the unit now included infection control processes training and updates.

From this meeting we ascertained that there had been no reported cases of the infectious disease C-difficile. There had been 2 cases of E-Coli from July to December 2018, and two cases of MSSA in this same time frame. These had been appropriately barrier nursed in side rooms and thorough decontamination had taken place after the patient had left the room. All cases had been monitored and followed up through the community. MRSA screening was undertaken during pre-assessment for a caesarean section operation, at re-admission stage and at the induction stage. Screening also took place following an emergency caesarean section operation. Pre-existing MRSA

was flagged up on the electronic record. (MRSA is a type of bacteria that is resistant to several widely used antibiotics. MRSA full name is meticillin-resistant Staphylococcus aureus). Results for the MRSA screening were usually available within 24 hours and the midwife and the infection control team could pick them up quickly and act with immediacy. If there was a positive result the women were quickly moved to a separate room until they were then moved to the postnatal ward. At the time of the inspection there had been four cases of MRSA in the previous year. The systems in place were comprehensive and thoroughly documented by staff.

Spot checks were conducted regularly and audits undertaken. These were co-ordinated with the staff that formed the infection control maternity team. Weekly spot checks were undertaken by the designated infection control nurse who moved around to each area on a weekly basis. These checks covered medical device checks, catheters, intravenous equipment and processes, observations of the general areas, hand hygiene and general cleaning schedules and processes. The Saving Lives audit that determined infection control around clinical practices for cannula and catheter insertion showed that the hospital performed well in the period July to December 2018, with a nearly 100% compliance rate recorded throughout.

After each check there was feedback to the matron for action or escalation. There were two recent examples of where audit had contributed to better practice. In the first example the audit of medical device handling and storage had resulted in the discovery that the insertion date was not being completed when women came from theatre to the recovery ward. This had led to it being marked by staff on the transfer form to ensure it was a safer process and demonstrably in line with better infection control practices. The second recent example was when high level dust was discovered by chance on a spot check - this had led to high level cleaning becoming a mandatory part of the cleaning audit.

Twice yearly there was a thorough documented audit of all infection control aspects of the department. There was a clear process embedded where all equipment was thoroughly checked for cleanliness and hygienic practice. This included all birthing pools, beds, clinical spaces, potential dust traps and sharps bins. Issues were highlighted immediately to the ward managers and



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recorded for future discussion and action. One recent issue was when it discovered that a cord blood machine was not always being cleaned to the required standard. This was discussed at the next staff huddle and an email sent to all staff regarding the best practice of maintaining proper cleaning processes. The information on cleaning this piece of equipment was also added to the departmental safety briefing and on the closed group midwife social media chat group.

Personal protective equipment such as aprons and gloves, and hand washing facilities were freely available for staff to use and we observed staff using them and disposing of single use equipment appropriately.

There were hand hygiene spot checks for each area for every week. The co-ordination of these was the duty of the matron lead for infection control. These generally consisted of ten observations where immediate feedback was then given. We witnessed excellent hand hygiene with staff regularly washing hands in line with the correct procedures. There was also a plentiful supply of hand gel that patients and staff and visitors were all encouraged to use before entering any wards. We saw ward clerks and midwifery and medical staff challenging people to use the hand gel upon entering any new area, and all visitors were generally refused entry to the ward until they had performed this task.

Sepsis training and continued monitoring was included for staff and there was a clear awareness and understanding of this potential fatal condition. The trust policy was clear on antibiotic treatment to manage obstetric infection. There was information on sepsis management and escalation.

After a room was used for a delivery it was routinely deep cleaned by a contractor and then checked and signed as clean by midwifery staff to state clean. Clinical equipment was checked and signed to be clean and staff took responsibility for this. We saw routine cleaning by domestic staff throughout the inspection, and this took place through the day and the night. Staff were also observed to clean spills appropriately and to ensure all surfaces remained clean and clutter free.

In total there were two infection control leads in each maternity area. The lead matron estimated that the

infection control part of the role took around 20 per cent of her workload and that there was an argument for the role to be a part time role to improve the safety and effectiveness further.

In an internal study commissioned in June 2018, called 100 Voices, 101 antenatal and postnatal patients were asked if they thought that the department was clean. 99% answered that they thought the department was clean.

## Environment and equipment

The maternity unit was over two floors in one of the newest parts of the building. There was only one public lift core that would access the two floors so that all visitors to the unit had to pass through the same way into the unit. All staff had to display identification at all times and use swipe cards to access the wards and the staff lifts. We witnessed all staff displaying the proper identification. We also witnessed visitors or new staff being challenged by staff to produce clear identification and explain the reason that they were in the ward. At the high dependency unit area, the inspectors themselves were challenged by several staff who wanted to ensure that we were allowed to be in the area.

On the sixth floor was the main labour ward and midwifery offices, along with the high dependency unit. On the eighth floor were the ante and postnatal wards, together with the midwife led Lotus Suite. The layout was generally very spacious and well laid out, with the high dependency unit being the only part where there was a more closed in environment and where space was less obviously available. All the corridors were wide and enabled spare equipment to be stored without compromising the accessibility of the corridors should the need arise. Generally, there were excellent facilities for all equipment and stock, and staff and patients appreciated the spacious communal spaces. The labour rooms offered good sound proofing and the overall atmosphere appeared quiet and ordered.

At the previous inspection there had been issues with the security of babies on the wards, despite some improvements having been implemented since the inspection prior to that one. An electronic baby tagging system had been due to be introduced in early 2017, but this had been deferred due to financial constraints. On our inspection this time there was a clear system in place for baby identification and there was now a comprehensive system of electronic tagging of each baby.

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Each baby had two labels on at all times with the relevant and correct personal data. Changes had been made to the type of label that were being used that were easier to administer. There was an explanation sheet that all mothers had to sign to enable consent and understanding, visible posters reminding parents of the importance of the labels and daily audits to check compliance.

The electronic tagging system was now embedded after activation in October 2017 and there were clear processes in place for the continuous monitoring of each tag. The ward clerks oversaw the security system and the tags were monitored 24 hours every day. There was a daily audit of compliance at ward level and random spot checks of compliance by the divisional team. Most mothers agreed to give consent for their babies to be tagged whilst they were in the unit and there had been no reported cases since the introduction of the system of baby security being compromised. The only issues had been with staff trying to move babies between wards without first notifying the staff monitoring the tagging system. All patients had the baby tagging system explained to them so that they were completely aware of the system and could give their informed consent. When asked, mothers were reassured by the system and were glad that it was in place. There were unannounced drills to ensure staff would react as they were trained to in case of a baby being taken without permission, or even a possible infant abduction. Staff had signed their commitment to the compliance of the infant abduction policy currently in place. A new updated infant abduction policy was awaiting ratification at the time of the inspection. There were around four drills per year where a baby abduction scenario was run for staff to stay vigilant and up to date with procedure.

At the previous inspection a risk had been raised that there was not a 24-hour reception staffing in place and no security guard on duty for part or all of the day and night. The two main reception areas to both floor 6 and floor 8 were now constantly manned by the ward clerks, 24 hours a day. The ward clerks checked the security of all persons entering and leaving the department, although there was still no security guard on either of the maternity floors routinely at any part of the day or night. Some staff, particularly the ward clerks, felt that this was a potential risk factor as if there was an issue or a confrontation with a visitor then a security guard had to come from a separate part of the hospital, which could take time. Three members of staff that we spoke to stated that they had dealt with an

agitated or potentially aggressive relative in the last year and felt uncomfortable that there was no security guard posted on the ward entrance. One midwife was concerned that they occasionally had to deal with aggressive partners who were staying the night on the wards, that did not want to adhere to the strictly enforced policy which stated that no one can leave the ward after 11pm (in order to prevent disruption). One example of threatening behaviour was given which had resulted in security being called from another department and a midwife helping a ward clerk to calm the situation. At the previous inspection it was seen that security guards had been patrolling the wards daily. However, we did not see any regular security guard presence at this inspection and there were no plans by management to instate security guards permanently. This was despite two ward clerks stating that they had flagged this as a continuing risk for the last year.

Since the previous inspection, there had been ten doors around the maternity department that had been identified as needing to be made more secure. These doors were now exit only or required swipe card access. Door security was checked daily on both floors and any issues logged immediately. A 'Stop and Challenge' culture had been encouraged within all staff groups and we witnessed staff challenging anyone who was not displaying identification or a relatives' lanyard pass. Partners of women on the wards were given a temporary lanyard pass for ease of access, but every person, regardless of whether they had a swipe card had to pass by a ward clerk to enter the ward. All persons were asked to stop and use the hygiene hand gel when on their way to the ward, and this gave the clerks a chance to check the identity of the person. Ward clerks worked twelve hour shifts to ensure that there was a 24-hour cover on the ward and acknowledged that they worked as a form of security, despite this not being part of their job description.

At the previous inspection there had been concerns regarding the number of unchecked visitors that could visit and the difficulties staff with monitoring them entering and leaving the facility. Local visiting rules were now strictly applied by all staff including the 24/7 reception cover and lanyards given as visible identification to approved visitors. This was witnessed as being enforced and there were signs to support this policy. Additionally, patients were informed

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of this policy before they were admitted to the hospital. However, some patients found the rules harsh and were upset that more family members could not attend, having previously been allowed.

Generally, the wards were clean and tidy and uncluttered. All facilities were in working order and the layout was spacious, easily cleanable and with accessible facilities. The ambient temperature was pleasant and there were temperature checks in place in some areas that ensured that these were kept within acceptable limits.

There were dedicated side rooms throughout the wards which had ensuite facilities. All were spacious. In the Lotus Suite there were facilities for water births in the four rooms and each room had the ability to be adapted to a different layout if required. There was good manual handling equipment in evidence, such as hoists and slings for helping mothers to be moved safely if required. There was ample space to move around and there were separate seating areas. Each room had large windows with a view. As in the birth unit, each room had a date and named midwife written on the board outside.

The one area that did not have the maximum availability of space was the high dependency unit where the bays were slightly overcrowded when all the beds were occupied. However, moving this area into a more spacious location, had been identified by the women's health leadership team and a business case was in development. These changes had been agreed as a key business planning priority for 2019/20.

There was appropriate emergency equipment on the delivery suite which was kept securely in designated areas of the wards. This included resuscitation equipment, equipment for specific emergencies such as sepsis or anaphylaxis, postpartum haemorrhage, and glucose for low blood sugars.

The emergency equipment was checked daily and signed as checked. These checks were seen to be consistently undertaken. There was a draft policy on one trolley regarding resuscitation flow chart. When this was flagged to the head of nursing it was replaced instantly with the correct final trust policy. All policies throughout the unit were then checked to ensure there were no further draft or out of date policies/ procedures in the wards. All emergency guidelines were laminated and accessible in the high dependency unit.

There were clear evacuation plans and floor layout charts throughout the unit.

## **Assessing and responding to patient risk**

There was a clear communication of risk within the department. Each ward had a Tree of Learning display that clearly showed the risk register at the present time and other risk assessment information or concerns from any relevant audits, the online incident reporting system or patient feedback. There were also weekly meetings for each ward lead and medical lead to discuss the risk register and any perceived or recently reported incidents entries.

In the previous inspection, it had been noted that there was no obvious shared learning at morning handovers. At this inspection there was a clear shared learning process in place at morning huddles, and a dedicated shared learning meeting each week for all staff. However, it was noticed that at the huddles the patients were talked about by bed number and not by name which could lead to issues if patients were moved.

At the time of the inspection the risks that were communicated via the public noticeboard were the current limit on the capacity of the high dependency unit (HDU) and lack of a dedicated maternity pharmacist. There was evidence that both these risks were being assessed and progressed with the management. A business case for an increase in capacity for HDU and also one for a dedicated pharmacist had both been sent to the senior management.

For the month of November 2018, incident reporting for the maternity unit showed one serious event and three complaints.

Learning had taken place following a recent serious incident (a Never Event) where a tampon had been retained. A board was now in place where two members of staff had to sign in and sign out all swabs and tampons when been placed and then removed.

Midwives completed the relevant risk assessments for women and babies from the antenatal to the postnatal period in line with national guidance. There was good practice evidenced for antenatal assessment where potential risk factors for health and wellbeing could be identified. There was an embedded process to detect and monitor those mothers who had diabetes, or who were at risk of gestational diabetes. These mothers had the relevant glucose tolerance testing. These assessments were

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used by staff to determine future planning, including the best place for a safe labour. The criteria for women planning to have their baby at home or at the separate birthing unit were in line with national guidance.

Community midwives referred women who they identified as high risk for a consultant led service at the Royal London Hospital. The department worked closely with the foetal medicine department and there was a multi-disciplinary relationship with other paediatric specialisms.

Better Birth guidance was used by midwives and it followed on from this that women were asked about the baby's movements at each antenatal contact with the mother. Mothers had access to the antenatal team and the triage unit if they had any concerns.

There were several initiatives and assessments that had become embedded as part of the improvement process since the last inspection and which were in place to mitigate risk. These included the venous thromboembolism (VTE) risk assessments that determined a patient's risk of developing a blood clot; a modified early obstetric warning score (MEOWS) that should lead to early recognition of deterioration in pregnant and postnatal women (by measuring blood pressure, pulse and other physical parameters); a World Health Organisation (WHO) surgical safety checklist; a buddy system and 'fresh eyes approach' to cardiotocography (CTG) tracing; and continued foetal growth assessment protocol use (GAP).

The WHO surgical checklist procedures had been subject to an audit in April and May 2018. This audit had thoroughly assessed the quality of the undertaking of the safer surgery checklist. It showed that the department was 100% compliant in three out of the five measures.

The fresh eyes approach had been subject to a recent audit. This audit was carried out as a result of an incident resulting in an unexpected admission of a term baby to the neonatal unit. This incident had demonstrated that the CTG had not been correctly interpreted during the active second stage and that there had been no evidence of a "fresh eyes" approach every 2 hours as per policy. The audit had highlighted the need to share learning regarding sticker usage within the policy framework, and we saw evidence of this shared learning at the inspection, and a wide knowledge of fresh eyes sticker usage and importance. There was a continuation of annual

mandatory training in the use of fresh eyes, a reminder for all staff at handovers and safety briefings to mention the use of fresh eyes and a full audit on a three month basis going forwards.

All staff undertook PROMPT training which aimed to reduce preventable harm to mothers and babies in maternity care. This programme was based in research conducted around the world, and has led to improved outcomes for women and babies globally.

The clinical lead team were planning to start K2 training – an online interactive perinatal training programme. This was a formal way of training and assessing many maternity topics, particularly areas such as foetal monitoring and maternity crisis management. However, this had not been implemented at the time of the inspection. The clinical leads thought that implementation would reduce further reduce risk and would be worth the investment as it led into skills and drills training too.

Large multidisciplinary team live drills were undertaken every one to two weeks. These took place in a variety of locations including the delivery suite, the antenatal ward, and the birth centre. The focus of many of the drills was to promote the clear identification of a leader in obstetric emergencies and to promote teamwork and communication. They were also used to identify latent errors in systems, allowing service leads to act on failures before they affected patient safety. They had been used to respond to serious incidents, picking up on important themes and to train staff when introducing new guidelines and services. Overall, the unit had improved patient safety, with a drop in serious incidents (from 17 in 2017 to 10 in 2018) and these drills were presented to the Royal College of Obstetricians & Gynaecologists as an illustration of how the unit had improved patient safety.

Governance surrounding risk assessment and response had been improved since the previous inspection. For example, there were now two safety briefings held every day in the wards that focused on the potential current risks, daily huddles to share learning, weekly governance meetings, divisional meetings to monitor risk and performance, and daily site safety huddles. These were part of a larger schedule of meetings that took place every week on a department, divisional and also a site level which discussed and reported on all aspects of quality assurance, including risk assessment and response.

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All emergency guidelines were available on the intranet, but were also laminated and clearly displayed in the clinical areas, particularly the high dependency unit. All the obstetric registrars that we spoke to were involved in staff drills for emergency scenarios and said that they were involved in the learning from serious incidents.

The department utilised an online application, that enabled quality snapshot audits (including infection control and safety checks) to be tailored to and easily taken by staff. These are then reported on and can be used for quality improvement and to assess and respond to potential or actual risk. They cover the five domains that we inspect to. We saw the most recent results for the wards on the sixth floor – safe was scored at 97.2%, effective at 94.1%, caring at 89.4%, well led at 85.3% and responsive at 93.1%. This was at expected good levels. There were actions from this perfect ward audit that were listed on the noticeboard for all staff and visitors to see. These included actions for staff to familiarise themselves with the risk register, to undergo a uniform policy check, to share meeting notes and to access the advocacy team.

## Midwife staffing

The trust reported the following midwife staffing numbers for maternity services in April 2018: there were 212.4 whole time equivalent (WTE) staff against a planned 216.2 - a fill rate of 98.2%.

In January 2017, there had been 34 whole time equivalents midwife vacancies. From May 2017 to April 2018 Royal London Hospital reported a vacancy rate of 9.7% for nursing staff in maternity services, this was higher than the trust target of 6.3%.

Staff stated that this had improved since the beginning of 2018, with an emphasis on recruitment. This proactive recruitment had led to staff in the maternity department calculating that they now had around 95% established substantive staff. The director of midwifery stated that at the time of the inspection that there were no current midwife vacancies, which was a large improvement on January 2017 when there were 34 whole time equivalent vacancies. At the end of 2017 the senior staff stated that the whole time equivalent per day was around 161.5 hours and now that had gone up to around 196.5 hours. Since the last inspection 2.6 whole time equivalent staff had been appointed and there was now a supernumerary coordinator on each night shift. Additionally, during the day shift the band 7 staff member was supported by a band 8

matron. This had made a considerable difference to daily management and further boosted staff morale. There was now enough staff availability to facilitate a new homebirth team and appoint a full time safeguarding midwife.

All staff interviewed at the inspection, except for one member of staff, felt that staffing had improved, although two members of staff felt there was still a shortfall in overall staff numbers. These perceived shortages were noted to be in the postnatal area.

During the inspection it was announced by the board that there would be an extra midwife role trialled in triage that had been filled and was due to commence within the following few weeks. This was aimed at increasing staff in the perceived high-risk area of triage. There was a noticeable positive effect on staff when this was announced as this was an area that they had highlighted to management in the past as a potential risk.

The maternity unit had noticed that more students wished to work in the unit post qualification whereas before the department had struggled to attract this part of the workforce.

From May 2017 to April 2018, Royal London Hospital reported a turnover rate of 11.7% for maternity staff in maternity services, this was lower than the trusts target of 13%. Staff stated that this was a continuing improving picture since the introduction of an improved roster system and a focus on managing leave more fairly and effectively.

From May 2017 to April 2018, Royal London Hospital reported a sickness rate of 4.2% for nursing and midwifery staff in maternity services, this was higher than the trusts target of 3%. Since April 2018 the department reported an improving picture for sickness with a robust sickness management programme. Staff told us that sickness rates had improved in the last year, with the inspection team being informed that staff sickness in 2018 to date was around 2.2% compared to the rate in 2017 of 5%.

From May 2017 to April 2018, the Royal London Hospital had a total of 8,866 nursing staff shifts in maternity. A breakdown of bank and agency usage and unfilled shifts was provided. It showed that bank staff had filled 79.6% of vacant shifts, agency 8% and 9% went unfilled over this time period.

Senior staff stated that this had improved in the months since April 2018 as there had been an increase in

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substantive staff to 95% of the workforce. In the month of the inspection in December 2018 there were virtually no agency shifts as the shifts had been filled by substantive staff.

From January 2017 to December 2017, the trust had a ratio of one midwife to every 25.88 births. This was similar to the England average of one midwife to every 25.19 births.

The Lotus Birth Suite management stated that there were no staffing issues at this midwife led department. The incidence of agency staff was only around one shift per month. There were also preceptorships supported for two-month rotation periods. Community midwives gave support during the day as required.

The community midwifery division had good staffing levels. The staff worked in two teams of 10-11 whole time equivalent staff per team. Staff were proud that they performed one to one care in a home setting and that good staffing levels allowed them to deliver individualised care.

## Medical staffing

The trust reported the following staffing numbers for medical staffing in maternity services in April 2018: there were 38.3 WTE staff against a planned 40.2 – a fill rate of 95%.

From May 2017 to April 2018, Royal London Hospital reported a vacancy rate of 2.6% for medical staff in maternity services, this was lower than the trust target of 6.3%.

Internal data displayed in the department showed clearly that vacancy rates had improved in the months leading up to December 2018.

The Royal London Hospital did not provide any turnover data for medical staff for maternity services.

Internal data displayed in the department showed clearly that sickness rates had improved in the months leading up to December 2018.

In March 2018, 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.

	This Trust	England average
Consultant	39%	41%
Middle career	7%	9%

Registrar group	47%	44%
Junior	7%	6%

(Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty, Registrar Group = Specialist Registrar (StR) 1-6, Junior = Foundation Year 1-2)

Junior medical staff induction was shared across all the three sites of the Barts NHS Trust specific to obstetrics and gynaecology and covers CTG interpretation, obstetric emergencies, instrumental deliveries, and human factors, including teamwork, leadership and communication, taught through simulation. Training and education was delivered generally on site; however, when we spoke to five obstetric registrars they all stated that they felt supported in their training and had chosen to come to the Royal London. One stated that there was a lessening of a hierarchical approach within medical teams and that it was easier now to approach all grades of colleagues for support than before.

At the previous inspection in June 2017 the delivery suite consultant level of cover during the week was 83 hours which was below the trust minimum level of 98 hours per week. At this inspection that trust minimum level of consultant cover was now in place. This had been achieved through further recruitment of two consultant staff to cover during the week, taking the number of consultants to 14, and had led to available capacity for their involvement in personalised birth planning and the specialised breech clinic. There were dedicated rooms available for staff on call as well that were located in the maternity unit.

When we spoke to the consultant obstetricians at the inspection, they anecdotally stated that the hours that were covered by anaesthetic consultants had increased in the past year across the week. This was partly in response to work that the consultants had been undertaking regarding the findings in the Every Baby Counts national quality improvement programme by the Royal College of Obstetricians and Gynaecologists. This study had the aim of reducing the number of babies who die or are left severely disabled because of incidents occurring during term labour. Although no babies had been shown to die due to lack of anaesthetic consultation as a sole cause, the programme concluded that it could be a contributing

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factor. Therefore, the Royal London maternity department had taken proactive action from this learning. There were plans in place for consultant anaesthetists to increase the cover provided over the weekend from January 2019.

The ward clerks that we spoke to at the inspection felt that staffing levels in administration and reception duties were fine, but that there was an inconsistency with the band that they worked at and the level of responsibility that they often were given. There were different bands for similar job roles within the department. Staff generally felt that the level of responsibility that they had with regard to the security of new born babies, and the challenging of patients and visitors to the ward, together with the supervisory roles of some, meant that they sometimes felt unappreciated by the management. Staff liked the team atmosphere but most that we spoke to at the inspection wanted more job progression and appreciation. Sickness vacancies were anecdotally harder to cover for ward clerk shifts.

Staffing levels were now no longer on the risk register. We saw that each ward had a noticeboard for staffing levels for the previous month and for the day. These showed that staffing had been at the recommended level, with no staff shortages, for November and December 2018. These notice boards also gave clear signage on the staff who were the on-duty co-ordinators and managers at that time.

## Records

At the previous inspection there had been concerns surrounding comprehensive, legible and completed patient notes. It had been noted at the time that there were improvements but they had not been fully embedded and there had been gaps in recording information.

At this inspection we looked at ten sets of records. All were found to be legible, all were dated and signed, and all were completed for the appropriate risk assessments, including antenatal risk. All had consent documented, health promotion advice given, care planning, and witnessed fresh eyes for review of the notes where cardiotocography (CTG) had occurred.

At the previous inspection there had been concern that venous thromboembolism (VTE) assessments were not always being completed. These assessments determined a

patient's risk of developing a blood clot and were in line with national recommendations. At this inspection, all the ten records we looked at showed these were correctly filled out and filed appropriately.

The department had a good uptake of modified early obstetric warning score (MEOWS) charts. These are designed to allow early recognition of deterioration in pregnant and postnatal women by monitoring physical parameters such as blood pressure, pulse and temperature. Of the four charts that we saw, two were filled out correctly, but two had not been completed as had not had their scores calculated.

There was a checklist, which was a trust specific record, for staff to fill out where women had an operative procedure. It was a one sheet record to attach to the front of the file to clearly record all the five steps of the World Health Organisation (WHO) surgical safety checklist for women having a caesarean section or other obstetric surgery. This was in line with national recommendations. Of the seven records that we looked at regarding compliance for these being completed, only four had been filled out correctly and attached to the notes as per trust policy.

Additionally, there were four sets of records where loose leaves were evident, which meant that there could not be complete certainty that the record was complete without any missing pages.

The maternity leadership had noted that the record keeping was improving but that there were still improvements to be made. There was a continued schedule for audits and a documented focus on striving to improve further the issues regarding completion and a reduction in loose papers. There was a longer-term aim for increased use of electronic recording. This had an additional aim of reducing the issues surrounding medical record storage facilities that was a continuing problem. At the time of the inspection the unit was expecting to take delivery of further locked notes storages so that all notes were secure always.

## Medicines

Medicines were found to be stored and managed securely and in accordance with best practice. Storage temperatures were monitored daily and this included fridge temperatures for all fridges in the department. We

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checked the controlled drugs register and confirmed that daily stock checks were recorded and all stock levels were correct. There were no missed checks at any time in the records.

The Royal London Hospital had a 24/7 pharmacy on site that provided a service for the maternity unit. A named pharmacist visited the maternity unit to help manage the ordering and storage, and all stock arriving was topped up by the pharmacy technician.

Resuscitation equipment was available to use in an emergency. This was checked daily to ensure fully stocked and in date. This was recorded appropriately.

At the time of the inspection there was a discussion surrounding midwife exemptions and the guidance on the administration, sale and supply of medicinal products by midwives. We saw that there had been a conversation with trust leadership covering the Nursing and Midwifery Council withdrawal of the advisory letter and referral to the legislation in the Human Medicines Regulations 2012. A memo had been issued to midwives supporting continued practice whilst the exemptions and reference to the act in existing policies were updated.

## Incidents

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.

From August 2017 to July 2018, the trust reported no incidents classified as never events for maternity services at the Royal London Hospital. However, at the time of the inspection there was a recent report of a never event. This had involved the retention of a tampon after discharge. This was evidenced as resulting in immediate action and the introduction of count boards onto the delivery suite. Discussion of this never event was also a standing agenda item for the serious incident weekly departmental meetings so that continued learning and assessment of remedial actions could be discussed.

In accordance with the Serious Incident Framework 2015, the trust reported 13 serious incidents (SIs) in maternity services which met the reporting criteria set by NHS England from August 2017 to July 2018.

The types of incident reported were:

- Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant): seven incidents
- Maternity/Obstetric incident meeting SI criteria: mother only: three incidents
- Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant): two incidents
- Medication incident meeting SI criteria: one incident

(Source: NHS Improvement - STEIS)

At the previous inspection there had been concerns regarding the backlog of serious incident action points that not been addressed. At this inspection there were marked improvements in this area and there were virtually no outstanding actions that had not been followed up on. There was evidence of when learning from incidents was now being shared with all staff groups via meetings, meeting minutes and correspondence.

There was an embedded process for risk management and a clear escalation procedure. This involved immediate bleep holder communication with the on-duty co-ordinators, staff huddle, feedback to site manager and managerial action where applicable. All staff we spoke to were aware of the process and were confident that the process worked well.

Where there was a need to close the unit, the escalation process would be activated. Maternity departments at three other trust sites would be considered as viable alternatives. The unit had been closed three times in the previous year – the last time the application had been made to close the unit was in October 2018, due to concern that there near full capacity. However, this had not been a successful application and the unit had remained open. Staff, when asked, stated that they had not perceived a risk at that time and that the unit had continued to offer the full service to all patients throughout.

A new serious incident process was being piloted at the Royal London Hospital. This had been introduced in October 2018 and the process centred on any incident that was to be investigated and externally declared. The department had to book a slot at a new standing weekly running serious incident panel within three weeks of the



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incident, and then nominate an investigating officer. There was a target time of four weeks for a final report to be in place. The panel could help direct the investigating officer to relevant staff that should be interviewed and any policy/guidelines that should be reviewed. This process would then identify the root cause, recommendations and an action plan. The report would be finalised with a sign off from the departmental management, the site lead (nursing or medical director) and the patient safety team. The report would be sent to the executive board for the final review. There was also a round table initiative where the aim was to get as many people involved in one incident together to share and discuss in order to gain further understanding and learning. We saw that this round table meeting process had taken place following the recent never event incident involving the tampon retention. This had led to shared learning and an escalation to the patient safety group.

Incidents were now managed in far more detail and with an embedded schedule by the department compared to the previous inspection. There were several dedicated meetings for incidents to be raised, discussed and actioned, and these meetings took place at both ward, department and site level. Examples included daily 'Share the Learning' huddles, weekly incident review meetings, monthly divisional management meetings, and weekly pan-site serious incident meetings. There were minutes from some formal meetings, such as the weekly perinatal morbidity and mortality meetings. These meetings provided an opportunity to review key themes and trends about perinatal deaths or morbidity rates. Any deaths could then be discussed in a multi-disciplinary forum. Information regarding specific incidents or risk were distributed to staff as either presentations or information sheets. There were dedicated daily multi-disciplinary teaching opportunities within the department for junior doctors to attend using learning from other sites within the trust. These followed each multi-disciplinary meeting for doctors, anaesthetists and midwives.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients or their families of certain notifiable safety incidents. They also have to provide reasonable support to that person. Staff, when asked, understood the principle of the duty of candour and the importance of openness and honesty. All staff stated, when asked, that they believed that duty of candour was adhered to in the department. The lead

clinicians documented duty of candour where able and there was a closed social media group where the senior leadership team could communicate on it. Duty of Candour compliance had been a focus for the trust and compliance had improved throughout the trust from 70% in 2016-17 to 87% in 2017-2018.

## 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 in July 2018 showed that the trust reported three new urinary tract infections in patients with a catheter from September 2017 to May 2018 for the maternity services.

The safety thermometer was piloted in the maternity unit following the previous inspection recommendation. This system was due to be rolled out in the immediate future as a permanent recording method. At the time of this inspection there was a locally produced monthly information record that tracked infections, harm and staffing levels. Each ward had a noticeboard that clearly displayed all the information regarding infections and any risks or harms that had been recorded in the previous month or designated period. For example, there was a colour coded chart to record a day when there was no infection, a reported case of MRSA or a reported case of C.diff. At the time of the inspection the department had colour coded the preceding month as one with no recorded infection in all the wards. There were also charts to show staffing levels and audit information recording harm and hygiene levels. These all showed to be no reported problems in the preceding month.

## Are Maternity (inpatient services) effective?

(for example, treatment is effective)

Good



At the previous inspection we had rated this service as good for effective. At this inspection we continued to rate it as good:

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- There was a system for reviewing and updating policies in line with national guidance and best practice, although not all policies and procedures had been checked to be in date and the IT system allowed access to legacy policies. This was resolved at the time of the inspection once it had been highlighted as an issue.
- Midwives were still supported by the department to maintain competencies and pursue professional development.
- Outcomes were generally in line with, or better than, expected national outcomes. This was unchanged from 2017, when performance had also been within national parameters.
- At the previous inspection there had been some issues with audits and data collection. The maternity department was increasingly improving feedback and audit programmes in order to increase quality improvements and there was a large range of audits and research scheduled for 2018-2019.
- There were more screening programmes offered to mothers than before and a 36-week growth scan was now included routinely to check for late onset pre-eclampsia.
- Baby feeding services provided a comprehensive service to all mothers before and after delivery. The baby feeding service was increasing its staff and remit to ensure that all mothers had contact with the team.
- There was good multi-disciplinary teamwork. This had remained good from the last inspection.
- Pain relief was effective. There was now better anaesthetist cover to provide more epidurals and reduce the waiting time that had been an issue at the previous inspection.
- There were systems in place to provide good consultant and midwife cover at weekends and this was looking to be improved with further staffing.
- At the previous inspection, one to one care had not been achieved at all times. At this inspection there was now 100% target achievement in 2018 for this.

## Evidence-based care and treatment

At the previous inspection in 2017 the service was following the London Quality Standards for maternity, which was consistent with effective national practice. The obstetricians were playing an active role in the North-East London network for benchmarking and peer review, and there was evidence of regular audits. Audits undertaken included both local and national themed audits, and

benchmarking with other maternity units. However, although the maternity unit participated in data collection for these audits and benchmarking programmes, it was acknowledged by the maternity leadership that some inconsistencies and gaps regarding collection of data remained. This had led the leadership to work with staff to improve documentation and data accuracy.

There was an audit lead within maternity who organised and co-ordinated the audit programme. There was forward looking to implement further audit and feedback. The audit programme was devised with multi-disciplinary input and with regard to service need, national audit and NICE recommendations. The screening audit was included in the programme, but was usually completed by the screening midwife lead. Audit was also responsively driven by the incident reporting system reports – a recent example was the use of fresh eyes for all cardiotocography (CTG) reviews and the auditing of the percentage of times this was occurring. There was a checklist following the National Safety Standards for Invasive Procedures (NatSSIPS) guidance issued by NHS England and which adhered to World Health Organisation (WHO) recommended practice for pre-operative checks. These were to be completed before an invasive procedure on the unit. An audit was undertaken to assess the compliance with the NatSSIPS checklist completion in December 2018 which found that there was a 93% compliance. (It was determined that the outstanding 7% non-compliance was due to an emergency situation where time prevented a full checklist being undertaken).

Working alongside the clinical educator there were also audit programmes driven by serious incident recommendation and this was fed into the team and wards to address training and education needs. Examples of audit included the postnatal bladder care audit that had been undertaken to assess whether there was a need for a bladder scanning on the postnatal ward. This had led to the change in practice whereby a scanner had been purchased and patients could be scanned to improve the quality of treatment offered in post-natal care for bladder management. Further to this, an audit on transitional care had led to other quality improvements. Additionally, there was a quality improvement programme of postnatal contraception during caesarean section (CS) and before discharge. This meant that contraceptive implants and devices could be inserted at CS and on the postnatal ward, which would have a measurable benefit in the community.

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Serious incidents were a driver for other audits, such as an audit on foetal genotyping. Having introduced a routine 36-week scan to screen for foetal growth restriction, the service had recently audited its outcomes and found it to be effective. Subsequent to this, research had commenced in order to assess for late onset pre-eclampsia at the same visit. There was now a planned audit around induction of labour to further improve quality of experience in this area.

Recent audit results had led to demonstrable improvements in record keeping and practice, and an engagement with staff to want to complete audit programmes. Line management was felt to be supportive of future audit improvements and implementations and a pride in the ongoing achievements regarding quality improvements in training. The preceptorship midwives were positive regarding the learning management in the department and the retention of preceptor midwives was good.

A trust wide maternity guidelines group oversaw the updating of the maternity department and all guidelines were drawn up with reference to best practice and the National Institute for Health and Care Excellence (NICE) guidance. Guidelines were updated regularly and reflected guidance from associations such as the Royal College of Obstetricians and Gynaecologists (RCOG).

Policies were available on the intranet which all staff had secure access to. Protocols had been changed across the trust and the roll out of these updates to staff was being taken through the use of staff huddles, social media and handovers.

The Royal London maternity department was working on an Enhanced Recovery in Obstetric Surgery programme (EROS) following on from nationally recognised good practice of enhanced recovery after surgery programmes that had been successfully implemented in other trusts with other specialities. The aim of this evidence led initiative was to reduce morbidity, reduce the length of hospital stay, enable mothers to return to normal activities earlier than otherwise, and improve patient satisfaction and experience. The rationale behind this was the increasing demand for elective caesarean surgery and the NICE guidance that a patient can be discharged one day after an uncomplicated non-emergency caesarean section operation. The team at the Royal London had looked closely at the findings from another London hospital and seen an evidential improvement in patient experience and

a successful reduction in time as an inpatient. The reason for implementing this at the Royal London was that around 500 women were delivered by caesarean section per year at the unit and that this would improve patient experience by empowering them to be more active in their own care, be a better use of resources for the trust, and improve productivity in line with recent Care Quality Commission recommendations.

As part of this research, there had been an audit on patient feedback after elective surgery which confirmed that patients would have liked more communication and felt that post surgery advice and support was not as beneficial as it could have been. Data showed that at the introduction of EROS in March 2018 there were 10% of patients that were discharged the day after surgery. However, by May 2018 over 70% were discharged the day after surgery. Latest data for July 2018 showed that the percentage had levelled down to around 40%.

The Royal London Hospital was involved in a large portfolio of reproductive health clinical trials. The Barts Research Centre for Women's Health (BARC) had become partners with the University of London to further research in the prevention of diabetes, including gestational diabetes. Research updates were presented monthly at dedicated audit meetings, which encouraged attendance from all staff levels to engage staff in research as early in their careers as possible.

Current research projects in maternity included:

EQUIPPT: Evaluation of QUIPP App for Triage and Transfer (QUIPP is a tool used to predict spontaneous preterm birth)

STATINS: Randomised controlled trial with pravastatin versus placebo for prevention of preeclampsia

EVENTS: Prevention of preterm birth in twins: Randomised trial of progesterone versus placebo

EMMY: Effectiveness and acceptability of myo-inositol nutritional supplement in the prevention of gestational diabetes: a pilot placebo controlled double blind randomized trial

OMAHA: Effectiveness and acceptability of metformin in preventing onset of type 2 diabetes after gestational diabetes in postnatal women: A feasibility study for a randomised, blinded, placebo-controlled trial

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PHOENIX: Pre-eclampsia in hospital: Early Induction or Expectant management

C-STICH: Cerclage Suture Type for an Insufficient Cervix and its effect on Health outcomes

BUMP: Blood Pressure Monitoring in high risk pregnancy to improve the detection and monitoring of hypertension

GBS2: Accuracy of a rapid intrapartum test for maternal group B streptococcal colonisation and its potential to reduce antibiotic usage in mothers with risk factors

There were a further 10 projects planned for 2019.

## Nutrition and hydration

Patients were offered refreshments and had access to the tea, coffee and water facilities. Hot and cold food options were available and patients were offered options for different cultural or moral choices and dietary requirements. There were fewer water fountains than previously in the reception areas as all visitors, with the exception to mothers on the unit, were encouraged to go to the floor below for all refreshments and not stay in the communal areas for water and other refreshments. Some staff felt that there should be more water fountains available for all persons on the ward.

There was a dedicated lead member of staff for diet and nutrition, and advice was clearly available on wards for health and wellbeing to mothers. There was also clear signage and literature for all mothers to find on baby feeding. Women had access to information throughout the pregnancy and post-delivery. If a baby was born with tongue tie (which could prevent effective feeding) then there were clinics in the hospital and in the community. There was an effective system in place to recognise and correct this condition, often with the first 24-48 hours of birth.

Maternity staff, and the dedicated baby feeding service, were available to advise on infant feeding, and to offer practical advice on positioning and attachment for nursing.

According to the Maternity Services Data Set (MSDS), from 2017-2018, at Barts Health NHS Trust, 73% of newborn babies received maternal or donor breast milk at their first feed.

## Pain relief

When asked at the inspection, patients felt that their pain was well managed. A recent internal survey had found that 95% of patients felt happy with their pain management.

There were dedicated 'pain relief in labour' classes that were managed on a drop-in basis. These sessions were held by an anaesthetist and a midwife. These were held monthly at the birth unit and advertised in the hospital to expectant mothers. The classes offered options and choices for pain relief during labour and gave a forum for expectant mothers to ask any questions they had about pain management.

During the inspection it was noted that staff attended to patient needs for pain relief promptly and that there was space for mothers to mobilise freely to help aid comfort. The pain relief options included a nitrous oxide gas that is inhaled by the patient and provides short term pain relief and was available in all the birth rooms. Other pain relief options were available, including paracetamol, an opioid and epidural anaesthesia. There were also birthing pools available for pain relief and water birth.

The trust had guidelines regarding the junior anaesthetists and their availability for epidurals. There were three medical staff at this level per day, and therefore the department found that epidural requests were easy to respond to. Out of hours were more problematic as there was not the same level of staffing, but anaesthetists could be requested from other departments in the hospital. If a consultant anaesthetist was required, they would attend if on call, even if at home at the time.

## Patient outcomes

In the 2017 National Neonatal Audit, the Royal London Hospital performance in the two measures relevant to maternity services was as follows:

- Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?

There were 144 eligible cases identified for inclusion, 87.8% of mothers were given a complete or incomplete course of antenatal steroids.

This was within expected range when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids.

The hospital met the audit's recommended standard of 85% for this measure.

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- Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?

There were 51 eligible cases identified for inclusion, 49% of mothers were given magnesium sulphate in the 24 hours prior to delivery.

This was higher than the national aggregate of 43.5%, and put the hospital in the middle 50% of all units.

(Source: National Neonatal Audit Programme, Royal College of Paediatrics and Child Health)

Barts Health NHS Trust, of which the Royal Hospital London is one of the hospital sites, had a total number of caesarean sections similar to the expected level. Also, from January 2017 to December 2018, the standardised caesarean section rates for elective sections were lower than expected and rates for emergency sections were similar to expected.

In relation to modes of delivery from January 2017 to December 2017, the percentage of deliveries by caesarean section and instrumental methods were in line with England averages:

From January 2017 to December 2018 the total number of instrumental deliveries and non-interventional deliveries were similar to the England average.

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

As of 29 May 2018, the trust reported no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

The trust took part in the 2017 Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit) and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 6.13. This is more than 10% lower than the average for the comparator group rate of 6.86.

Comparing this provider to other trusts with similar service provision in the 2017 MBRRACE-UK Perinatal Mortality Surveillance Report for Births in 2015, performance was better than expected for stabilised and risk-adjusted extended perinatal mortality rate. There is currently no national aspirational standard for this audit.

(Source: MBRRACE UK)

There were audit forums for staff. The obstetricians had recently attended a Joint Obstetric Anaesthesia Audit Meeting. The department was involved in the initiative of the Every Baby Counts programme that reported on the role of anaesthesia with relation to baby outcomes, with an aim to reducing preventable injury to newborns. This involvement centred around shared learning and discussion of the programme with the consultant team, and discussion of action points to be implemented. This shared learning forum with the consultant team also extended to learning of improvement of outcomes for mothers after obstetric surgery and had led to internal action points for staff to adhere to.

There was a dedicated breech clinic that patients from within the trust, and from other hospitals, could be referred to. The clinic is led by a consultant obstetrician with senior midwifery input to work through a birth plan with the mother to ensure that a safe and individual birth could be planned for. At the inspection we tracked the communications the hospital had with a mother with a clear breech presentation. This mother did not want a C-section at her designated hospital and had been recommended to refer herself to the Royal London team to explore other options. The Royal London team had been able to accommodate her requests for a vaginal birth, with options that had even included a water birth. There was also audit led research surrounding the pathway for the breech clinic and antenatal management and that led to local policy.

There were birth plans for complex needs that had been discussed with the obstetric consultants and senior midwives. We looked at one example of where a woman with various complications had received thorough consideration and advice regarding her birth plan, with the consultation then written up with explanations afterwards and sent to the patient. There was clear evidence that the woman had been given options and that all the suggestions for the birth plan were based in national guidelines.

At the previous inspection it had been raised that 95% of women had received one to one care whilst in labour. The target had been 100%. At the time of this inspection audits demonstrated that 100% of women in labour received one to one care. In addition, the department was committed to

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the Better Births project, had invested further into the Gateway team (for better outcomes for vulnerable patients) and the senior midwifery team had committed to case leading to promote better patient experience.

The maternity dashboard showed an improvement in the vacancy and sickness rate over the three months to December 21018. Recent dashboard showed a rise in post-partum haemorrhage (PPH) reporting, although the department did think that they managed haemorrhage well and consultants would always attend when asked to by staff on the ward.

## Competent staff

The Royal London Hospital supplied appraisal data for staff within maternity services. This demonstrated an improvement in appraisal rates for nursing staff to a level of 95% for recent compliance of annual appraisal. Medical staff had a compliance of 91%, whilst administrative staff were all 100% compliant for appraisal within the last year.

We saw that staff were rotated around different divisions within the maternity department. Staff that we spoke to about this enjoyed the variation this offered and the increased experience that it brought. The department actively supported revalidation and supported the Training Skills Passport scheme that had been introduced by Health Education England. This had an aim to assist staff to plot a pathway towards leadership positions in the trust.

The department had recently undertaken a Birthrate Plus review and results were being reviewed across all Barts Health maternity units. The review would provide an updated view of staffing ratios and acuity within the unit. There was an ongoing audit using this workforce planning system to determine a further understanding of midwifery time required throughout labour, the need of mother and baby, and the real time data on length that a woman required with more complications than a normal delivery would incur. The management were looking ahead to March 2020 to use data such as this to implement the vision and strategy for the longer term.

At a focus group that included six doctors, all stated that trainee doctors were feeling well supported and had chosen to come back to the unit. All were involved in the weekly skills and drills scenarios for potential emergency situations in the unit and all were involved in the learning

from the serious incident investigations. All were also involved in receiving patient feedback and the team working initiatives including the 'Star of the Month' award scheme.

Consultants were involved with the morning handover on all days of the week, including weekends. There was good support from other grades of doctors on site and a good multi-disciplinary team of medical staff available at all times either on site or through the on-call system. We witnessed consultants of all disciplines undertaking ward rounds and communicating with staff regarding patient status and future planning. Staff generally felt that working relationships had improved since the last inspection and that there was an increase in communication between teams and specialities.

There was an induction programme in place and training session support for all medical staff. This level of training support had increased in the time since the last inspection and there was more protected time for training due to the increase in staffing levels. Feedback was given regularly, and this had become part of the learning culture now embedding itself in the department.

The infant feeding and wellbeing service was a part of the baby feeding (breastfeeding) service within the maternity department. This service had recently been presented with a certificate of achievement by Public Health England for sending a large proportion of staff on Making Every Contact Count (MECC) training. MECC is an approach to behaviour change to make every interaction that individuals have encourage change of behaviour to make a positive change to health and wellbeing.

A maternity survey conducted internally by the trust in May 2018 surveyed preceptorship and junior band 6 midwives. Out of a total of 30 midwives surveyed, all but one had attended an induction day. All stated that they had been given time to attend their preceptorship study days. 93% felt that they had received appropriate support from lead midwives. The clinical educator for the service had played a large part in the roll out of the preceptorship programme and could provide evidence that a larger majority of the new cohort of student midwives would be staying on at the Royal London hospital to carry out their preceptorship programme compared to previously. Overall the results of the survey showed that staff felt well supported within the clinical area and the training and programme provided met

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their expectations and needs. The clinical educator was intending to work closely with the lead midwives in the clinical areas and the preceptorship lead to improve staff experience, training and the preceptorship programme.

Staff in certain areas, such as the community teams, employed technology to help them keep in contact with colleagues and maintain support and advice amongst peer groups. This included the use of closed group social media.

The role of clinical educator was a full-time role within the maternity department. Responsibilities included the orientation of preceptorship midwives – a 12-month programme that included time spent in each area of the maternity department (including community) by the preceptors. The educator also ran six core study days for staff and six action learning days per year. Feedback was around relevance of these in relation to midwifery as these were also attended with general nurses, so the programme had been adapted for midwifery relevance.

Communication within the preceptorship had recently been improved with a closed social media group for managerial support and peer support. Support had been increased with the buddy system where an experienced midwife offered support to the preceptor, alongside the education team support.

Speaking to administrative staff, including the secretarial and PA staff, there was a consensus that the clinical leads had been instrumental in keeping the unit progressing and improving. One staff member stated that they viewed the clerical work as an obligation to the unit and those clinical leads to 'make things better'. These staff felt that they were well supervised and had regular appraisals. However, there was an indication that some felt that there was no clear career path within the trust and that there was a barrier to more flexible working patterns. Whilst clinical training was available, there was a perception that there were no managerial courses for administrative staff.

The administrative staff felt included as part of the maternity unit team by staff, and were always included in the social activities within the ward, and the out of hours social occasions.

## Multidisciplinary working

There were formal monthly multi-disciplinary meetings for the maternity department. These were minuted meetings and were generally well attended. There was a clearly effective multi-disciplinary team working across the

divisions and across the department of gynaecology and children's services. Following on from the positive feedback from the last inspection, staff felt that there were good working relationships with different clinical groups and that communication was clear and consistent. At a focus group with staff, it was found that the multi-disciplinary approach to working had been introduced at a far more consistent and regular way in the last eight months preceding the inspection.

In addition to this there were informal multi-disciplinary meetings for all staff, where, for example, the parent educator could interface with the antenatal midwives to discuss expected patient demand.

Theatre staff communicated with the maternity wards and staff felt that this was part of the improved integration and communication. There was proximity of paediatric theatres for emergencies and liaison with specialist staff. The sonographer staff came under the supervision of the radiology team. They were appropriately trained and worked alongside the foetal medical team.

There had been a renewed importance attached by the leadership in continuing the initiatives that had commenced at the time of the previous inspection and which centred on making the Royal London Hospital a centre of expertise. This involved continuous support from specialists from many other areas of medicine within the trust, such as cardiologists. There were also further examples of improved involvement of obstetricians and midwife staff meeting with other professionals and community leaders to discuss better management of cultural needs.

One member of the baby feeding support team would attend each weekly ward meeting to manage staff expectations of what they do and what they would be offering that week, and share any relevant information or initiatives.

## Seven-day services

The birthing unit, the delivery suite and the antenatal and postnatal wards were open for 24 hours a day, seven days a week. The full range of imaging services was available 24/7 too. Ante-natal and scanning clinics were offered during the week days of Monday to Friday, and occasionally at weekends.

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Transitional care of babies enabled mothers to stay with their babies when the baby required extra support and care. There was close working with the paediatric facilities and staff.

Access to medical support was available seven days a week and telephone advice was supported within the unit for all mothers under the care of the hospital.

## Health promotion

There were a number of leaflets on display in the antenatal and postnatal departments and there were poster displays around the entire unit that provided some information on health and wellbeing.

The patients we spoke to confirmed that they felt well informed regarding dietary advice. There was a clear emphasis in the maternity department on issues surrounding diabetes due to the high incidence of this condition within the local population. This included specialised clinics and designated midwife leads to promote a healthy pregnancy for women with this condition.

The breastfeeding clinic was promoted throughout the department and they supplied their own literature and advice for the expectant mothers and those that had delivered a baby. The breastfeeding team also offered advice to those using bottled milk and continued giving advice in the community to all mothers who continued to nurse their own children to any age post-partum.

There were two midwives that co-ordinated the parent education classes. These classes were generally booked through GP or midwife referral, but the team were open to all who wished to attend, provided there was space to accommodate them. Classes could be taken as a four-week programme or as a one-day full programme. Topics covered included healthy lifestyle choices, preparation of changes to lifestyle with parenthood and information regarding birth choices. There was a dedicated parent education room that was spacious enough for mothers and partners to receive the classes in comfort, with refreshments. There was clear signage regarding health promotion and wellbeing, and contacts for help groups surrounding mental and physical health. There were dedicated drop in classes for Bengali mothers that were conducted in Bengali (there is a large Bengali population in the locality).

There was a clear checklist that all mothers were given, that emphasised breathing and rest before labour, and how to improve the home ready for a safe environment for a new baby.

There were several classes that were open to all expectant mothers, including those covering breastfeeding. There was a new initiative that was now embedded in the schedule, where all mothers could attend an antenatal colostrum harvesting workshop. This was particularly aimed at those women with gestational diabetes, high risk pregnancy or a history of breastfeeding difficulties. It promoted the qualities that colostrum contains and the health benefits of giving colostrum to the new born baby. The colostrum could be harvested in advance of the delivery so that it could be administered to babies if they were premature or had special care needs. Antenatal breastfeeding workshops were also available each month for Bengali mothers, and were free for a mother and female companion to attend.

The on-site breastfeeding team consisted of 14-part time staff that were all trained in providing breast feeding support. They had begun as volunteers and were now established as a funded part of the department and in the community. Workshops were run on site and in other areas of the locality.

The administration had adapted to the increasing demand and now used an internet booking system, although patients could call or seek staff out in person, or attend the ad hoc workshops. The team offered bedside assistance whilst the mother was in the hospital and were freely available to all mothers at the hospital between the hours of 10.30am and 11.30 am each morning. The staff gave a total of four hours per day to the maternity wards. All mothers based in the catchment area of the London Borough of Tower Hamlets had a follow up phone call upon discharge, and if no answer to this follow up would ensure that a text, voicemail or letter was sent as well. This was to further promote and ensure support for all mothers and to keep them informed. Help could be offered on the telephone regarding bottle feeding too and staff considered themselves to be baby feeding specialists rather than breastfeeding support specialists. There was six to eight week target for all follow ups.

There was a new initiative for baby massage offered twice a week. The focus of this was to encourage mothers to attend



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in order to socialise and to see mothers breastfeeding, even if they were not breastfeeding themselves, in order to encourage them to possibly consider breastfeeding for future pregnancies.

A tongue-tied clinic was offered at the hospital and in the community, which staff considered was improving diagnosis and treatment times.

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

Staff were clear regarding their responsibilities to understand and document consent and to undertake capacity assessments where needed. This was an improvement from the previous inspection where this had been raised as a concern. We saw consent had been recorded on medical records for operative procedures.

Mental capacity and consent was not reported by the trust as part of the mandatory training completion statistics. However, mental health awareness was part of the training that all staff received as part of the induction for new staff. There was evidence of multi-disciplinary support with community services and social services.

The empowerment of mothers was an ongoing initiative that staff were actively involved in, which included supporting patient choice with regards to screening and ongoing treatment. One senior member of the midwifery staff identified that challenges were ongoing with regard to supporting mothers who made choices that meant that the risk to them and their baby may increase. However, all staff, when asked, stated that they respected a patient right to choose with regard to care offered.

## Are Maternity (inpatient services) caring?

Good



At the previous inspection we rated this service as requires improvement for caring. At this inspection we rated this as good for caring because:

- Previously there had been a mixed view from women reporting varying standards of care. Some had felt that they had not been treated with dignity and that some

staff did not treat patients as individuals. However, at this inspection, there was a high level of positive patient and stakeholder feedback which was an improvement on previous inspections.

- At the previous inspection there had been some comments that women had not been involved in their care and in decision making. However, at this inspection there had been more emphasis on empowerment to women and a greater focus on antenatal education and choice.
- There was a dedicated bereavement team and facilities.
- As before there were support teams of staff to help care for the more vulnerable mothers, and a dedicated Gateway Team. There was an excellent support group for postnatal mothers to utilise and staff who kept contact with patients for sometimes years after the delivery of their child.
- There was a marked improvement on staff and user recommendation of the unit, and a focus by the leadership to improve communication of all feedback to staff. Despite the Friends and Family feedback showing lower levels of satisfaction with care to June 2018, and areas for improvement highlighted by the CQC maternity survey, we heard many examples of and saw evidence that patient experience had improved from the previous inspection.
- There was a focus on continuity of care and for more support to community groups and to the homebirth team. There had been more care and emotional support offered in languages other than English in order to be more inclusive to the diverse local population. This care was increasingly being delivered with the aid of specially trained advocates.
- Staff were more open to feedback and had benefitted from consultants coming in and observing staff and suggesting improvements for care. One example had been the suggestion to maintaining eye contact with patients for them to feel more supported.

## Compassionate care

At the previous inspection there had been concern raised by feedback from patients, relatives and stakeholder organisations that the level of care given by some staff fell below the standards expected. At this inspection there was evidence that this situation was improving and feedback was generally more positive.

The leadership identified that many of the issues surrounding compassionate care had stemmed from the

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difficulties of low staff morale and staffing vacancies/sickness. To combat these issues the clinical and midwifery leads had introduced staff wellbeing days where staff brought in food and cakes, or were offered spa type services such as aromatherapy sessions and massages.

The most recent friend Friends and Family Test (antenatal) performance for the month of November 2018 for The Royal London Hospital showed that 92% of respondents would recommend the maternity services. This was in line with the England average.

The most recent friend Friends and Family Test (birth) performance for the month of November 2018 for The Royal London Hospital showed that 95% of respondents would recommend the maternity services. This was in line with the England average and was a marked improvement from the year before.

The most recent friend Friends and Family Test (postnatal ward) performance for the month of November 2018 for The Royal London Hospital showed that 95% of respondents would recommend the maternity services. This was in line with the England average and an improvement on the year before.

Since 2017, staff noted that the feedback from Friends and Family Test had improved. There were now family group sessions once every week to gain feedback from women, their partners and family members. Staff felt that this had helped to reduce complaints by seeking feedback before they left the hospital environment.

The trust performed worse than other trusts for 9 out of 18 questions in the CQC maternity survey 2018. However, this was an improvement on the previous year. Although, examples of where the service was deemed by the survey to still be performing worse than other trusts included:

- If you raised a concern during labour and birth, did you feel that it was taken seriously?
- If attention was needed during labour and birth, did a staff member help you within a reasonable amount of time?
- Thinking about your care during labour and birth, were you spoken to in a way you could understand?
- Thinking about your care during labour and birth, were you treated with respect and dignity?

- Did you have confidence and trust in the staff caring for you during your labour and birth?

In June 2018, the head of midwifery had commissioned a study to gauge feedback from patients. The study – called 100 Voices - had the aim of providing a picture of current practice and a point of comparison with the past and for the future. On one designated day around 100 women (52 antenatal patients and 49 labour/postnatal patients) were given forms to fill in and encouraged to complete. The results showed that 100% of the patients were satisfied with the care that they had received and 96% considered that they had been treated with respect and compassion. Of the women surveyed, they rated the unit as very good or excellent for post-natal care. There were some action points for staff learning that came out of this including, more time to ask questions, better food options and some staff still needed to make more eye contact throughout. These findings had been presented to staff.

A Healthwatch report stated that overall the Royal London Hospital was regarded as a better place for care and treatment in 2018 than it was in 2017. Midwives were among those praised for their empathy, efficiency and knowledge. It was stated that the attitude of midwives had improved compared to previous years. Patients stated positive experiences, amazing care and midwives providing reassurance to mother, supporting them and empowering them to feel in control of their birth experience.

Speaking at the inspection to a focus group of medical staff, one locum consultant obstetrician stated that there was an increasingly positive culture at the maternity unit, and that there was now a noticeable amount of positive feedback in the local community. Of the 17 staff in the focus group, all 17 would recommend the maternity service to family and friends. There was a dedicated patient experience midwife that had been in post for two years. The job role involved collecting friends and family data and asking for patient feedback whilst under the care of the Royal London maternity department. The data we saw at the inspection showed that the friends and family results had improved and were now all above 90% for recommendation of the unit.

Walking around the hospital wards, there were many examples of comments and thank you cards where

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patients were effusive with their praise of their treatment. We spoke to eight patients on the days of the inspection and all were positive regarding their care and generally thought the midwifery staff were polite and respectful.

One patient stated that it was as if her own family were looking after her. Patients stated that everyone seemed to be treated as an equal. One patient stated that this was not her first pregnancy and there had been issues in the past when she would not have wanted to birth at the Royal London Hospital. However, she stated that she felt her pregnancy would be safer this time around, and wanted to birth here, because she felt less stressed due to the trust she had in the staff.

There were many other comments from parents stating that the care had been excellent, the experience wonderful and the staff understanding and kind. We saw at least thirty of these as we looked around the wards.

## **Emotional support**

There was a dedicated midwife for bereavement services. Support was provided for the mother and the relatives that attended the hospital and a room was dedicated solely for the purpose of these patients. The chaplaincy team worked with the bereavement team to provide further support and care.

One patient stated that they had previously had a stillbirth and despite the trauma of this event that looking back this experience had proved to be more positive than it could have otherwise been. This was because of the excellent emotional support that the midwives had provided. She stated that she would recommend this unit without reservation.

Midwifery staff involved in the parent education team were instrumental in the increasing improvement initiatives in the care of mothers who required extra support. This had led to the introduction and training of advocates for mothers and plans in the future to implement more classes for specific local cultures. The hospital provided a tour of the maternity unit every week so that mothers and partners could be reassured and understand the process and the layout of the maternity wards. They also co-ordinated the monthly Birth Reflections clinic for parents to discuss their labour and where any trauma, sadness or difficulties could be shared and support given. The parent education team did tend to offer support beyond the required channels,

and there was a vast amount of evidence from mothers who had remained in contact with previous patients for weeks, months and even years as they appreciated and needed the support given.

The parent education team believed in empowering the women at labour, by letting them make their own choices and give consent to involvement by others. This was evidenced by the feedback given to the team where mothers were grateful enough to write to express their thanks for giving them this empowerment and support.

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

At the previous inspection there had been feedback from some women and their partners that they did not feel sufficiently involved in decisions about their care, and were not proactively involved in the care.

At this inspection there was evidence of feedback and more empowerment to women than before. One patient spoken to on the inspection had recently undergone a caesarean section and thought that the experience had been a positive one, with excellent communication from all medical staff, including speaking to the surgeon before the surgery. There had also been access on the day of the operation to other speciality surgeons (due to other medical issues) which the patient had found reassuring.

Three of the patients interviewed at the inspection, when asked, stated that they had been involved with their care and involved in all the decisions made. Staff spoke about the importance of empowering women who came into the maternity department.

Since the last inspection it had been introduced that partners could stay overnight in the unit if they so wished. At the moment that normally meant that they could sleep in a chair only, but some patients appreciated that partners could stay.

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## Are Maternity (inpatient services) responsive to people's needs? (for example, to feedback?)

Good



At the previous inspection we rated this service as requires improvement for responsive. At this inspection we rated this as good for responsive because:

- There was an antenatal provision for all mothers to attend classes and specialist advice workshops. This had been extended and there was a large amount of antenatal workshop and baby feeding classes offered.
- At the previous inspection, there had been an inconsistent approach to translation and interpreting services and an inadequate provision of written information for women and their families. At this inspection, there were processes in place to enable the staff to request interpreters, with some on site. There was also a facility for telephone interpreting services if required, information leaflets for patients, and a welcome pack which provided advice on the discharge process, breastfeeding and maternity contact numbers. There were also information sheets for birthing partners giving them a lot of important information.
- In the birthing unit there were information posters in nine separate languages offering PALS assistance and signposting to the interpreting service and the deaf service
- Antenatal classes were also offered in another language to cater for local need.
- The unit was increasingly using, and providing training for, advocates for patients with language or cultural needs beyond those routinely offered.
- There was a dedicated daily team of staff providing baby feeding advice and classes, who provided follow up consultation and telephone advice.
- There was a clear commitment to initiatives to provide improved continuity of care, including buddy systems and case loading. At the previous inspection there had been concern that women did not have a named midwife and that midwives did not give continuity of care or individual needs assessments.
- At the previous inspection, there had been concerns regarding the lack of flow through the unit due to poor

levels of staffing and a lack of postnatal beds. At this inspection it was found that there had been large improvements in the flow, helped by the increase in staffing and the embedded positive impact of the Lotus Birth Suite which had improved bed availability elsewhere. Senior midwife led research projects for increasing flow and access were an ongoing and improving addition to improving the patient experience overall.

- There was an embedded multi-disciplinary approach to both community and hospital setting delivery.
- There was continued commitment to best practice programmes, including the placenta accreta service, the 'My Body Back' clinic, and birth reflections clinic, a birth planning clinic, a specialised breech service, a homebirth team, a specialised obstetric team, a self-administered inpatient medication project and a postnatal contraceptive provision.
- At the previous inspection, there had been overdue complaints that had not been addressed in the policy timeframe, and some issues with communication and service improvement when it came to learning from complaints. At this inspection there was a clear and embedded process for complaint management where each complaint was assigned to staff to ensure ownership, and where resolution meetings with the complainant could be arranged if suitable.
- At the previous inspection, for the year July 2016 - June 2017, there had been a record number of complaints received. There had been a reduction in the year 2017-2018 in the real number of complaints and an increase in shared learning from those handled.

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

Tower Hamlets was one of the fastest growing local authority areas in the UK in the thirty years to 2017, with one of the most densely populated areas in the UK. The growth was due to high local birth rates and also a high level of immigration into the area. There was a high diversity of cultures and religion, with a growing population of Muslim residents and a prominent Bangladeshi population. The overall population was relatively young compared to the national average. In terms of median age, Tower Hamlets had the 4th youngest population of all the local authorities in the UK.

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From October 2016 to September 2017, the bed occupancy levels for maternity were generally higher than the England average. From October 2017 to March 2018, the trust's bed occupancy for maternity was lower than the England average.

In addition, there were 93 reported moves at night between beds reported for the ward 8F (birthing unit) and four reported moves at the Barkantine unit from April 2017 to March 2018.

The service treated patients from a very diverse background, both culturally and ethnically. The demand for translation services for around 100 different languages had been acknowledged as an area that placed a large demand for resources within the maternity department. As we found before, there were systems in place for the large Bengali population that were served by the hospital, with advocates in place and dedicated Bengali only antenatal classes and a large amount of Bengali accessible information. Demands for the advocacy service were high reflecting the needs of local people the service was under review to include other translation services as well as British sign language. There had been work with producing more leaflets in other languages and mothers were encouraged to use a Baby Buddy App that gave advice to mothers via an electronic device. This advice was aimed at promoting health and wellbeing through pregnancy through to the first six months of the baby's life, and could be accessed by those for who English was not their first language.

The homebirth team had been set up in January 2018 and data had been collected to assess the progress in the first six months. The homebirth team had been set up with the recruitment of three band six midwives and one band seven midwife. 67 mothers had been referred to the homebirth team, of which 47 had been cared for. Of these, 29 had ended up birthing at home. This was already an increase on the previous year (2017) before the homebirth team had been set up and when in the 12 months there had only been a total of 22 home births. 92% of the mothers who had birthed at home since the birth team had been set up in January 2018 knew the midwife and had fed back to staff their high levels of satisfaction for continuity of care.

The Lotus Birth Centre had been open for two years and there was a dedicated Birth Centre Manager supported by 12 whole time equivalent staff of band five and seven staff.

There were about 55-60 deliveries per month in this midwife led unit. There were always three midwives at any one time supported by community midwives during the day.

Gestational diabetes had been identified as an area that required further resources. The prevalence had increased in the local population from 11.5% in 2013 to around 13% now. This was considerably higher than the national average of around 4%. There were dedicated clinics for this group of patients and advice on lifestyle, diet and implications for pregnancy and after delivery. There was also an understanding that diabetes in the community was disproportionately high compared to national averages and there was a dietician based in the antenatal clinics for patients to be referred to. This was in addition to consultant and midwife dedicated diabetes clinics for monitoring and progress of each pregnancy. This was another area where the hospital, in addition to antenatal classes and feeding services, where local advocates were being employed. These advocates were not just interpreters for language needs, but had been trained by hospital staff to understand the issues surrounding the normal and the more complicated pregnancy.

## Meeting people's individual needs

There was a breastfeeding team that ran a breastfeeding class every morning. Patients spoken to at the inspection had all been informed of the breastfeeding help that could be sought and which was being provided by a large team of employed staff who had their own management team based at the hospital.

Some side rooms in the labour ward were available for use as amenity rooms and were charged at £150 per night. This meant that women could stay there with their partner if they wished and take advantage of the baby feeding and the other support groups available, while having the privacy of a room rather than a bed on the ward.

The catering included food suitable for most religious, cultural or moral options, including halal. However, partners of patients were not allowed to order food or refreshments to eat with the patients, which some relatives and patients were unhappy about. This rule had been brought in with the objective of ensuring improved patient care as there would be less noise and movements going on

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in the maternity department with people ordering food. Generally, it had resulted in partners or relatives eating and meeting away from the maternity wards, and therefore less people staying for long periods of time.

Of the patients we spoke to during the inspection, they stated that they felt listened to and well informed. They also told us they appreciated the honesty of the information given and felt reassured and safe.

There were processes in place to enable the staff to request interpreters, and interpreters in the Bengali language on site were easily accessible, due to the large Bengali local population. There was also a facility for telephone interpreting services if required. The details of these were available for all staff on the intranet.

Information leaflets for patients were in English, but there were contact details to obtain leaflets in different languages. In addition, each patient had a welcome pack which provided advice on the discharge process, breastfeeding and maternity contact numbers. There were also information sheets for birthing partners giving them information on what equipment and support they could provide, and what to expect.

In the birthing unit there were information posters in nine separate languages offering PALS assistance and signposting to the interpreting service and the deaf service.

There were monthly antenatal and antenatal breastfeeding classes that were aimed solely at Bengali women and were conducted in their first language. These were freely provided by the trust and were easy to book through staff referral or through an internet booking system.

Staff were trained in dealing with all religious and moral beliefs and, provided they were satisfied in the patient capacity to consent, would support the patient right to choose or refuse treatment.

There was a clearly accessible pathway for staff to follow for vulnerable patients and to enable them to be responsive to the individual needs presented, as well as taking account of the safeguarding needs that may be considered.

The bereavement team ensured that there was always support available for the parents, and this sometimes involved patients being given staff personal numbers where appropriate. Feedback was taken wherever possible through direct communication and through the bereavement groups. This had led to discussions regarding

improving the facilities in the dedicated bereavement room. There were now departmental plans to move the suite to a larger space where tea and coffee making facilities would be made available and where the decoration would be improved to make it more comfortable. At the time of the inspection the dedicated room was not particularly welcoming or comforting.

There was also a group set up within the trust to ensure that staff had a support network in place for when they needed emotional support.

In June 2018, an internal study was commissioned that reported on the feedback from 49 women who were in postnatal care. The results were positive. When asked if they thought that they or their partners were involved as much as possible in the decisions and the agreement of a care plan, 94% agreed that they had been. When if they felt that any concerns they had during labour had been listened to, 88% responded that they had. When asked if they understood all that the doctors and nursing staff had said to them during labour and birth, 100% said that they had. 95% stated that they had received the pain relief that they requested. Overall the study recommended, based on the findings, that the maternity department progressed the Better Births (2016) plan that they should strive to provide even more continuity of care and to inform women when they were leaving the room and that they could call for a health professional when required. There was evidence of the commitment to the Better Births plan and a commitment to a named midwife and buddy system for midwives (for continuity if one midwife was unavailable) and to case loading amongst senior midwives. Generally, the study had demonstrated that most women rated their care as excellent or very good at the Royal London.

The Lotus Suite was involved with GP locality meetings to inform patients of key improvement programmes and maternity pathways such as choice of place of birth, triage principles and referral pathways. This was on track to be continued on a quarterly basis throughout the year. Additionally, the staff were actively involved in the Tower Hamlets Together initiative which promoted joint working with Public Health England, children's services, health visiting, education, social care and the voluntary sector. There were several initiatives that were now more embedded and widely offered than at the previous inspection. These included the placenta accreta service, the 'My Body Back' clinic, and birth reflections clinic, a birth

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planning clinic, a specialised breech service, a homebirth team, a specialised obstetric team, a self-administered inpatient medication project and a postnatal contraceptive provision.

The trust website was now updated with a maternity specific section being developed to include easier access to pregnancy leaflets and an ability to translate the literature through an internet translator application.

The birth unit staff attended community events with the Tower Hamlets area to further provide support and information to the local community. There was a continued implementation of social media as an effective way of communicating messages to the community.

The Lotus Birth Centre, which was the midwife led part of the birth unit, had 721 births from April 2017 to April 2018. There were four large birthing rooms available that all offered either a permanent plumbed in birthing pool, or the option of an inflatable pool. There were a variety of facilities available, including birth balls, slings for support, bean bags, stools and technology such as televisions and provision for media devices to be used. The lighting could be dimmed as appropriate, and the rooms were large enough to allow the mother to walk around freely and for any partners to have ample room to wait in the room alongside. There were double beds available too if desired. The Barkantine was a standalone smaller unit, also completely midwife led, that had five birthing rooms available, with birth pools. There was the option for mothers to attend here if unable to attend the Lotus, provided they still met the low risk criteria for a birthing unit.

## Access and flow

Several staff stated that the Lotus Birth Centre now located in the hospital had made a difference for the better in the last year. The flow of certain patient groups had been improved with needs being able to be met at the one location. The opening of the centre had also increased capacity and resulted in less unit closures due to inability to cope with the fluctuations in demand.

A senior midwife had undertaken a postnatal project that had an aim to improve flow in this area and staff did comment that flow was getting better. We asked four matrons their thoughts on the improvements in flow and the response was that flow had improved dramatically with the introduction of the on-site Lotus Birth Suite that had

reduced the volume of patients going through the other wards and had a positive effect on the patient experience for those at the suite. It had resulted in more diabetic mothers also being able to use the Lotus Suite which had freed up the flow in other areas. There was one caveat however, in that the Lotus Birth Suite staff had highlighted to management that there was an issue at certain busy times with getting mothers transferred to the high risk delivery suite when the need arose. This was clearly a potential risk and had been highlighted to the maternity management team. This was currently being addressed with discussion and a resolution to all staff to ensure the right access to the most appropriate birthing division.

There were other ongoing projects concerned with increasing the triage and antenatal flow and with the processes attached to the induction of labour to assess if further capacity and flow could be improved. The programme of introducing Enhanced Recovery in Obstetric Surgery (EROS) for planned C-section operations had further contributed to increased flow within the wards.

Prospective parents were encouraged to consider other options in addition to the site at the Royal London itself – such as the local purpose-built midwife led centre in the Isle of Dogs, and also the possibility of referral to the home birthing unit. The aim was to further future plan and ease the pressure on the Royal London birth unit.

There was a discharge lounge at the end of the postnatal wards. Women were taken here while they waited for their discharge paperwork and medications, meaning that the bed they were in could then be vacated for the next patient. Discharge patients were highlighted at the handover every morning and there was a specific midwife in charge of discharge.

There were a maximum of six inductions within the unit, by appointment. Elective C-sections were sent straight to the labour ward on arrival. There were then two theatres and one recovery bed within the high dependency unit (HDU), although if there was capacity in the HDU a second bed could be used for recovery.

There were spare beds for pre-HDU mothers as well as 15 beds in the labour ward, to give further flexibility for moving patients around to accommodate the unit need.

The antenatal clinic had made improvements in the previous two months to improve waiting times by spreading the clinics over a longer period of the day. Full

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staffing levels had helped accommodate this. In this department there were ten consulting rooms, and each clinic was consultant led, midwife led, or a mixture of both, depending on need. This is also where the breastfeeding and dietician facilities could be accessed by patients. However, waiting times were still an area identified by patients and staff as one area that needed to be improved upon to enhance the patient flow through the department.

## Learning from complaints and concerns

From April 2017 to March 2018, there were 75 complaints across 17 wards within maternity services at Royal London Hospital. The trust took an average of 62 days to investigate and close complaints, this was not in line with their complaints policy at the time, which stated complaints should be completed between 10-60 days.

The top three wards with the highest number of complaints were:

- Ward 6E: 20 complaints
- Ward 8F: 17 complaints
- Antenatal clinic: 12 complaints

Thirty-six complaints related to diagnosis/treatment. The general themes from the complaints related to the poor care provided by staff; misdiagnosis, poor patient handling, lack of compassion and care from staff towards patients and poor attitudes from nurses.

Since this data was compiled a new complaints policy review had taken place that allowed a timeline to be agreed on an individual complaint basis, provided that the complaint was acknowledged within a three day timeline. We saw an example of a complaint that had been investigated by the management of the department and written by the head of nursing for the Royal London Hospital. The response was well considered and fair and contained all the correct information for taking the complaint further.

The time period of December 2016 to June 2017 had seen a record number of complaints (60 in total for a 6 month period). From July 2017 to July 2018, the number of complaints to the Royal London site fell by 42% on the previous level of complaints in the year before. This reflected the views of staff and patients on the inspection when they stated that patient experience was now improved and that feedback was asked for and learned from.

Several members of staff felt that the staff and the management were listening to patient feedback, and complaints. Staff cited this as a reason that the number of complaints to the department were going down and one staff member thought this had a direct bearing on the level of serious incidents also reducing over the last few months. Trends were being analysed and actioned. One area for continuing need of improvement had been identified as the waiting time length. This still needed to be addressed as an ongoing concern.

Each complaint was allocated to a matron or service/ward manager to ensure that one person had responsibility for each complaint to further ensure that they were dealt with appropriately. At the time of the inspection there were six pending complaints that were being dealt with in a timely manner. All complaints were sent to the director of nursing for sign off by them or the chief executive. These could sometimes lead to resolution meetings where the clinician and the complainant could meet, with another member of staff who could offer support to both parties, (or two clinicians and the complainant) to discuss and gain an understanding of how to progress or manage the complaint. Each complaint would only be signed as having been dealt with once a final letter with details of the Health Service Ombudsman had been sent and received by the complainant.

The patient experience midwife met with the governance lead to assess and report on the PALS queries and the complaints that had been made to the trust. This member of staff was also a PMA (professional midwife advocate) who supported midwives in their clinical practice and was an advocate for women. Generally, there was support for this role, although it was noted that there was no protected allocated time in the shift for this work.

Complaints and patient experience were also discussed at the trust maternity board and the trust patient experience committee.

The postnatal ward had recently won a trust award for the improvement in the reduction of complaints. Working on patient feedback one improvement they had made was to allow partners to stay overnight on an adjacent upright chair.

From April 2017 to March 2018, there were 39 recorded compliments given to Barts Heath NHS Trust. No site or core service breakdown is available.



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There were many further compliments that were displayed in the unit, for all the wards. In the delivery suite there were several recent thank you cards and sentiments that expressed appreciation for the compassionate care, the individual attention given and the support shown and given.

## Are Maternity (inpatient services) well-led?

Outstanding



At the previous inspection we rated this service as requires improvement for well-led. This inspection we have rated it as outstanding for well-led because:

- There had been a large improvement in governance overall in the department, with an increase in meetings and communication between staff. At the previous inspection, there had been concerns regarding inconsistent and ineffective systems of governance. Now we saw that leadership was effective and clear with forward planning and ambitions to work with international quality programmes and to measure highly against national markers.
- The service had recently been restructured so that maternity and women's services were separate to children's services. This had meant a change in management responsibilities for some staff, but the department was working effectively and staff felt communicated with and understood the management structure. Non-clinical and clinical management shared office space and this contributed to the reduction in barriers to communication and shared ideas in the day to day management of the department.
- There was a progress in information technology, although going forwards improvements were still to be made. We evidenced trust commitment, however, to continuously support and proactively drive data and information sharing and accessibility.
- The trust board were now perceived as working more constructively with the maternity department. Staff knew the leadership structure and were able to present their business cases to the board for consideration and there were examples of the board acting on maternity demands for staff and environmental improvements.

This was a large improvement from the previous inspection where staff felt that the leadership was top down only and that the trust board were not necessarily receptive to staff consultation.

- The maternity department was now more integrated into the site and the trust as a whole with regard to inclusion in site and whole trust meetings and initiatives, for example infection control meetings.
- Staff culture had improved considerably since the previous inspection in 2017, when there was evidence of bullying and unprofessional behaviour. There had been staff sickness issues too. At the latest inspection in December 2018, staff vacancies and sickness levels had improved noticeably and staff thought that the culture change had been led from the leadership and clinical/midwifery leads. There was more evidence of team working and honesty among colleagues and a sense of shared purpose and inclusion. All staff could speak up and contribute.
- There had been a focus on better and more resilient training. Mandatory training was now compliant with trust targets and staff were encouraged to act up to more senior roles where possible in order to achieve further work experience and encourage career progression.
- There was now an embedded and comprehensive risk management system and escalation process, that also included a well-managed feedback and learning to staff. At the previous inspection, there had been a backlog of incidents and an ineffective process with dealing with them. There was now a robust and highly effective system in place and all risks that had been addressed in a timely and appropriate way. This was continually reviewed and all issues addressed quickly and openly.
- Staff embraced the leadership plans for improved patient experience and continuous improvement. There were effective and embedded processes for learning in response to feedback, incidents and complaints. Leadership demonstrated a high level of knowledge of the challenges and priorities in their service and in the healthcare environment and there was a clear culture of innovation and improvement regarding sustainable and high quality care to patients.
- There had been robust and effective changes to ensure better baby and mother security was in place. Generally, staff concerns and risks had been listened to and action plans initiated accordingly. There were still some residual concerns by some staff over the presence of a

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security guard, but overall the risks had been understood and addressed well and infant abduction processes and drills were comprehensive and sophisticated.

- There was an embedded and ongoing system of engagement with the local population to improve and tailor the care to the specific needs of the community. Feedback and participation was actively encouraged. There was a clear commitment from leadership to all staff, patients and stakeholders to continually advance the service.

## Leadership

There was a director of midwifery that covered the three trust sites that included the Royal London. Each site had a head of maternity that had professional responsibility to the director of midwifery.

There were several formal meetings with senior management and the number of these meetings had increased in the last year. For example, one senior member of staff was a member of the clinical board which met monthly and ensured cross site communication with an aim to best practice. Another example were the monthly executive meetings where the business cases for the unit could be presented.

Cross site board meetings had also led to standardised criteria across all sites in the trust for many aspects of care being offered, such as transitional care and intrapartum care.

There had been a recent split of services at the Royal London so that children and women departments were separately managed, and maternity was managed alongside gynaecology. This meant that the head of midwifery for the Royal London site was managerially responsible to the divisional director.

The director for midwifery for the Royal London hospital cited three major improvements since the previous inspection – staffing levels, staff wellbeing and better governance. Generally, this was thought by many staff to have improved through more responsive leadership. The trust board now had a maternity champion and business cases had been presented to the board for their consideration.

Most midwifery staff, when asked, felt that management had improved since 2017 and was continuing to improve. They felt that management led by example on many

occasions. There were only a couple of dissenting voices that felt that sometimes the leadership felt too distant and that senior managers should be seen more often on the wards. Most staff felt that leadership was now much more visible on daily shifts and that this had changed the culture and the attitude of staff for the better. There was a good awareness of who the line management were, and the leadership structure above this.

Progress was being made regarding further ratification of site guidelines and further alignment with trust wide policies. This included standardising the criteria for both the Barkantine Birth Centre and another trust midwife birth centre at Barking.

## Vision and strategy

There had been a clear strategy in place since the previous inspection by the CQC in 2017, where there were concerns raised that the maternity department was not meeting the needs of local people as responsively and effectively as it could. Staff had been informed of the changes that were required of the service through an approach by management that had focused on honesty and transparency. It was made clear that improvements in patient experience were required and that the culture of the department needed to be enhanced. Strategy was communicated through various staff level meetings and through better use of the intranet and correspondence, and through the improved use of noticeboard message boards and quality improvement initiatives and targets.

There was a process in place to promote band seven midwives as leaders and not to promote only from the senior management team. Staff now felt that career progression and ambition could be more achievable and that good work was recognised.

Management used a variety of forums to enable them to generate ideas for strategy going forwards. This included weekly governance meetings which focused on multi-disciplinary meetings; monthly governance meetings that focused on looking at trends and quality improvement; junior and senior consultant weekly meetings; midwifery daily huddles and weekly thematic meetings; monthly quality and safety meetings; and idea generation meetings involving the doctor, midwife and management staff.

Feedback was encouraged by the leadership. This was clearly acted upon and the feedback from the patients, the

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community, and the staff, was leading to further engagement in community birthing and better tailored care within the hospital for the local population. There was a clear vision to personalise the service for the benefit of all stakeholders and service users.

## Culture

There was an emphasis on improving staff morale and in retaining and progressing those in employment with the trust. There was a culture that had begun in the last year for staff to have opportunities to undertake duties in higher bands for a limited time to gain experience, and hopefully, progress up the staff bandings. There was an increase in secondments also as part of this. Several staff gave examples of where they had been able to increase their duties and this had led to more pride in their work.

There was a culture of ambition within the department and an increase in training completion for mandatory and job specific training.

There was a recently introduced culture of increased openness and honesty. Every ward had a noticeboard that clearly showed all the up to date data on complaints, compliments and displayed staff availability and the risk register. This could be accessed and read by all staff, patients and relatives. This was part of the Tree of Learning display that staff contributed to.

Staff were rewarded for their dedication to their job and there was a system in place to nominate and vote for the star staff member of the month. The staff member who achieved this accolade was given a certificate for their staff records and given a paid day off from work.

One patient, and occasional consultant, wanted to be interviewed by the inspectors. She wanted to express her satisfaction with the unit and stated that she found the turnaround in the department to be extremely good. Further she added that ‘if you could go back in time and tell me two years ago that I would be having my babies there I would have laughed, only because the atmosphere was so unwelcoming. With the same staff, and same premises, the atmosphere is completely different, thanks to the hard work of the management team, the RLH executive support and consultant recommendations.’

A newly qualified member of staff stated the culture had improved greatly since the beginning of their training and that hard work was now recognised. Staff appreciated the

new initiatives that management had put in place where there was a star of the month award and an internet compliments system where good practice could be acknowledged by all staff.

The inspection team noted the general sense of pride that staff stated they now felt in the department and the comments surrounding the number of positive changes in the last two years. Staff and management were honest about feedback and several staff stated that there was an inclusive and happy environment. This was a noticeable change from the previous inspection where there were seen to be staff difficulties and a more pervasively negative environment. At the time of this inspection staff were dealing with the death of a staff member and it was noted that there was an immediate support network implemented by management to allow staff to take time to talk about their loss. A staff meeting was called in order that everyone was informed and offered compassion by management. It was evidenced that staff were constantly asking about the welfare of colleagues and ensuring that they could take time from work for a refreshment and a talk with a colleague. There had been counselling offered to all staff when a recent traumatic incident had been dealt with at the hospital. Staff stated to inspectors that they felt that management in the department had improved with the caring culture for staff and for parents. One doctor described the excellent support that they had received following a recent personal bereavement, and that staff from all disciplines within maternity had offered help or to listen to them. We saw that over the Christmas period all staff had a welfare check to ensure that they had taxis booked if required.

On the inspection it was seen that all staff, including all medical and midwifery staff, would bring cakes and other homemade food in for all staff to eat on the shift. This had the effect of staff coming together on a casual basis for refreshment breaks in a designated room, and fostered a good atmosphere and a chance to chat about personal and professional topics. Staff seemed to appreciate the ability to take time to unwind from the shift for a few minutes. It also encouraged a culture where staff from all over the maternity wards could mix with staff that they may not otherwise converse with. There had also been an increase in other social aspects such as staff celebrating other staff birthdays more often, and workshops where staff could determine what would make a good day.

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## Governance

The leadership within maternity were involved in the site quality and safety meetings that occurred once a month, and where all Royal London Hospital concerns could be discussed. It was also a forum for discussion of standards in general, patient experience, equality and diversity and signposting in hospitals.

Governance standards of the Royal College of Midwifery states information should support midwives and other clinical staff so that they have access to the relevant data to assess and improve outcomes. This was not in place at the time of the last inspection, but significant improvements had been made in 2017 and 2018, and at the time of this inspection there was a clear governance dashboard on display, with maternity information and risk register information available for staff and service users to access. Feedback was encouraged and in the literature around the displays were ways to contact the management and the trust. Each ward had a display area where all the information was available and both positive and negative news was clear and transparent. This included staffing levels, risks, incident reporting, compliments and complaints and never event information.

At the time of the inspection there were virtually no outstanding serious incident actions as most had been acted on and resolved. The focus was to act quickly and to pursue actions until they could be closed.

The inspection team attended a governance meeting that was held weekly in the department. We saw that there was an extensive and comprehensive remit where complaints, panel review outcomes, serious incidents, incident reporting dashboard, and the risk register were all discussed. Updates were discussed, and this included perineal support advice, FGM policy and procedure refresher updates, post-partum haemorrhage learning and future workshops taking place (which included perineal suturing and educating junior staff in forceps deliveries as an example).

There was a monthly governance newsletter that was displayed for all persons to see on the wards, and communicated to staff. This newsletter set out the top five current risks, the prevention of never events, current incidents, complaints and then good news regarding audits or other performance indicators. The newly in post maternity management stated to inspectors that there was

a governance heavy structure to the maternity unit with a heavy focus on safety. The management had a weekly governance meeting and felt that the maternity unit was run as a 'hospital within a hospital'

At the time of the inspection, there were around 30 guidelines relating to maternity care to be found on the intranet that were easily available to all staff. These had been reviewed at the time of the inspection as some had initially been found to be out of date for review. This was blamed on an IT issue with legacy policies being available. The leadership were reviewing the policy governance systems at the time the inspection team were at the hospital.

When asked if there could be improvements, some management stated that governance may be improved with a permanent operational lead in place that could liaise further with the clinical board and progress recent concerns more effectively, such as foetal imaging archiving and the lack of current capacity for this. A buddy system was soon to be implemented in management, so that another managerial colleague could attend the unit and oversee governance when a maternity manager was unavailable.

## Management of risk, issues and performance

A hospital assurance framework was in place and that brought to trust attention the risks flagged by the maternity department. All risks had a monitored risk rating and a colour code for immediate attention if the risk was deemed to be medium or high. The storage of anomaly scans was deemed a high risk, that had been brought to a low risk at the time of inspection through being raised and an action plan generated and pursued. Management also reviewed the performance meetings monthly, the maternity dashboard, waiting times, reports to senior management, clinical board liaisons, and the weekly executive management meetings.

One member of staff stated that one slight worry that they still had, despite the working environment improving in the last year, was the time required to undertake administrative duties. Sometimes these administrative duties had to be delayed as clinical duties would always take precedence. The member of staff was not sure that the answers to the administrative burden would ever be completely managed

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in the short or long term as it was an ever-present problem in modern healthcare. However, the member of staff did concede that the increased recruitment was a positive move by the trust and had lessened the issues.

It was evidenced through staff feedback that there was a growing supportive environment about mitigation of risk. One example given was when there was an urgent need for an anaesthetist. There was now interdepartmental co-operation and a knowledge that there was a culture where consultants could be contacted whenever, and not just when at the hospital. There were examples of previous perceived risks due to lack of theatre staff and this had led to staff acknowledging that medical staff were now more inclined to attend when required.

One risk that was highlighted was the shortage of a midwife in the triage area. At the commencement of the inspection process it was shown that a new midwife had been recruited and would shortly be working in this area. This demonstrated the increased responsiveness that the trust was showing to the department and the emphasis that was being placed in mitigating the risks that had been flagged to the leadership.

The latest business case presented involved an allocation of £350,000 for a project to be able to feed foetal images on to the electronic systems and patient notes to ensure that risk was reduced regarding concerns not being followed up, and to be more effective with the care offered.

Management felt that local leadership performed better for the offices of managerial, non-clinical, staff being based within the clinical staff offices, so that there was a daily communication between both. Since 2015 the trust had been continually working towards a more local site based leadership presence with the aim of improving governance and risk management.

## Information management

Since the previous inspection there had been a continued staff investment in the use and accessibility of information technology (IT). There were still some issues trust wide with IT and therefore this remained on the risk register for the trust. These risk issues centred around accessibility and reliability of the IT system. Management stated to inspectors that the IT systems were not wholly robust and there needed to be equipment replacement in the near future.

During the inspection it was found that there were some difficulties in locating a small amount of current policies. This was immediately reported to the senior leadership who quickly located the problem as a temporary routing issue that had occurred that week and this was immediately remedied. In the two months leading to the inspection, the central 'We Share' team had been working to make the pathway to new guidelines more direct. This had meant that there had been a change in how to locate the local policies and local protocols. New posters and literature to signpost staff to this new process of searching for policies had been distributed and policies could now be searched for effectively using key words. This recent change, done centrally by the We Share website team was intended to reduce the numbers of 'clicks' to a document and therefore was more user friendly and less time consuming. The Perinatal Board had been involved with this new process and the clarification of guideline reviews and prioritisation when the maternity policies were uploaded onto the system. There were however, a few outstanding concerns that remained at the end of the inspection regarding some policy location, including the omission of a 'fresh eyes' procedure on the cardiotocography (CTG) policy on the intranet and the updates still required for the maternity sepsis policy that was in draft form only and had not been ratified. The anaphylaxis flow chart attached to the anaphylaxis box was different to the trust policy on the intranet. This was identified during the inspection and the leadership were updating this at the time of the end of the inspection period.

Of the legacy policy that were found by inspectors that were being removed by the leadership at the inspection were the out of date Declining Blood Products in Pregnancy policy and the Antenatal Foetal Heart Rate policy, which stated that review was due in 2013. The updating and reviewing of these policies was supported by the site medical director, the corporate director of midwifery and the chair of the Women's and Neonatal Clinical Board.

## Engagement

Staff stated that since 2016 the maternity department had been more connected to the trust board and to the other departments in the hospital. Senior maternity management had been invited to the trust meetings, including the infection control meetings, which had not been the case before. There were more opportunities for

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staff clinical training and staff stated that they were now more aware of training days and career progression. This communication had been extended to gathering feedback from other stakeholders in the trust and the commission of a Healthwatch report. This Healthwatch report had reported a 70% positive patient feedback in 2017.

A consultant worked with the management after the previous inspection in 2016 and recommendations were taken on board to improve the working environment. The wards had used wall stickers to brighten up the space, and the midwives had also used battery powered candles to soften the lighting to enhance the patient experience. The staff and management undertook workshops where the team started to think about how to shift the culture, and how to fix some of the issues that the midwives had historically complained about. The management team took time to listen to staff and then started to reward them through all the hospital/trust award schemes.

There had been further engagement with staff revolving around improving the rotas, and staff now have their rota confirmation and holiday allowance confirmed a year ahead which staff state has made a positive difference to their perception of work. One member of staff stated that the senior midwifery staff had made changes in the last year and that staff felt more supported and listened to. This view was corroborated by several other staff in the department.

GP antenatal care in the community was being phased out, and this was a focus going forwards for the management team, in addition to the rolling out of the home birth initiative.

There was engagement with the other sites across the trust, including the Barkantine Birth Unit, Newham University Hospital and Whipps Cross Hospital. This was mostly through the director of midwifery.

## **Learning, continuous improvement and innovation**

After the previous inspection, it was identified that the patient outcomes were good, but that patient experience had still been found to be an area of concern. A patient experience consultant was brought in who identified that there were areas for improvement from maintaining more eye contact with the patients to brightening up the wards and introducing further ways to ensure the atmosphere was more conducive to enjoyment for staff.

The management of the department were clear that further initiatives were to be taken soon to maintain a culture of further improvement and innovation. These included continuing the women centred care philosophy and offering women more options where feasible and to continue to improve the patient experience. Staff, including senior management, had the aim to providing individualised personal care for all. There were progressive plans commencing where each member of staff in a management role would carry a caseload. This was already rolled out amongst the band eight staff, and some band seven staff, and was going to be rolled out to other grades. This would ensure continuity for antenatal through to postnatal care.

Major risk for the trust was the financial position going forwards. The finance director of the trust had highlighted that because of the financial position there was a possible major risk that capital requirements would be higher than the capital allocation for the hospital. Although no specific risk was allocated to the maternity department by the board under this risk, it was acknowledged by maternity staff that finances may have a future bearing on risk. Plans were in place to improve the bereavement room and to increase the capacity of the high dependency unit, but staff stated that these were subject to budgetary considerations.

The move toward community treatment was an area of continued improvement in line with the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists guidance and the Better Births five year plan.

The head of midwifery services stated that she wanted to see continuous improvement. One piece of evidence to support this was the commissioning of a study in June 2018 that aimed to achieve continuous improvement in the quality of patient care provided in response to patient feedback.

There were future plans which involved a caseload team of four midwives that would aim to increase continuity of care. From January 2019, midwives would be involved with women from four different health clinics and caseload them from booking to postnatal, with the aim of birthing at the Barkantine or Lotus birth centres. There was also a documented plan to link with the homebirth team to promote the birth centre. The trust website was to be updated imminently with maternity videos and better interfacing advice.

## Maternity (inpatient services)




There were social media and community held forums to inform and educate prospective mothers regarding the home birthing team and the benefits of this for certain groups of patients. This was an area that the unit were looking to expand, following national initiatives.

Another managerial focus was to ensure that the standards across the trust, including the Royal London Hospital, Newham University Hospital and Whipps Cross Hospital,

and the Barkantine Birth Unit, all had the same rigorous approach to baby safety and staff welfare. This was identified to inspectors as an area of continuous improvement.

When the issue of residual security concerns, despite the improvements, and administrative banding grades were raised with management, it was stated that this would be considered further and would review further in the future.

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Safe	Good	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Good	
<b>Overall</b>	<b>Good</b>	

## Information about the service

End of life care encompasses all care given to patients nearing the end of their life and following death. Patients received care in any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, bereavement support and mortuary services.

The definition of end of life includes patients who are 'approaching the end of life' when they are likely to die within the next 12 months. This includes patients whose death is imminent (expected within a few hours or days) and those with:

- advanced, progressive, incurable conditions,
- general frailty and co-existing conditions that mean they are expected to die within 12 months,
- existing conditions that put them at risk of dying if there is a sudden acute crisis in that condition,
- life-threatening acute conditions caused by sudden catastrophic events.

The Royal London Hospital is a large teaching hospital in Whitechapel, east London and is part of Barts Health NHS Trust, serving 2.5 million people across east London.

The Royal London Hospital provides district general hospital services for the City of London and the London Borough of Tower Hamlets. There are 675 beds and 110 wards.

The London Borough of Tower Hamlets has a population of 272,000 which includes a large Muslim population and an established British Bangladeshi business and residential

community. The local authority for the City of London, namely the City of London Corporation, has a resident population of 9,400 but over 300,000 people commute to and work there daily.

There is a leadership team at site level, led by a managing director and supported by a site management board which is comprised of a deputy managing director, director of nursing, medical director, head of quality and efficiency, head of finance, director of estates and director of operations. They report to the trust executive. They are responsible for operational management, clinical improvement, governance and budget management. Clinical divisions are led at site level and report to the site management board as well as to the clinical boards of cancer, cardiovascular, children's health, emergency, medical, surgery and women's health.

End of life care was delivered on most wards at the Royal London Hospital, by ward staff who were supported by specialist multidisciplinary input from professionals such as occupational therapy, delirium and dementia, cardiology and gastro-psychiatry. There is a specialist palliative care team (SPCT) who provide specialist palliative care and end of life support, advice and education across the hospital.

Between November 2017 and October 2018 there were 917 deaths at the Royal London Hospital. 45% of those patients were seen by the SPCT. The team is comprised of palliative consultants, clinical nurse specialists, a nurse and a social worker. The role of the team includes assessment and care



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planning for patients with complex palliative care needs, treatment, medication, symptom control and psychological support for the patient and their relatives and loved ones.

During our inspection we spoke with four patients and their relatives. We also spoke with 43 members of staff, which included ward managers, nurses and healthcare assistants, ward doctors and specialist support staff such as occupational therapists and practice development nurses. We also spoke with senior managers, porters, mortuary staff, chaplaincy, bereavement coordinators and all members of the specialist palliative care team including trust wide leads.

We observed care and treatment within the wards and reviewed 18 care records. We reviewed a comprehensive number of documents relating to performance, risk and governance. We also reviewed 27 Do Not Attempt Cardio-Pulmonary Resuscitation forms.

## Summary of findings

At our previous inspection in 2016 we had rated end of life care as requires improvement overall. At this inspection we rated end of life care as good overall. It was rated as good in all domains. We found:

- The hospital worked well with assessing and responding to patient risk. The specialist palliative care team staff engaged well with wards and identified patients at risk of deteriorating or dying. Patients' nutritional and pain needs were being met.
- Teams caring for patients at the end of life were adequately staffed.
- We came across good examples on wards where anticipatory medicines had been prescribed.
- There was a system in place to identify and learn from incidents that related to patients receiving end of life care. Complaints and compliments relating to end of life care were being appropriately reviewed.
- Staff groups across the hospital were suitably competent in their roles relating to the delivery of end of life care to patients and their relatives. People from different disciplines and with different skill sets worked alongside each other well to provide end of life care to patients and their loved ones.
- The hospital had implemented a care plan called the compassionate care plan (CCP) for the dying patient which replaced the Liverpool pathway. The hospital was working to published national guidance and standards in its delivery of end of life care.
- The mortuary was compliant with national minimum standards.
- End of life care was delivered to patients by caring and professional groups of staff. Emotional support was provided by ward staff and incorporated into the holistic assessments carried out by the specialist palliative care team.
- The specialist palliative care team were accessible to ward teams who told us they were responsive to patient needs. They saw 95% of patients within 24 hours of referral.
- The hospital had teams in place that were meeting people's individual end of life care needs.

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- There was clear accountability at board level and clear leadership for end of life care within the hospital structure.
- There was a trust wide and site based end of life care steering group with good engagement at each level. The hospital demonstrated improvement work being monitored within this structure. There was an end of life care strategy that was aligned to published national guidance. Progress with guidance was monitored at the end of life steering group.
- The hospital demonstrated that learning and improvement were taking place at a meaningful level. Risks were being effectively monitored.

## However;

- The system for loaning out and recovering syringe drivers had led to a shortage which meant they were occasionally unavailable.
- Staff were unclear about how and where assessments of patient capacity should be recorded. As a result, the specific section within the electronic patient record was not being completed.
- Patients' preferred place of care was being documented in the electronic patient record. At sustainability and transformation partnership (STP) level, metrics were being set up locally to measure achievement of preferred place of care but at present, the hospital was not measuring this.

## Are end of life care services safe?

Good



We rated safe as good. At our previous inspection in 2016 we had rated this service as requires improvement for safe. At this inspection we rated it as good because there had been improvements:

- At the last inspection some ward staff told us they had not received training on how to use the new nursing bundle documents and there were gaps in patients' nutrition and fluid records during the night shift. At this inspection we found the hospital worked well with assessing and responding to patient risk. The specialist palliative care team staff engaged well with wards and identified patients at risk of deteriorating or dying.
- Statutory and mandatory training and completion rates of all end of life care staff groups demonstrated compliance.
- End of life care training was not mandatory for all staff. This was planned to start in 2019. However, there was a comprehensive number of training and advisory activities throughout the hospital for staff that enabled them to care for patients at the end of life and their relatives competently.
- Ward staff and specialist palliative care team staff were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults and children.
- All areas of the hospital we visited were clean and hygienic. This included wards, the mortuary and viewing suites.
- Teams caring for patients at the end of life were adequately staffed.
- We came across good examples on wards where anticipatory medicines had been prescribed.
- There was a system in place to identify and learn from incidents that related to patients receiving end of life care.

## However;

- At the last inspection we found that syringe driver stocks were running low due to patients taking them home and

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the syringe drivers not being returned or collected. At this inspection we found the system for loaning out and recovering syringe drivers had led to a shortage which meant they were occasionally unavailable.

## Mandatory training

Statutory and mandatory training and completion rates of all end of life care staff groups (including medical staff, nurses, HCAs, porters, mortuary staff) was provided up to November 2018. SPCT team nurses and clinicians were 100% compliant with statutory and mandatory training apart from one who was below the trust target at 87%. Bereavement and portering staff groups were both 100% compliant.

The trust provided details of the statutory and mandatory training topics that end of life care medical and nursing staff within the specialist palliative care team (SPCT) were required to attend. The comprehensive list included: complaints, equality and diversity, conflict resolution, fire safety, early warning systems, 4 Harms - catheter acquired infections/ slips, trips and falls/ pressure ulcer prevention/ VTE, dementia awareness and basic life support.

For chaplaincy services, there were seven members of staff who all had 100% compliance. Modules included conflict resolution, dementia awareness, infection prevention and control and safeguarding adults and children levels 1 and 2.

All first year training doctors and core medical training doctors had palliative and end of life care included in their training programmes. End of life care was also being added all medical induction modules.

End of life care training was not mandatory for all staff. Senior managers told us there was a recognised need for training in end of life care to be mandatory for staff. This was raised in the trust wide end of life steering group and a commitment had been made for end of life care training to be provided on the trust induction programme. This was planned to start in 2019. However, there were a large number of training and advisory activities throughout the hospital for staff that enabled them to care for patients at the end of life and their relatives competently.

## Safeguarding

Safeguarding training was incorporated into mandatory training. SPCT staff were trained in safeguarding levels 1 and 2. They did not have to do level 3 children because they did not work with children directly. All SPCT staff did the same training.

Ward staff and specialist palliative care team (SPCT) staff were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults and children. All staff had access to the trust wide safeguarding policies and procedures. These were accessible via the trust intranet. Information regarding safeguarding vulnerable adults and children processes was also on display on the walls of wards we visited.

There was a safeguarding lead for the hospital for direct support. Any safeguarding issues that came to the SPCT's attention in their work were highlighted in daily handover meetings and during weekly multidisciplinary meetings. The SPCT staff referred to the safeguarding lead for the hospital when escalating any potential issues. We were told the team's social worker also worked for the local authority and sometimes had prior knowledge about some patients already.

## Cleanliness, infection control and hygiene

We visited all areas of the hospital that provided end of life care to patients and their families. We found wards were visibly clean and hygienic. Hand washing and hand hygiene was observed as being followed. Cleaning schedules were in place and being followed.

The deceased viewing suites were clean and tidy. Toilets were available for visitors which were also clean and hygienic. The mortuary was clean and free from any odours. Fridges were visibly clean and cleaning schedules were in place.

Personal protective equipment (PPE) such as face shields, gloves and aprons were available for use by staff in relevant areas. Porters confirmed they had received training to ensure they were competent in mortuary procedures.

In the autopsy suite there were four tables. One was used for children. A separate high risk autopsy suite with one table was for infectious patients such as with tuberculosis.

The multi-faith rooms were visibly clean, tidy and well maintained.

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## Environment and equipment

The design and layout of most wards at the hospital meant there was a good number of single rooms on wards. For instance, ward 13E was a 26 bed ward with ten single rooms. This meant that although infection prevention remained a priority for single rooms, end of life patients being offered single rooms was not problematic.

There was a last offices resource trolley (bereavement box) on most wards we visited. This took the form of a compact set of metal drawers, containing information and equipment for use on patient death. For instance, information on spiritual care for all religions on death, shrouds for bodies and bags for patient possessions for the family when a patient had died.

We observed nurses using personal protective equipment such as gloves and aprons appropriately. For instance, as they entered a side room to obtain the patients' notes.

Mutli-faith rooms were visibly clean, tidy and well maintained. They offered quiet spaces where people could pray or reflect. There were four rooms catering for Christian, Jewish and Muslim faiths plus changing and washing facilities. We found all facilities clean and tailored towards those using them.

There were three deceased viewing suites, all designed to serve different needs. These were located through a separate entrance next to the mortuary. There was a waiting area. In the first viewing area was through a glass screen, with doors for access to the body. The second room was close by with direct access to the body with no glass screening. The third viewing room was a children's viewing suite. There was an option of a cradle or a cot for the body. All suites had been well maintained. There was seating available in all three and toilets were available nearby. There was also water fountain for general use.

The mortuary was located on the hospital campus in a building separate from other services. The mortuary fridges were located on the lower ground floor of the building. There was a separate entrance for hearses to be able to back up in to. This was beside the mortuary for easy and discreet collection of bodies. There were 47 spaces available with five allocated for children and four larger fridge spaces for bariatric patients. 20 additional fridge spaces were available nearby at Mile End Hospital which was also part of Barts Health NHS Trust, where there were currently no inpatient services. The mortuary manager told

us this provided adequate space. There was also a process for bariatric patients when larger fridges were needed than the bariatric fridge space available on site. These were also located at Mile End Hospital.

Fridge temperatures were checked manually; daily, in the morning. A control panel above every unit also monitored power faults. There was also an electronic system in place that constantly monitored fridge temperatures through a quality management system. If fridge temperatures went outside of the acceptable range, an alert was sent automatically. This system was tested weekly. Fridges were ten years old and were serviced twice a year. Regarding faults, we were told that one bank of fridges required regassing last year. The servicing contract is with the fridge manufacturers, who came out the following day after the fault was reported. One bank of fridges totalled ten fridges so capacity was easily managed if there were faults of any kind with one bank.

There were 15 freezer spaces available. We were told that due to funeral poverty, demand for freezer space was increasing. This was on the mortuary risk register and plans were being made for the provision of extra freezers. An area next to the mortuary had been identified for use. However, this was not currently owned by the trust and negotiations remained ongoing. The hospital carried out some funerals for people where poverty prevented them taking place. This was organised through the bereavement office.

The hospital mortuary and post mortem facilities were regulated by the Human Tissue Authority (HTA). HTA licensed establishments are required to meet HTA standards of consent, governance, traceability and premises, facilities and equipment. The hospital mortuary was last inspected in 2016. The HTA found the premises to be suitable in accordance with the requirements of the legislation. All applicable HTA standards were assessed as fully met. Eight recommendations were made.

There were two concealment trolleys for transporting bodies from wards to the mortuary. A baby carrier was also available.

The CME McKinley T34 syringe pump was in use for delivering medication by continuous subcutaneous infusion.

Wards had advanced trainers who cascaded training to ward staff. The SPCT end of life care facilitator had IV training and the SPCT clinical nurse specialists (CNS) were

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advanced trainers. Refresher training for this took place every three years. CNSs liaised with doctors to start a syringe driver on a patient and assisted wards with their safe use. Access to syringe drivers was via the clinical equipment library, which was staffed between 9am and 5pm. Porters took over this function out of hours.

Ward managers told us that for patients who were local, syringe pumps went with the patient when discharged. A stamped addressed jiffy bag went with them for return of the equipment. The district nurse was also notified.

There was a reported occasional lack of syringe drivers available at the hospital. It was a common comment from ward staff, the SPCT and managers. It was also reported to us that there was a lack of lockboxes to accompany syringe drivers which kept medication safe and prevented tampering. We were told there were a variety of reasons for this situation. It was reported that this was partly because the equipment library did not check them out properly. The system was that patients should be going home with a return envelope but this was not always happening. Ten new syringe drivers were ordered in February 2018, all with lock boxes but all the lock boxes were now gone.

Patients had occasionally gone without a syringe driver and had needed to be cannulated. For instance, one patient was currently receiving frusomide intravenously, and it had been difficult to cannulate this patient as well as being painful for them. Another issue reported to us was that there could potentially be delays in transfer to hospices as intravenously medicated patients were not accepted.

We went to visit the clinical equipment library. The room was unoccupied. We called the number stated on the door which was incorrect. There was a bleep number for contacting the team when no one was available in the library. However, when the CNS we attended the equipment library with had attempted to contact the team via the bleep, the switchboard were not aware of this method of contact. We were told by the equipment library they would address this matter.

We met with the managers of the equipment library. We were informed there were 26 syringe drivers available in the hospital and six were available for use right now. A further ten were missing with whereabouts unknown. An asset database showed where the syringe drivers were last known. We were shown the 'loan process' policy. The library managers told us they thought the loan process of

sending jiffy bags with each loaned driver that went to the community was a successful process. There was a board system that showed where the syringe drivers were currently, which was on the wards.

It appeared that there was some disconnect between what service was being provided by the clinical equipment library and what was needed. None of the syringe drivers were supplied with lock boxes which were tamper proof and recommended by McKinnley guidelines. However, we were told that it was trust policy not to use them. They told us this was a directive from the specialist palliative care team. However, the SPCT nurses strongly disagreed with this statement and told us they would much prefer them to be in place. We were also told by the equipment library managers that each nurse needed to risk assess each patient in relation to this. However, staff were unaware of this and no risk assessments of this type were in place. We were also told that the lock boxes and their keys were stored on wards which was also not the case. We were told a number of other things such as boxes were not considered a necessity, that boxes could cause more harm, that the drivers could be tampered with even with boxes, including battery removal, that the keys could be taken and cut at local locksmiths.

The SPCT acknowledged that they needed to take ownership of the issues affecting availability and safety of syringe drivers. We were told they would like to introduce a follow up phone call to check in with patients and relatives, assist with quality improvement and chase up on return of syringe drivers.

Following our inspection and verbally reporting our findings, we were updated on actions for the management of the T34 syringe drivers.

It was reported that to support improved experience with the use of T34 syringe drivers, the hospital had implemented a syringe driver champion on site; a SPCT CNS. The role was to take some responsibility for the monitoring of the equipment for discharged patients. The policy for syringe drivers was to be amended and re-presented at the next policy group in January 2019. It was also reported that on-going education was to happen on the wards and discussion with ward matrons about policy, registers, and returns of T34s to the medical equipment team was to take place. No further detail on this was provided.

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## Assessing and responding to patient risk

There was a specialist palliative care team 9am daily handover meeting between the Royal London Hospital and Saint Bartholomew's Hospital. This was done as a conference call. At 9.15 there was a hospital SPCT meeting which discussed all patients on the caseload at the hospital. A daily list of current patients was produced for this meeting that included new referrals, which ward and which bed number they were located at.

We attended a SPCT handover meeting. In attendance was the band 8A team leader, two CNSs, the palliative care consultant and registrar, the band 7 end of life practice facilitator and the trust lead palliative care consultant. A handover sheet was distributed with 15 patients to be allocated. We were told there was not normally this many. Patient electronic records were seen and patients were discussed and allocated to each CNS for making contact with today. Some patients not on the list were also discussed.

Referrers called in to a central number, monitored by an administrator and assigned on to the electronic patient record system. The team respond to the referral and call the referrer back to get more information and to provide any immediate advice. During the daily morning meeting, triage and allocation occurred and patients were allocated to individual team members for seeing that day.

SPCT staff engaged well with wards and identified patients at risk of deteriorating or dying. Good links with different teams around the hospital meant open communication and a more proactive approach to working with the SPCT. We were told by the medical and nursing SPCT leads that this was a key component of their strategy. The medical and nursing SPCT leads were also confident in how care of the elderly staff identified those who were deteriorating. In practice, patients at risk of deteriorating or dying were picked up at an early stage by SPCT team members interacting with ward staff, going to the ward huddles when they can, and by identifying which patients had complex needs and by who had a DNACPR in place.

Ward rounds were sometimes attended by the SPCT although resources meant this was limited. Other meetings also took place such as attendance at the renal dialysis multidisciplinary meeting once every two months. This was in order to go through their cause for concern register. Information about patients from the community team, including hospice patients and advanced care planning

was shared for patients attending the dialysis clinic. Work also took place with the hepatology team with regular multidisciplinary meetings attended, mostly to discuss outpatients. There was SPCT presence at the motor neurone disease clinic, which was considered as important in terms of advanced care planning.

People who were dying or at the end of life were being appropriately reviewed. National early warning score (NEWS) was in use on all of the wards we visited. All examples we checked, charts were being correctly completed and patients appropriately monitored on patient records we saw. The nursing notes of two patients at the end of life on one ward, showed assessment and monitoring in line with care plans. It included the malnutrition universal screening tool (MUST), mouth health assessment, SSKIN nutrition and hydration 4 hourly. On another ward a chart monitored blood sugar four times a day. The MUST score assessed the patient as high need and nutrition and fluid was being monitored 2 -3 hourly. On another ward we found NEWS recorded observations 4 hourly. Pain was measured every time NEWS was checked and the patient was nursed on a pressure preventing mattress.

We observed a SPCT CNS asking about a patient's symptoms. Mouthcare at the bedside was in evidence and the patient looked comfortable. The relative was happy with the plan of care and the patient was to be reviewed tomorrow regarding moving on to the compassionate care plan (CCP).

On another ward we found the nursing care bundle was thoroughly completed. It included SSKIN assessments and comfort rounding. A patient we reviewed was not on the CCP, but there was a section in the nursing bundle to record activities of daily living care plans such as hydration and nutrition, personal hygiene etc. There were detailed and comprehensive nursing notes for each day, which were signed and dated and were mostly legible.

The trust's SPCT leads told us the CCP was used for patients identified as dying. It was reported that current uptake was 68 percent of all patients with expected deaths. One reason reported why this figure not being higher was because it was not used in ITU as they used their own version, specific to the needs of their patients. We found examples where the compassionate care plan (CCP) was in use. They were appropriately and correctly completed and used. For instance, we saw the CCP of one patient on the surgical

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wards, it was well filled in and complete. It had been signed and dated and contained evidence of discussion and good rationale for decision making. There was evidence of MDT discussion and involvement of the family. Symptoms were reviewed regularly. On one ward we found that the regular CCP had been started by one ward for a patient who had transferred from ICU. The CCP was appropriately completed. Rationale for decisions was explained. Discussions had been documented. The observation chart was being used. A DNACPR form had been comprehensively completed. However, a capacity assessment was not in evidence, even though it had been noted on the DNACPR form the patient lacked capacity. Pain was managed through the regular NEWS observation chart. The ward nurse was able to explain how they assessed pain and recognised the importance of end of life care.

On another ward, we found the compassionate care plan form was located at the front of the patient notes folder. It was in bright yellow to ensure staff were aware of the need to review and complete it. The priorities of care for EoLC patients were clearly documented on the CCP front page. The priorities included: recognise, communicate, involve, support, plan and do. The named consultant was recorded. Factors of death and professionals involved in the assessment were listed. It had been signed and dated by the doctor and validated by a consultant and senior nurse. It included a record of discussion with patient's family members about the patient's current status, including a record of any specific family, religious, spiritual or cultural matters. The family wishes were documented.

There was a section in the CCP on daily compassionate care for the dying patient, which was a daily nursing record to report any additional details of care required at specific times of day. It included space for nurses to record daily observations and interventions such as communication needs met (recognition of any cognitive impairments or family communication needs), privacy and dignity maintained (patient was in a side room for privacy purposes), patient comfortable and not agitated, patient does not have pain (pain scored using evidence based model for non-verbal cues), patient does not have vomiting or nausea, and patient not distressed by respiratory tract secretions. Each of the sections had recorded hand written notes; however, in some sections the writing was not entirely legible and in some cases the record was perfunctory, such as a two word sentence (e.g. 'patient

comfortable', or 'none observed' with no further context or information). The record was up to date up to the day of inspection and there was a complete set of notes from the date the patient was admitted for end of life care.

## **Nurse staffing**

The specialist palliative care team consisted of the following nursing staff: one whole time equivalent (WTE) 8A team leader, three WTE band 7 CNSs (possibly 4 because of rotations) and a full time band 7 end of life practice facilitator. In addition to this, there was a SPCT trust nurse lead. For development and experience, the SPCT nursing staff were rotated annually around the four hospitals that made up Barts Health NHS Trust.

Regarding vacancies and turnover, we were told there was recently one CNS vacancy which had been recruited to. There was also a forthcoming vacancy for the end of life care facilitator as they were leaving. The SPCT team leader for the hospital was currently covering another role within the trust, with another nurse acting up in to the position of team leader.

## **Medical staffing**

There were three palliative consultant doctors. The trust lead palliative care consultant was 0.6 WTE at the hospital as was another palliative consultant. Another was 0.5 WTE. There was also a specialty trainee. Senior medical staff felt this was an appropriate staffing level. There was an out of hours on call rota that included palliative consultants from the trust's four hospitals, another trust and the local hospice.

## **Staffing**

There was a full time social worker for the SPCT and administrative support that could be accessed from the trust's nearby palliative care team at St Bartholomew's Hospital.

The bereavement team had a staffing establishment of four and were fully staffed. The team consisted of one WTE band 5, 0.2WTE (Band 4), one WTE band 4 who worked across the Barts Health sites, one WTE maternity leave and one band 8A WTE who was trust wide.

The mortuary staff team had a staffing establishment of five and were fully staffed. We were told that in 2018 two staff left the mortuary and three were recruited; one band 6 senior and two band 4 trainees.

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The chaplaincy had an establishment of 5.8 WTE and were currently staffed to 5.51 WTE with a total of seven staff. There was a mix of faiths; Muslim, Roman Catholic, and Christian available and employed access to Jewish and others as required and based on need.

Porter staffing was calculated by hours required for jobs requested. This was calculated as 2983 hours needed and 2573 hours in post meaning there was currently a 13.7% vacancy rate.

Sickness rate for all staff groups was 3.2% as at November 2018.

## Records

The electronic patient record system that had recently replaced paper notes. Records were held securely on the EPR system which was accessed by NHS smart card. The 'red folders' contained admissions information and DNACPR forms. The folders were stored securely in the multidisciplinary room which was locked and only accessible to staff.

Plans for interventions, observations, and investigations were recorded in CCP, as were medication, hydration and nutrition plans.

Examples of SPCT write ups on electronic patient record system were observed. They were found to be clear, specific and of good quality.

The trust's SPCT leads told us that Coordinate My Care was the system used locally. It had been agreed by the area's sustainability and transformation plan (STP). We were told they needed to have an 'in context' link with the contracted software providers. Presently it was not integrated into the electronic patient record so it was not matching up and cumbersome to use. However, they did have the 'east London patient record' which was included in the contracted software system which links up all of the east London NHS trusts for acute and community and some GP records. It had been in place for over a year. Some of the links were new or in development. Coordinate My Care should be accessible via this route as read-only. In terms of supporting to primary care, we were told this was done through TTAs, rapid discharge checklists, discharge summaries and verbal handovers with GPs.

Chaplaincy services documented on the electronic notes system.

The mortuary register recorded date of death, time received in the mortuary, name, ward, age, gender and fridge number. Signing out checks were completed. The identity band check was completed jointly by the funeral director collecting the body and a mortuary staff member. A release form was completed that included identity number and coroner's name if needed.

There was a porter's receiving book for out of hours. It recorded name, date, time, ward, fridge number and porter's initials. Two porters would sign to verify. A separate porter's signing out book was kept for out of hours, which recorded the same information as the regular signing out book. This was checked by mortuary staff on Monday morning and then an entry was made in to the regular book.

## Medicines

The trust had guidance on anticipatory prescribing / 'just in case' medication at end of life. Anticipatory medicines were prescribed to control key symptoms such as agitation, excessive respiratory secretions, nausea, vomiting and breathlessness, which may occur as an individual reaches the end of their life and can be given if required without unnecessary delay.

Anticipatory medications training was incorporated into the end of life care training days for ward staff. We came across good examples on wards where anticipatory medicines had been prescribed. For instance, with one patient due to be discharged where regular medicines had been stopped. We enquired with the pharmacist if the prescribed medicines were in stock. They had been ordered for timely discharge to a hospice.

The trust's SPCT leads told us they worked with medical staff on wards to support patients' anticipatory medication needs. They were recorded within the CCP. The end of life care facilitator supported nurses on the wards. We were told that in practice, if the SPCT saw a patient they thought needed to start the CCP, they would also identify what medicines were needed at that time. This was an individualised approach for each patient based on individualised need. For instance, looking at their renal function.

One palliative patient we spoke with told us that medicines were readily available as required. This was supported by evidence from drug charts, which supported regular appropriate administration of 'when necessary' PRN



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medication. Elsewhere in notes we checked, we found medication records were clearly recorded on the paper inpatient medication prescription and administration record in the patient notes. Allergies were recorded too. Medication record was completed in full, including record of any allergies.

However, we also found one palliative patient on another ward, who was on controlled drug prescription for morphine. The dose had been crossed off and rewritten on the same prescription which should have been rewritten.

The SPCT team leader for the hospital was a nurse prescriber but was currently covering another role within the trust, with another nurse acting up in to the position of team leader. There were presently no nurse prescribers within the SPCT. The medical lead for the SPCT did not feel this was an issue as they were well served by SPCT medics and CNSs working well with the wards.

One of the palliative consultants was working to prepare specific guidance on end of life care medicine management for patients with renal failure (this was a QI project). An audit was presently being undertaken and had been registered and performance was being monitored.

The SPCT had also worked on making new pharmacist links. At each site within the trust there was now an identified pharmacist lead for end of life care, which was welcomed by the SPCT. It was also in response to opioid administration errors elsewhere in the trust. All of the identified pharmacist leads for end of life care were band 8As. The teams were in the process of meeting each pharmacy lead. The intention was for the pharmacists to carry out related activities such as link together, attend the end of life care steering group and review medication incidents. The trust SPCT leads also told us they were writing a business case to appoint a palliative care specialist pharmacist to the team.

## Incidents

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. The hospital confirmed there were no never events that related to end of life care.

The trust used an electronic incident reporting system widely used in the NHS to report incidents including near

misses. This was also used within the mortuary and allocated to the correct department for investigation. Staff we spoke with were aware of how to report incidents. Staff told us learning from incidents was shared at ward safety huddles and handovers.

The trust advised their policy for Responding to Deaths indicated that initial review for all adult inpatients was within one week of death and an additional second stage review took place where significant sub-optimal care had been highlighted.

There was a medical examiner in post who worked 9-5 Monday to Friday. They carried out reviews of deaths and liaised with relatives. Their duties included categorising deaths, attending serious incident meetings chaired by the Responsible Officer weekly, and feeding back to the SPCT on information regarding the CCP. They also ensured death certificates were completed correctly. Learning from deaths was shared monthly via the trust mortality review group, information from which was cascaded to services via clinical leads. Additional service level mortality review meetings took place locally across the trust and circulated to all members of the team.

Staff were aware of the Duty of Candour under the Health and Social Care Act (Regulated Activities Regulations) 2014. The Duty of Candour is a legal duty on healthcare providers that sets out specific requirements on the principle of being open with patients when things go wrong. Staff knew what duty of candour meant and could describe their responsibilities and principles relating to it. We observed Duty of Candour posters on ward notice boards. The posters detailed the principles of DOC and processes for staff to follow and when DOC needed to be discharged. The poster displayed contact details for staff to seek support on discharging DOC. The medical and nursing leads in the SPCT told us that the culture of transparency and good communication and being open and honest was central to the way they worked. They also felt this was embedded amongst nurses and due to the nature of their work, they mostly supported other teams in their responses to the Duty of Candour.

We were provided with an excerpt from the end of life care dashboard which showed that incidents relating to end of life care were being recorded and categorised in to themes such as diagnosis, communication, delays in care, treatment, medication, falls and pressure ulcers.

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All incidents logged by staff were opened and reviewed by local management teams. Patients receiving care at the end of the life were identified using a check box. In 2017/18, 175 incidents were recorded through the online incident reporting system, that involved patients receiving end of life care. This included incidents such as pressure ulcers, medication, continence, treatment and communication issues. All had been signed off within a short timeframe.

There were three serious incidents reported in 2017/18 that related to end of life care patients. Incident themes were aligned to deteriorating patients and missed diagnosis. Any serious incidents were summarised into a monthly slide pack once the investigations were completed. They were then circulated to all clinical teams and to the other sites in the trust to enable them to discuss the findings and to share the learning from it. At the monthly end of life care steering group all incidents and complaints identified as affecting patients receiving care at the end of their life were discussed. This included mortuary incidents. In this year, four incidents had been reported with a theme of incorrect application of last offices. The Bereavement CNS brought the issues to the EOLC steering group. The learning had been included in the revised bereavement support packs on the wards.

There were five incidents recorded on Datix that related to the mortuary at the Royal London Hospital. Themes included the temperature alarm, space for bariatric patients, communication regarding a neonate patient who was deceased and deep freeze space availability where two incidents were raised.

The end of life care dashboard populated the themes, and trends from the incidents for monitoring were discussed. Trends and themes emerging from these dashboards were taken from the steering group and incorporated into the education strategy and programme for the trust.

## Are end of life care services effective?

Good



We rated effective as good. At our previous inspection in 2016 we had rated this service as requires improvement for effective. At this inspection we rated it as good because there had been improvements:

- At the last inspection we found that staff on ward did not always use pain charts to record patients' pain scores. At this inspection we found patients' nutritional and pain needs were being met.
- The hospital had implemented a care plan called the compassionate care plan (CCP) for the dying patient which replaced the Liverpool pathway.
- The hospital was working to published national guidance and standards in its delivery of end of life care.
- The mortuary was compliant with national minimum standards.
- Staff groups across the hospital were suitably competent in their roles relating to the delivery of end of life care to patients and their relatives.
- People from different disciplines and with different skill sets worked alongside each other well to provide end of life care to patients and their loved ones.
- Relatives were encouraged to contribute to giving care to their loved ones by ward staff and the SPCT.

### However;

- At the last inspection we found there was a lack of consistency with some staff confused about decision specific assessments of capacity. At this inspection we found that staff understood capacity but were unclear about where assessments of patient capacity should be recorded. As a result, the specific section within the electronic patient record was not being completed.
- The specialist palliative care team had just commenced Saturday working with plans to extend to a seven day service in 2019.

### Evidence-based care and treatment

The trust had a care plan called the compassionate care plan (CCP) for the dying patient which replaced the Liverpool pathway. The implementation of the tool began in 2016. The CCP was in line with the recommendations published in June 2014 by the Leadership Alliance for the Care of Dying People (LACDP 2014), National Institute for Health and Care Excellence (NICE) guidance NG31 'care of dying adults in the last few days of life' December 2015.

The trust's end of life care strategy was first published in 2016. The trust's revised strategy 'End of Life Care strategy 2017 – 2020 moving forward: Supporting our staff to care for our community' was finalised in December 2017. The below documents were used to write the EOLC strategy and are referenced in the document;

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- Ambitions for Palliative & end of Life Care: a National Framework 2015 – 2020, National Palliative & End of Life Care Partnership 2015.
- Follow the Child: Planning and Having the Best End of Life Care for Your Child; Sacha Langton-Gilks: 2018; Jessica Kingsley Publications.
- Palliative & End of Life Care for Black, Asian and Minority Ethnic groups in the UK, Marie Curie & Public Health England 2013.
- End of Life Care: Achieving Quality in hostels and for homeless people: A route to Success, National End of Life Care Programme 2010.
- Integrated Person Centred Planning for Children, Young People and Families receiving Palliative Care: A toolkit: Riley, Tyler & Ramus: 2018.
- National Institute for Health and Care Excellence
- Next Steps, Marie Curie 2014
- Care of Dying Adults in the Last Days of Life. (NG 31), National Institute for Clinical Excellence 2014.

An improvement plan was provided that set progress with 'Ambitions for Palliative & End of Life Care: a National Framework 2015 – 2020, National Palliative & End of Life Care Partnership 2015', and tracked the hospital's progress against them.

A retrospective case notes audit took place to identify how end of life care was documented within medical/nursing notes for adult patients dying in an acute setting. 15 sets of notes were reviewed using an audit tool to measure delivery of care against the five priorities for care of the dying adult. It was reported that the implementation of the compassionate care plan (CCP) showed improved compliance with the five priorities for care of the dying adult.

Against priority one; 'recognise': The possibility of death was recognised in 12 out of 15 cases, and more than 48 hours prior to death on 10 occasions. The CCP was implemented on 6 of these 10 occasions. Multidisciplinary discussion had occurred on 6 occasions. Against priority two; communicate: The possibility of dying was discussed with family members in 8 out of 15 cases, the possibility of dying was discussed with the patient in 2 out of 15 cases, reduced consciousness or lack of mental capacity was documented as preventing discussion, families were aware

of the possibility of death on 13 out of 15 occasions including whenever the CCP was implemented. Against priority three; involve: Nutrition and hydration was discussed in 5 and 6 patients respectively (only performed if the CCP was in use), good evidence that the patient's symptom control was assessed and reviewed if the CCP was in use. Against priority four; support: Patient preferred place of care was known for 6 out of 15 patients but was changed by family or not achieved in 4 cases. Against priority five; Do: Spiritual input was offered to the patient on five occasions and accepted on three. It was offered to the family on three and accepted twice.

The report concluded that the sample was small and was to be repeated quarterly, results to be shared with end of life steering groups, improve future audits to target education and the use of the CCP and to involve end of life care facilitators to improve recognition of the possibility of dying.

A report identifying recommendations set out in the Royal College of Physicians' End of Life Care Audit – Dying in Hospital 2016 was provided, which indicated the extent to which the trust had implemented the recommendations. A local action plan had been created in response to the service's performance with most actions achieved.

A policy had been written for the implementation of the treatment escalation plans (TEP), including DNACPR, to replace the current resuscitation policy. A second design meeting was taking place in December 2018 to progress work.

The hospital mortuary and post mortem facilities were regulated by the Human Tissue Authority (HTA). HTA licensed establishments are required to meet HTA standards of consent, governance, traceability and premises, facilities and equipment. The hospital mortuary was last inspected in 2016. The HTA found the named responsible individuals to be suitable in accordance with the requirements of the legislation. All applicable HTA standards were assessed as fully met. Eight recommendations were made.

## Nutrition and hydration

From the SPCT daily handover meeting we attended, we found evidence of speech and language therapy support was being accessed for patients. This could be accessed by the SPCT or ward teams. There was also a nutrition

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multidisciplinary meeting. Monitoring of nutrition and hydration was carried out by wards. We also found any decision to continue/stop had been documented in the CCP along with the rationale for doing so.

There was engagement between the SPCT and the nutrition team about individual patients. Nutrition and hydration was reviewed as part of the CCP and the SPCT also carried out education at ward level. The trust SPCT leads told us they had carried out work with speech and language therapy around a risk feeding policy to cover issues such as if it was safe for patients to swallow and if a patient needed nasogastric feeding.

The trust's SPCT leads also told us that nutrition and hydration often came up in family meetings and discussed with family members. There was a particular focus on patients with dementia and neurological conditions and the team were involved in decisions around nutrition and hydration.

We found patients were having their hydration and nutritional needs met. We found fluid balance charts, malnutrition universal screening tools (MUST), Waterlow scores and regular skin checks were taking place in accordance with care plans. On one ward we found, within the nurse notes, a section on 'insertion of devices' as the patient had a nasogastric (NG) tube. This was completed in full. There was a separate form on enteral feeding regime, which detailed NG feeding requirements. There was a daily central line monitoring chart which was completed. Fluid balance charts and drain charts were completed in full. NEWS score had been completed daily. MUST was recorded twice daily. Waterlow and regular skin checks were also completed.

On another ward, we observed posters on MUST audit performance, which showed completion of all components of the MUST documentation. The results were variable across different questions, with some areas for improvement. For example, the audit showed steps 1-4 were completed in 90% of cases sampled, but in terms of accuracy there was a performance of 0%. However, appropriate action was taken in 90% of cases. The audit also showed 'previous weight' and 'weight on admission' were completed in 0% of cases. The contact details for the hospital dietician team was published on the poster to enable ward staff to contact the team for support.

## Pain relief

The SPCT team had a good relationship with the hospital pain team. Referrals took place between the teams who tried not to replicate the work of each other. The pain team were helpful to accommodate procedures for terminally ill patients. The trust's SPCT leads told us they worked closely with the pain team, who referred patients to them and carried out joint visits if there was a shared patient. There was a new consultant who was keen to promote what the acute pain team could do to support end of life care. The pain team carried out consultant ward rounds and the SPCT could ask them to review patients they had identified patients as needing specialist input and support. The pain team had also provided training to the SPCT on palliative care pain relief.

Ward staff and the SPCT staff assessed and monitored patients to see if they were in pain. We observed a CNS from the SPCT asking a patient about pain and giving advice regarding pain management to staff. We reviewed and spoke with two palliative patients on one of the wards we visited. They were both complimentary about the care and the timeliness of their pain management. Another patient told us "I didn't feel any pain during my admission".

The SPCT did pain relief assessments as part of the initial holistic assessment, which was part of the whole record the SPCT handover to the nurse in charge and added to the care plan. A matron on one ward told us the SPCT supported them with pain assessments, to get a pain history from the patient and ensure the pain management plan was tailored to the patient. This could also include anti-nausea assessments if a patient was on chemotherapy.

Patient files showed pain was being monitored on a pain scale and measured every time NEWS was checked. Patients were given appropriate care.

## Patient outcomes

The trust participated in the End of Life Care Audit: Dying in Hospital (NCDAH) 2016 and performed better than the England average for two of the five clinical indicators. For the remaining three indicators the trust performed worse than the England average. These were:

- Is there documented evidence that the patient was given an opportunity to have Concerns listened to? The trust scored 79% yes, lower than the England average of 84% yes.

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- Is there documented evidence that the needs of the person(s) important to the patient were asked about? The trust scored 44% yes, lower than the England average of 56% yes.
- Is there documented evidence in the last 24 hours of life of a holistic assessment of the patient's needs regarding an individual plan of care? – The trust scored 36% yes lower than the England average of 66%.

We were provided with a progress report that included actions against key recommendations and organisational recommendations. These included clinical guidelines and supporting documentation in place, key components within the trust end of life care strategy, end of life facilitator and SPCT staff attending daily huddle when dying and deteriorating patients were highlighted and regular education by the end of life care facilitator on wards to emphasise the importance of early identification. Attendance at surgical board rounds to identify deteriorating or dying patients early for proactive referrals, project to map all board rounds/ward multidisciplinary meetings and prioritise SPCT attendance at those most appropriate to proactively seek out deteriorating/dying patients, a 69.3% compassionate care plan uptake.

At site based level, the end of life care dashboard had showed a month on month improvement with CCP compliance so far this year. In April 2018 there was a compliance rate of 56% and by December 2018 this had risen to an 92%. The compliance rate was calculated by looking at the number of deaths reviewed by the medical examiner and the number they had identified as being appropriate for a CCP.

A SPCT consultant had written a proposal to use key outcome measures. This was currently being discussed at team level. Also the electronic patient record had capacity to record outcome measures including IPOS (palliative care outcome scale) and 'phase of illness'. However, progress with these was in very early stages.

## Competent staff

There was an end of life care facilitator role within the SPCT. This was a band 6 nurse who supported and educated ward staff. They also went on to the wards and reviewed patients who needed to go onto the CCP.

End of life care education took place on wards and on formal study days. There were full day courses that SPCT

ran. The aim was for 100% ward staff to have attended. They were currently at 60%. The SPCT planned a year's worth of study days. SPCT staff attended the ward development days.

We came across end of life care champions on wards. Training for them took place for one hour each month. End of life care champions met on a monthly basis for training. In 2018, topics for training included difficult conversations in EOLC, pain management, support for patients and carers, terminal agitation, advance care planning, spirituality in end of life care and breathlessness. All sessions were led by the end of life care facilitator and were cascaded to ward staff.

Other education also took place on wards. A practice development nurse on one ward told us that multidisciplinary teaching took place weekly and that every week covered a different topic. This had included a SPCT team visit on 9 January 2018 to teach different groups of staff about the 'fast track' process for end of life care patients. Teaching also took place in March 2018 on how to complete the CCP. We saw the record of attendees for these, which showed it had been well attended. There were two link nurses on the ward who were end of life care champions to support nurses to provide compassionate care for patients. The practice development nurse told us that in 2017 there had been an all staff away day focused on end of life care, led by one of the end of life link nurses and that most ward nurses attended it. They had also invited a SPCT CNS to come in on a planned basis to provide ward teaching for new nurses. They were able to describe the processes involved in daily compassionate care and gave a good account of the different principles of compassionate end of life care, including ensuring basic needs were met such as nutrition and hydration.

We were given a competent, clear account of end of life care processes by another practice development nurse on one ward, including the training and principles of compassionate care. There was clearly a focus on ensuring staff had the skills and competency to provide sensitive and compassionate end of life care for patients.

A matron on one ward told us that everyone had training in end of life care and that it is a study day. One of the CNSs from the SPCT also did a one hour training session. They had two end of life care champions who were band 6 nurses who received extra training from the SPCT.

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There was a planned training programme for 2019 for palliative and end of life care study days – multiples dates available throughout the year to make it accessible for healthcare assistants and nurses to participate. 'Sage and Thyme' training was part of the end of life care training package, which enhanced communication skills around having discussions and managing difficult conversations. Ward staff commented that the SPCT were supportive and accessible. The SPCT on call number was available by the nurses stations.

Chaplaincy services were involved in education, including records of teaching across disciplines, including having an end of life care focus.

Porter mortuary champions were introduced two to three years ago in response to incident learning and had training for their role. Porters were utilised for out of hours (OOH) access for viewing a body or for an out of hours body release. They also carried out the moving of a deceased patient from wards to the mortuary at any time.

Champion porters cascaded down learning. It was intended for there to always be one champion on duty. To become a champion there was a workbook of competencies that need completing. Competencies we saw included set up a viewing, release and receipt of a body, health and safety in the mortuary including use of PAT slide, PPE, hydraulic body lifts and use of body fridges. There were also specific standards for babies and children. A porter had to attend three viewings under supervision to pass. Also three baby viewings and complete a competency checklist before training was signed off.

The intention was to have 20 mortuary champions. However, this number was currently lower due to people who had been trained, leaving. There were currently eight champions but this number was being built up. We were told there was always access to a porter mortuary champion. Managers and supervisors had completed the training. If a porter was doing a body release, the champion was on hand for advice. The mortuary manager could also be paged for advice. We were told this did not happen often but they were available if needed. There was a train the trainer process in place and champions were able to supervise activity. For body release and viewings more experienced porters were allocated to the job.

Porters were also trained in completion of the mortuary register. All porters had completed the 'care and dignity of

deceased patients' module which followed principles of care, dignity and respect. All porters were expected to be able to transfer bodies to the mortuary. The first time they did this task it was as an observer of a more experienced porter.

SPCT staff had undertaken the following training specific to their role:

Consultants were all on the specialist register for Palliative Medicine and were required to maintain appropriate CPD for appraisal and revalidation. The speciality trainee had a training number and was being trained and appraised using the Palliative Medicine curriculum.

End of life care was embedded into all SPCT nursing training including specific training on: symptom management, advanced communication skills, leadership skills, teaching and participating in conference, teaching and audit, local formal and informal teaching

End of life care for all (ELCA) online web-training, Macmillan, RCN community of practice.

In addition, we were also told there was a continuous programme of multi-professional education within the service every 2 months for 3 hours. All consultants had attended advance communication skills training. All CNSs had completed advanced communication skills training.

The trust held an end of life care conference in November 2018 which was open for all staff to attend. Topics for presentation and discussion included human rights, improving access to end of life care for gender and sexual minorities, spirituality and complementary therapies.

First year and core medical training doctors at the hospital had a minimum of three end of life care teaching sessions, given by the palliative care team, on their respective mandatory teaching programmes. These sessions covered core topics within EOLC such as pain management, symptom control, care at the end of life and important EOLC discussions.

EoLC/palliative care teaching was also provided to departments on departmental teaching programmes. Specific examples include presence on the ITU teaching rota, oncology juniors teaching rota and oncology SpR teaching rota.

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The SPCT held palliative care study days twice a year, predominately attended by nursing staff but doctors were also welcome to attend.

Junior doctors were encouraged to spend a 'taster' week or day with the SPCT or attend the multidisciplinary meeting or clinics. It was reported that there was a reasonable take up for this.

Ad-hoc teaching took place on the wards on a daily basis on each site when the SPCT were involved in the care of ward patients where they discussed and advised on management plans with the junior doctors.

End of life care was part of the specific induction programme for first year trainee doctors. We were told the SPCT were also part of the trust consultant's induction programme. We were also told discussions were in place to have an end of life care session on the medical and non-medical trust induction programme.

100% of new starter nurses, midwives and HCAs have received EoLC training as part of nursing and midwifery induction in the last year. The end of life care facilitator and SPCT taught on generic training sessions such as preceptorship, care certificate, dementia training, REACT and forums- skills and drills, key mentors, patient safety and tissue viability.

Appraisal rates for staff undertaking specific end of life care duties were given for the bereavement team, palliative care nurses, mortuary staff, chaplaincy and palliative care clinicians. All staff groups were up to date with appraisals.

## Multidisciplinary working

People from different disciplines and with different skill sets worked alongside each other well. CNSs from the SPCT and other specialities worked well together. For instance, ward teams worked alongside the SPCT to deliver end of life care to patients. Both were supported by other teams working to meet patients need such as long term conditions, nutrition and hydration, pain and spiritual need.

It was widely reported to us by different disciplines that there was a positive working environment. We were told there was a good multidisciplinary culture too for the same reason. All of which enhanced the care and treatment provided to palliative and end of life patients. For instance, there was a meeting taking place at 3pm on the day of our inspection for one patient near the end of life, which involved the relatives as well as ward doctors, therapy staff,

the SPCT CNS, senior doctors and occupational therapy. The electronic file for one patient we saw showed good multidisciplinary input from the delirium and dementia team, a psychiatrist, cardiologist, therapies and occupational therapist. On another ward a senior nurse told us that a gastro-psychiatrist was available to visit the ward and visited four times a week for all patients.

We observed good practice of the SPCT working well across the wards and alongside ward staff and doctors. Discussion and joint decision making between SPCT and ward doctors and nurses was taking place. We observed the SPCT CNS speaking with doctors about patient care and pain relief. They discussed discharge and PRN doses. The SPCT attended cancer multidisciplinary meetings for the most part. However, they did not routinely attend ward rounds but planned to develop this. The SPCT had good links with the local hospice and had a joint consultant appointment between the two teams.

The chaplaincy service liaised with other faiths outside of the hospital. A resource folder was available to wards.

## Seven-day services

The SPCT began Saturday working in November 2018. One CNS was on duty to cover both the Royal London Hospital and another trust hospital, located nearby. Ward staff told us this new arrangement offered them more support. Senior SPCT staff told us they were pleased to have got this off the ground and felt resources had prevented them from doing it sooner. This was a pilot until January 2019. We were told the SPCT had received very positive feedback from nurses and doctors on wards and identified a clear need for this support so were going to write a business case to expand the staffing for it.

We were told by SPCT staff that they were able to access new referrals at the weekend by dialling in to the voicemail system, thus being able to see new referrals within target times.

Weekend and out of hours consultant arrangements were jointly covered by Barts Health NHS Trust, a neighbouring acute trust and the local hospice. This had been in place for several years. Weekends were described as busier than night time. The need was mainly for symptom control advice. It was mainly telephone advice but we were told doctors will come in if needed.

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## Health promotion

Relatives were encouraged to contribute to giving care to their loved ones by ward staff and the SPCT. We were told they were shown how to provide mouthcare and assist with feeding. We were told this was encouraged as it had a therapeutic and calming effect on patients and helped their wellbeing.

The trust's SPCT leads told us identifying people in the last 12 months of life was incorporated into everything they did and emphasis was placed on hospital staff networking with the SPCT, who were always working on improving this part of their role. Patients were signposted according to their needs. For instance, the team were currently doing outreach with the renal and hepatology teams to better identify those patients within the last 12 months of life. There were plans for DNACPR and treatment escalation plans. We were told there were treatment escalation plans within Coordinate My Care, but the trust were awaiting the contracted software provider to progress development. Coordinate My Care was aligned with the respect document to provide clarity to staff about what they needed to do.

A quality improvement project had taken place with the older people's care service on communication with patients not yet requiring EoLC but who may need to plan ahead about their needs. This was also to help patients and relatives to better identify their needs and identify those patients who need SPCT support.

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

A do not attempt cardio pulmonary resuscitation (DNACPR) form compliance spot check audit took place in June and July 2018. However, the documentation stated that due to a lack of resources only two wards were visited and a total of four forms audited. Recommendations made were as follows: Consultants to record the date and time of their validation within 24 hours. Nurses to ensure that handover sheets are updated with resuscitation status. Resuscitation status to be handed over when a patient is transferred between departments.

We reviewed 27 do not attempt cardio pulmonary resuscitation (DNACPR) forms that were in place at the time of our visit. We found that all (100%) of the forms could be found immediately at the front of the notes. 26/27 (96%) of the forms stated the name and designation of the person completing the form and had been signed by them. All of

the forms had been dated when signed and all of the forms clearly identified the rationale for clinical decisions. 26/27 (96%) of the forms indicated that the patient, their relative or next of kin had been involved in the discussion.

We also checked the recording of patient capacity on the forms. It was indicated in 16/27 (59%) of forms that patients had lacked capacity at the time of completion. We then looked to check that a mental capacity or best interests decision had been recorded. However, ward staff, medical staff and SPCT staff were all unclear about the location of the assessment. In some instances we were directed to the electronic medical case notes. Ward staff searched for the capacity assessment but were unable to locate it there. We were told it had most probably been buried in previous case note entries and was now difficult to find. Other staff pointed us towards the nursing care bundle which asked questions about consent rather than capacity. Some staff told us there was a specific section within the electronic patient record that recorded assessment of capacity but it had not been completed in the examples we were shown. We could find only three instances out of ten where any assessment of capacity had been recorded.

The director of nursing confirmed that capacity assessments should be recorded in a specific section within the electronic patient record. However, this was not clear to staff. Under staff supervision on one ward, we looked through the electronic file of a patient whose DNACPR form stated they lacked capacity. We were told the capacity assessment would be in the case notes but it was not found. On another ward we asked a doctor about mental capacity assessment. They told us they would complete it in the clinical notes. On another ward, a nurse looked on the system at our request to show us the template for assessment of capacity but they were unable to find it. The nursing assessment bundle was then produced which held some information around consent. However, this was not a capacity assessment and was not decision specific. On another ward we saw the mental capacity template within the electronic patient record. However, it was not being used on the surgical wards.

In one instance, we found a DNACPR form was present at the front of the notes but two copies were in existence. One was dated 31 October but crossed out and since superseded by the current DNACPR form dated 21 November. The first form stated the patient had capacity, but the second form stated patient did not have capacity.



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We asked the nurse in charge to see the capacity assessment on the electronic patient record. We looked at the EPR together but it was not present in the documentation section where the MDT notes and records were saved (the nurses in charge said “I believe they would be stored here”). When we couldn’t find it, the nurse said that was because a capacity assessment had not been completed for the patient since the patient was admitted. At the time when the second DNACPR form was completed, the patient was delirious so unable to consent. It was not clear why the DNACPR form was updated again at this time when the patient could not consent. The DNACPR form stated resuscitation wishes were discussed with a family member at the time as the patient was delirious (it was not clear on the form if they patient had deteriorated hence the completion of a new form). The form was signed and dated by a consultant and nurse. A carbon copy of second version (most current) DNACPR form was not in the folder.

In discussion with one matron and practice development nurse, we were told that initially nurses completed a capacity assessment on admission and a best interest assessment, which sometimes led to a Deprivation of Liberty Safeguard. This was done as part of the nursing bundle during admission. In relation to end of life care discussions such as around the DNACPR, we were told the doctors record that; mostly on the electronic patient record.

If nurses found issues regarding capacity they would inform the doctor. We were given an example of this whereby one patient who wanted to go home against medical advice. Doctor said the social worker might have the forms but was unsure. We observed that DNACPR discussion took place in a SPCT handover meeting. This included what was documented on the DNACPR form and what was discussed with family.

The trust had a do not attempt cardiopulmonary resuscitation (DNACPR) policy in place.

## Are end of life care services caring?

Good



We rated caring as good. At our previous inspection in 2016 we also rated it as good. At this inspection we rated it as good because:

- At the last inspection we found that patients were treated by caring staff who involved them in decisions about their care. At this inspection we found this was still the case.
- End of life care was delivered to patients by caring and professional groups of staff.
- Emotional support was provided by ward staff and incorporated into the holistic assessments carried out by the specialist palliative care team.
- Patients and those close to them were involved in the care they received.

### Compassionate care

There was a bereavement care, before, during and after death policy which described the care given to a body after death. The process demonstrated respect for the deceased and their religious and cultural beliefs, as well as health and safety and legal requirements.

The hospital carried out annual bereavement surveys. We were provided with the outcome from the most recent bereavement survey. The survey reported on experiences returned by people for the period between July 2016 to November 2016. It followed the experience based design approach (EBD), developed for the use of front-line NHS services as a way of better understanding people’s experiences of care. There were 392 deaths over this period. 239 surveys were sent out and 41 (17%) surveys were returned. The survey reported on different aspects of experience; Care (91% positive), staff (92% positive), beliefs (84% positive), at the time of death (96% positive), return of personal items (92% positive), viewing (71% positive) and bereavement officer (91% positive). Service improvement had been produced as a result of the survey. This included team based learning on wards in small numbers, with time away from clinical care, using simulation training and role play about communication, piloting reflective discussions about deaths as a ward based exercise 30 mins per month and encouraging consultants to offer / juniors to ask to be present to observe / take over EOL discussions.

A SPCT CNS told us it was good to hot desk on the wards as they felt part of the wards which enhanced communication. They told us the culture on the wards was kind, so ward staff were kind to patients. They added that patients often wanted to die on the wards because they felt cared for and looked after. Our overall experience on the wards was of openness and caring, with emphasis placed on compassionate care for patients at the end of life.

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One patient told us staff were always busy, that staff were caring and always answered the call bell.

A practice development nurse on one ward told us there was a good understanding amongst nurses and the multidisciplinary team about the need for compassionate care at the end of life. There was a focus on maintaining privacy and dignity of patients and their families at what was a distressing time.

One ward sister showed us a framed letter from a family. It stated their grateful appreciation for how the ward staff cared for their loved one during their final moments. It said the family felt blessed to be able to be with their loved one during their passing and the staff had showed understanding and compassion. It stated this had given them comfort and provided the family with reassurance and peace at a difficult time. The ward staff were proud of being able to have provided this and to have been able to make a difference.

However, on another ward upon our arrival prior to introduction, the ward clerk appeared unwelcoming. They did not make eye contact or appear concerned or interested that we were a visitor to the ward. This did not suggest a welcoming introduction to the ward for patients' relatives or loved ones who may be feeling distressed or vulnerable.

There was a medical examiner who carried out reviews of deaths and liaised with relatives. They made themselves available to relatives to answer any questions, ensuring terminology was explained to relatives.

Staff we met in the bereavement office had a very caring and compassionate attitude.

Porters were utilised for out of hours access for viewing a body or for an out of hours body release. They also carried out the moving of a deceased patient from wards to the mortuary at all times. All porters completed a 'care and dignity of deceased patients' training module, which followed principles of care, dignity and respect. Emphasis was placed on care and dignity. Porters were required to be engaging and respectful in their role with deceased patients.

## Emotional support

The chaplaincy service offered support to patients and families and offered informal support to staff, including after death debrief. They were very involved in

bereavement care as needed. They visited wards routinely, liaised directly with wards and maintained a visibility. The chaplaincy service carried out regular services and additionally special occasions such as remembrance day.

There was an annual memorial service organised by the bereavement office and held jointly with the local hospice. It attracted 700 attendees including staff. This was a highly valued activity. From the bereavement office, cards were sent out the week following a bereavement and included an experience questionnaire. Consent was sought for this from relatives. People were encouraged to ask any questions at any point, even if months later. The bereavement office signposted people to bereavement counselling services. There were none in house but good links were maintained with external agencies.

Emotional support was also provided by ward staff and the SPCT and was incorporated into their holistic assessments.

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

Patients and those close to them were involved in the care received. The relative of one patient told us the consultant had made themselves available and answered all of their questions. They had discussed the option that their relative might not be well enough to transfer to the hospice. The reasons for this were explained and they were happy with this. They told us that the care had also been discussed with a SPCT CNS.

There was evidence of routine involvement of patients and their families. There were conversations held around decision making and DNACPR decisions were observed. The wishes and needs of patients and family were included in case notes and care plans. For instance, discussion with a relative of a patient about prognosis and patient's preferred place of care. The patient did not have capacity.

On another ward, we observed a CNS discussing options of a syringe driver and treatment plan with a patient. On another ward, the SPCT CNS did not introduce themselves as a palliative CNS as the patient had received a late diagnosis, showing sensitivity to the situation.

One patient told us a family meeting took place earlier that day. They told us they felt involved during the meeting and were meeting at home with the nurse later today regarding modifications. We asked if they had seen any specialist

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nurses and were told that a few weeks ago a doctor had said they should have some level of palliative care. They were aware they were going home this weekend with a package of care.

There was a hospital bereavement CNS coordinator. Relatives were asked if they wanted to receive information after the death of the patient. There was a condolence card that had the bereavement offices contact details on. The SPCT social worker also followed up on this.

## Are end of life care services responsive?

Good



We rated responsive as good. At our previous inspection in 2016 we had rated this service as requires improvement for responsive. At this inspection we rated it as good because there had been improvements:

- The specialist palliative care team saw 95% of patients within 24 hours of referral.
- The specialist palliative care team were accessible to ward teams who told us they were responsive to patient needs.
- The hospital had teams in place that were meeting people's individual end of life care needs.
- The hospital's bereavement services took account of different faiths and cultures.
- Wards were adequately resourced to deal with patients passing away.
- Side rooms were prioritised for infectious patients, patients at the end of life and patients with delirium and dementia. Staff tried to accommodate palliative patients in side rooms whenever possible and the specialist palliative care team advocated for this too. The layout of wards meant this was not problematic.
- Arrangements were in place for access to the deceased viewing suites out of hours.
- Complaints and compliments relating to end of life care were being appropriately reviewed.

### However;

At the last inspection we found that patients' preferred place of care was not being recorded. At this inspection we found the specialist palliative care team were documenting patients' preferred place of care in the electronic patient

record. At sustainability and transformation partnership (STP) level, metrics were being set up locally to measure achievement of preferred place of care but at present, the hospital was not measuring this.

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

Side rooms were prioritised for infectious patients, patients at the end of life and patients with delirium and dementia. End of life care was delivered on most wards, by ward staff who were supported by the specialist palliative care team (SPCT). Staff tried to accommodate palliative patients in side rooms whenever possible and the SPCT advocated for this too. The design and layout of most wards at the hospital meant there was a good number of single rooms on wards. For instance, ward 13E was a 26 bed ward with ten single rooms. This meant that although infection prevention remained a priority for single rooms, end of life patients being offered single rooms was not problematic. We were also told that palliative patients would sometimes choose to remain on larger bays because of the positive interaction with staff and other patients.

We found an example where relatives were staying overnight with a patient at the end of life accommodated in a single room. The relatives had stayed on a mattress on the floor. On another ward we were told there were no mattresses or chair beds available for relatives. However, relatives could sleep in two comfy chairs pulled up together. Wards provided blankets if needed. The SPCT had applied for funding from a charity to purchase chair beds for relatives staying at patient bedsides. There was also a relatives' accommodation block. This was mainly for use of patients at another of the trust's hospitals. However, it was located nearby and could be accessed free of charge for those who lived out of area.

There were no visit time restrictions for relatives of patients at the end of life. However, there were some restrictions on large family groups that sometimes came along. This was in order to not disrupt other patient care. Wards had day rooms so that groups of relatives could be accommodated. They were also organised to take turns to visit bedsides. Relatives of patients at the end of life were offered tea and coffee on tea rounds, along with biscuits and morning toast. The nearby canteen was open from 7am to 7pm.

Mortuary hours were 8.30am to 5pm. Porters carried out viewings outside of these times with help of the site team.

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There were a set of champion porters, trained in carrying out viewings and release of bodies. It was intended for there to always be one champion on duty. Managers and supervisors were trained as champions.

## Meeting people's individual needs

The trust's bereavement policy took account of different faiths and cultures. To meet the local Muslim community's needs, arrangements were in place to ensure documentation needed to help with the registration of a death was handled swiftly. The bereavement office hours were 9-5 Monday to Friday with out of hours managed by the site manager, which meant that death certificates could be issued as needed. Chaplaincy supported the out of hours arrangements for death certification and could be directly involved in arranging quick funerals for religious groups. The bereavement office also offered to book appointments for relatives at the registry office.

Mutli-faith rooms offered quiet spaces where people could pray or reflect. There were four rooms catering for Christian, Jewish and Muslim faiths plus changing and washing facilities. We found all facilities clean and tailored towards those using them.

Information was available for patients about the chaplaincy services. This was provided by information leaflets available on the wards. Information regarding Macmillan services were contained in an information booklet given to bereaved relatives on wards or at the bereavement office. Further information was available in the bereavement office on offer to all.

There were three deceased viewing suites, all designed to serve different needs. These were located through a separate entrance next to the mortuary. There was seating available in all three and toilets were available nearby. There was a waiting area with seating and water fountain for general use. In the first viewing area was through a glass screen, with doors for access to the body. The second room was close by with direct access to the body with no glass screening. The third viewing room was a children's viewing suite. There was an option of a cradle or a cot for the body. A variety of religious texts were available for use in the viewing area, including the Quran, New Testament, Holy Bible and Bhagavad Gita.

There was a last offices resource trolley, also known as a bereavement box, present on most wards we visited to show staff what items were required and what tasks should

be done when a patient had passed away. This took the form of a compact set of metal drawers, containing information such as a bereavement checklist. It included a bereavement care plan for clinical practice, copies of the CCP, information on spiritual care for all religions on death and leaflets on 'what to do when someone close to you dies' (these leaflets were also available on literature stands on the ward). There was equipment for use on patient death such as shrouds for bodies and bags for patient possessions for the family to collect when a patient had died.

On one ward we were told the SPCT team were involved in end of life care planning for all identified patients from the beginning of their admission. There was also a complex discharge team which worked across the hospital to facilitate arranging support for patients in the community if they were discharged to die at home.

There was a new consultant role within the SPCT. This was joint role between the hospital and the community palliative team, making for better joint working and understanding of community issues such as when palliative patients were admitted from community settings. People from different disciplines and with different skill sets worked alongside each other well to meet individual patient need. Palliative and end of life patients were supported by ward staff and the multidisciplinary SPCT, who were both supported by other teams working to meet the individual needs of patients. We came across examples such as long term conditions team, nutrition and hydration support, pain team, a learning disability nurse and chaplaincy were all involved with patient care. There was also input from the delirium and dementia team, a psychiatrist, cardiologist, therapies, occupational therapists and a gastro-psychiatrist. Delirium and dementia screening took place for all new patients on some wards. If there was a high score from this the dementia and delirium team would visit and recommend a care plan as part of the enhanced care bundle.

## Access and flow

Ward staff were knowledgeable about how to make a referral, including urgent referrals, to the SPCT. These were by phone, in person or by email. Ward staff consistently told us that the SPCT were very proactive in responding to referrals. Consultant and nursing staff told us the referral process to the SPCT was easy, as was accessing the team. Referrers called in to a central number, monitored by an

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administrator and assigned on to the electronic patient record system. The team respond to the referral and called the referrer back to get more information and to provide any immediate advice. The SPCT held a daily morning meeting which discussed patients on the caseload. New referrals were allocated to each CNS for making contact with that day.

There was an internal KPI for responding to referrals and requests for advice and support. This was one working day for anyone with symptoms. Medical staff had access to end of life care consultants through the referral system, or out of hours through the hospital switchboard. The hospital was measuring compliance with seeing patients within 24 hours of referral. 254 SPCT referrals and contacts occurred in quarters 1 and 2 of 2018/19. Of these, 95% were seen within one working day. Reasons for patients not being seen within this timeframe were stated in each case, such as needing to see advocates, allocated for the social worker to see, waiting for family, having a procedure and referred on Friday and seen Monday.

Between November 2017 and October 2018, there were 917 deaths at the Royal London Hospital. 45% of those patients had been seen by the SPCT. Ward staff told us that SPCT staff were very involved with the wards. For referral and contact the ward said they will call them and had their mobile numbers for a responsive service. We were told by ward staff that they “rely on them a lot” and “they are very helpful”. Another ward told us a consultant from the SPCT visited every Monday, recently for the Monday board round and out of hours cover was provided by a palliative consultant on call. SPCT CNSs now visit the ward on Saturdays. We were told wards felt supported by this, especially with managing pain and offering palliative support.

The end of life care dashboard had showed a month on month improvement with CCP compliance so far this year. In April 2018 there was a compliance rate of 56% and by December 2018 this had risen to an 92%. The compliance rate was calculated by looking at the number of deaths reviewed by the medical examiner and the number they had identified as being appropriate for a CCP.

We spoke with one SPCT CNS regarding the order of their day. They had a caseload of five patients to see. The day started with attending handover meeting and then visits to

wards to see patients on their own caseload until 1 o'clock. Patients were allocated depending on caseload size. In the afternoon they planned to see other patients not on their caseload.

The SPCT were currently asking and documenting patients' preferred place of care (PPC) as part of the holistic assessments. The electronic patient record recorded preferred place of care. The recording of preferred place of care and preferred place of death formed part of the initial assessment and was recorded on the electronic record in all cases we saw. For instance, one patient record stated that the preferred place of death was a hospice and the plan was to await a hospice bed. This PPC/PPD information was not currently being collated and reported on.

The trust's SPCT leads told us that the need for these outcome measures to be collated had been identified. At sustainability and transformation partnership (STP) level, metrics were being set up locally to measure achievement of preferred place of care. In early 2019, an online function would enable the trust to have access to Co-ordinate My Care via the East London Patient Care Record. It was reported that all SPCT staff would receive training in completing these records. PPC would be recorded on this advance care plan. Deaths were then recorded, which would enable hospital and community teams to pull the data and ascertain the percentages achieved.

The trust's SPCT leads told us there were not many times when a patient could have gone home but did not or that the patient did not die in the right place. In practical terms we were told it was about facilitating patient choices, implementing fast track discharge and putting in place packages of care in the community. It was described as very fluid and dynamic, and situations changed with circumstances; it was not always realistic for all patients to die at home and was not something the SPCT felt they were not getting right.

The SPCT felt that the most challenging parts of achieving preferred places of care were coordinating the different resources needed in a timely manner. However, they also felt this was what they were good at. The complex discharge team was planning to audit this part of the process. Accessing carers or district nurses locally once people were discharged was described as straightforward. However, challenges lay with those patients with complex needs, such those discharged with tracheostomies.

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The fast track discharge process was a package of care to enable death at home with suitable support. It was a multidisciplinary approach to planning for the specific needs of a patient to support them to die at home/in the community. The fast track meeting happened as quickly as possible on admission or when it was identified that the patient wanted to die at home. Typically, community palliative nurses, occupational therapy and GP were involved.

Fast track applications were usually done by ward staff with assistance from the discharge coordinators and SPCT. The SPCT held a rapid discharge checklist they gave to wards to support the process. There were complex discharge coordinators and discharge teams. Occupational therapists and physiotherapists could also initiate the discharge process. The SPCT also got involved as they wanted to be involved as patients deteriorated.

There was online documentation for completion which we were told was usually completed by the practice development nurse or the nurse in charge. The complex discharge team also helped nurses to complete the forms. We were told that depending on need, it could take time to approve and delays could exist once the forms were sent to Continuing Healthcare for funding approval. We were also told that the provision of equipment was not an issue and we observed discussions of a hospital bed being requested by the ward and delivered to patient's house. We also came across another patient who was going home that day, with medications, a bed, mattress and slide sheets all in place.

The target timeframe for rapid discharge was within 48 hours. We were told that until April 2018 the acute trust delivered the community health service assessments. At this time, data was kept locally. Since the TUPE of the service to another provider, the trust had not had consistent data. It had recently implemented spot check audits for timeliness. No results were available at the time of our inspection.

SPCT CNSs and ward teams ensured the ward doctor called the GP on the day of discharge. Conversations were usually between the consultant and the GP. Usually by phone initially and information was sent by secure email if needed. Where a DNACPR was in place the GP was also informed as it was only valid until the patient got home, (it did not transfer to the community) and the GP needed to complete one. Discharge summaries were completed by wards. Specific information was sometimes requested and

added such as by the pain team about opioids to be included. The trust lead SPCT nurse told us they would like to introduce a follow up phone call to check in with patients and relatives, and assist with quality improvement.

For access to porters, wards called a helpdesk which then came through to the porters office as a job for allocation. Jobs could be for relatives' viewing of a body out of hours, a body release out of hours, or the moving of a deceased patient from wards. The porter manager and site manager were emailed by the mortuary on Friday afternoon with update on fridge spaces, viewings and notification of out of hours releases.

For access to chaplaincy services, they received referrals from patients, relatives, community teams, ward staff and SPCT staff. Chaplaincy service visited wards routinely and maintained a visibility. A 24 hour service was provided.

## **Learning from complaints and concerns**

The trust had a complaints policy and procedure in place. Information on the trust's complaints policy and procedure was available on the trust's internet website. SPCT were aware of the trust's complaints policy and of their responsibilities within the complaints process.

The SPCT told us they had a role to advocate on behalf of patients and communicate their needs to ward staff if appropriate. They also signposted people to PALS or ward managers to help patients to communicate their needs. There was a bereavement survey to identify any areas of feedback and comments were cascaded to ward staff where relevant.

Regarding complaints and compliments relating to end of life care, we were told by the trust's SPCT leads, they had produced a trigger list of issues and concerns about the main types of things end of life care patients and their families complained about. We were also told they felt they needed to get better at collating all the really positive feedback and thanks that was received in relation to end of life care to demonstrate a picture of how well they were working.

An end of life care steering group met monthly and reviewed a number of standing items that included incidents, complaints and risks. They had also carried out investigations of complaints. It was attended by ward

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managers, associate director of nursing, liver consultant, respiratory registrar, older people's and palliative care consultants, the bereavement CNS, chaplaincy, the hospital governance lead and the end of life care facilitator.

## Are end of life care services well-led?

Good



We rated well led as good. At our previous inspection in 2016 we also rated it as good. At this inspection we rated it as good because:

- At the last inspection we found senior managers understood the risks and challenges to the service and clinical leads were visible and approachable. At this inspection we found this was still the case.
- At the last inspection we found there was a system of governance and risk management meetings at both departmental and divisional levels. At this inspection we found there was a trust wide and site based end of life care steering group with good engagement at each level. The hospital demonstrated improvement work being monitored within this structure.
- There was clear accountability at board level and clear leadership for end of life care within the hospital structure.
- There was an end of life care strategy that was aligned to published national guidance. Progress with guidance was monitored at the end of life steering group.
- We observed an open and engaged approach towards end of life care, symptom control and ward engagement with end of life care. The specialist palliative care team had a positive approach to being visible and engaged well with the wards.
- The hospital demonstrated that learning and improvement were taking place at a meaningful level. Risks were being effectively monitored.

### However;

- Information systems needed further development to link up with the community.

## Leadership

The chief medical officer (CMO) had specific responsibility for end of life care on the trust board. There was a named non-executive director on the trust board leading on end of life care and usually chaired the quality assurance committee.

At site level, the director of nursing was the senior responsible officer for end of life care at the hospital and was responsible for EoLC nursing on site.

The SPCT had a trust medical and nursing lead as well as a nursing team leader at site level.

Regarding chaplaincy services, there was a manager who reported to the deputy chief nurse. There was also a deputy manager, which was a recent addition. Bereavement services also sat under the responsibilities of the deputy chief nurse.

The mortuary manager reported to the pathology divisional manager. The hospital mortuary and post mortem facilities were regulated by the Human Tissue Authority and there was a consultant pathologist who was the designated individual for the hospital's registration with the HTA.

## Vision and strategy

The trust first published its 'End of Life Care Strategy 2016 - 2019,' in 2016. The 'End of Life Care strategy 2017 - 2020 moving forward: Supporting our staff to care for our community' was finalised in December 2017. The trust strategy was based on the 'Ambitions for palliative and end of life care: a national framework for local action 2015 - 2020'.

Progress of delivery of the strategy was monitored by the trust's End of Life steering group. An action plan was in place to support delivery of the strategy which focused on the following six ambitions for the service:

1. Each person is cared for as an individual.
2. Each person gets fair access to care.
3. Maximising comfort and well-being.
4. Care is co-ordinated.
5. All staff are prepared to care.
6. Each community is prepared to help.

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The action plan was red, amber and green (RAG) rated to indicate if the action points had been completed, were in progress or overdue.

## Culture

We observed an open and engaged approach towards end of life care, symptom control and ward engagement with end of life care. We also observed that the SPCT had a positive approach to being visible and engaging with the wards. The SPCT staff were accessible and available. They were familiar to ward staff, attended wards to support patients and staff, and also did ward based teaching when required.

Ward staff told us that overall it was a good place to work and nurses and senior nurses were supportive of each other. We observed teams that were proud of their efforts and ongoing investment in end of life care. One SPCT CNS told us the culture on the wards was kind, so ward staff were kind to patients.

The trust's SPCT leads told us they felt there was a culture of enthusiasm and energy to develop services at the hospital. An awareness of end of life care needs at senior level, had given palliative and end of life care good links with senior people in the trust to get things done and make changes. It was felt this existed at ward level too and a good understanding of what was going on with end of life care existed across the hospital.

## Governance

The trust's end of life steering group met bi monthly and was chaired by the trust's chief medical officer (CMO) which reported to the quality board. The named non-executive director on the trust board leading on end of life care usually chaired the quality assurance committee.

The director of nursing was the senior responsible officer for end of life care at the hospital and responsible for EoLC nursing on site. They chaired a hospital based end of life care steering group which met monthly. The group were part of the NHS Improvement End of Life Care Improvement Collaborative. NHSI were linking trusts taking part in the collaborative, creating a supportive network for the changes they were implementing. It was attended by ward managers, associate director of nursing, liver consultant, respiratory registrar, older people's and

palliative care consultants, the bereavement CNS, chaplaincy, the hospital governance lead and the end of life care facilitator. We were told that in the last year there had been better medical engagement with the group.

The mortuary manager reported to the pathology divisional manager. There were monthly mortuary meetings attended by all staff.

## Management of risk, issues and performance

The work of the SPCT was monitored using a performance review dashboard. The dashboard was used to detail the number of expected deaths, the number of patients who had been fast tracked, the number of completed compassionate care plans (CCP) as a percentage of deaths, EoLC training delivered to staff, and number of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms completed as a percentage of deaths. The dashboard did not have key performance indicators (KPI) or monitor if patients were supported to die at their preferred place of death.

The hospital end of life care steering group met monthly and reviewed a number of standing items that included incidents, complaints and risks. They had also carried out investigations of complaints. Minutes from the end of life care steering group demonstrated attendance from the acute assessment unit, critical care, governance, wards, theatres, senior nurses, SPCT nurses and consultants. Learning from incidents and complaints took place with numbers of monthly complaints and numbers of incidents stated. Deep dives of each took place at each meeting. DNACPR compliance was monitored.

Education given to hospital staff in aspects of end of life care was documented for the month and presented to the hospital end of life care steering group. August 2018's meeting showed that some form of EoLC education took place on most days in July 2018, such as through audit, preceptorship, QI training, a debrief session, the healthcare assistants' forum, teaching, meetings, junior doctors induction, EoLC champions' meeting and the practice development nurses' meeting.

Learning from deaths was reviewed and presented to the hospital end of life care steering group. August 2018's meeting showed that in Q4 of 2017/18, 95% of 269 hospital deaths were reviewed. One complex case was discussed in detail for learning.



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Risks were reviewed at the hospital end of life care steering group. In October 2018's meeting, it was stated that since new syringe drivers were purchased (in February) staff felt they were easier to access. However, syringe driver availability was stated as remaining on the risk register with the group continuing to monitor.

November 2018's hospital end of life care steering group minutes stated that six day working was starting as a pilot for two months on Saturdays to assess the impact, which once embedded in the new year, then move onto seven day working.

The end of life care improvement plan was reviewed and updated at the hospital end of life care steering group. The end of life care improvement plan was updated monthly and demonstrated work was taking place on a number of themes. An improvement plan was provided that set progress with Ambitions for Palliative & End of Life Care: a National Framework 2015 – 2020, National Palliative & End of Life Care Partnership 2015, and tracked the hospital's progress against them. All 21 'foundation' actions, such as embedding monthly site group meetings, achieving site leadership engagement, establish site level governance and accountability through a steering group, agree governance and leadership structure for SPCT and end of life care teams, recruit SPCT consultants and SPCT Nurses, had been marked as achieved. Progress against the five ambitions was monitored and reviewed at the end of life steering group. There were a total of 49 items under the ambitions which were marked as; task to begin, in progress, achieved, ongoing, delayed / At risk or not achieved. November 2018's update showed only three of 49 items as delayed or at risk. Most actions had been achieved.

An updated performance dashboard was provided following our inspection. It showed that the number of deaths were monitored and broken down into the following: the number of deaths managed through the bereavement office, number of deaths reviewed by medical examiner (ME), the number that on ME review would have been appropriate for CCP, the percentage where CCP had been used, calculated performance with CCP compliance, percentage of adults with a palliative diagnosis and percentage of deaths with SPCT contact. It also recorded DNACPR audit, incidents, complaints, hospital staff who

had attended end of life care education and fast track. Some of these items, such as DNACPR audit, numbers on fast track discharge and breakdown of bereavement surveys month by month were not fully completed.

November 2018's end of life steering group meeting minutes showed that the end of life performance dashboard was discussed. Supporting documentation stated that a dashboard for end of life care to support improving patient and family experience had been developed. It reported that the dashboard had been problematic due to sites within the trust having differing interpretations and a mismatch in where data was drawn from. It stated that currently performance could not be reported on electronically in the same way across all sites, and therefore a process that provides a consistent method of data collection needed to be agreed on. Actions were stated that each site needed to nominate a dashboard handler who requests data each month. The dashboard handler must complete and submit the dashboard to the trust monthly.

There was a risk register for end of life care issues which was hospital based. There was also a palliative care risk register which was trust wide and controlled by the SPCT. The trust's SPCT leads told us they were a networked service within the trust, which meant all risks relating to the networked service were recorded on the service risk register. Local risks, such as syringe driver availability was on the site risk register. The director of nursing told us this model was aligned to the site assurance framework.

A mortuary audit schedule was in place and one audit item was reviewed each month and any shortfalls addressed. The most recent audit was a last offices audit, where patient details were checked. This included auditing identification, date of death, infection status, whether the patient arrived in the mortuary with a cadaver bag and shroud were audited. Where all elements were not in place, an incident report was completed and appropriate action taken.

The hospital mortuary and post mortem facilities were regulated by the Human Tissue Authority (HTA). HTA licensed establishments are required to meet minimum standards of consent, governance, traceability and premises, facilities and equipment. The hospital mortuary was last inspected in 2016. The HTA found the named

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responsible individuals to be suitable in accordance with the requirements of the legislation. All applicable HTA standards were assessed as fully met. Eight recommendations were made.

## Information management

The electronic patient record system had recently replaced paper notes. Records were held securely on the EPR system which was accessed by NHS smart card. Paper records contained admissions information and DNACPR forms and were stored securely in the multidisciplinary room which was locked and only accessible to staff.

The trust's SPCT leads told us that Coordinate My Care was the system used locally. It had been agreed as part of the area's sustainability and transformation plan. We were told they needed to have an 'in context' link with the contracted software providers. Presently it was not integrated into the electronic patient record so it was not matching up.

However, they did have the 'east London patient record' which was included in the contracted software system which links up all of the east London NHS trusts for acute and community and some GP records. It had been in place for over a year. Some of the links were new or in development. Coordinate My Care should be accessible via this route as read-only. In terms of supporting to primary care, we were told this was done through TTAs, rapid discharge checklists, discharge summaries and verbal handovers with GPs.

The mortuary register recorded date of death, time received in the mortuary, name, ward, age, gender and fridge number. Signing out checks were completed. The identity band check was completed jointly by the funeral director collecting the body and a mortuary staff member. A release form was completed that included identity number and coroner's name if needed.

There was a porter's receiving book for out of hours. It recorded name, date, time, ward, fridge number and porter's initials. Two porters would sign to verify. A separate porter's signing out book was kept for out of hours, which recorded the same information as the regular signing out book. This was checked by mortuary staff on Monday morning and then an entry was made in to the regular book.

## Engagement

Relatives were sent a bereavement survey six weeks after their loved one's death. Information gathered was

incorporated in the trust's annual bereavement survey. We were provided with the outcome from the most recent hospital bereavement survey. The survey reported on experiences returned by people for the period between July 2016 to November 2016. It followed the experience based design approach (EBD), developed for the use of front-line NHS services as a way of better understanding people's experiences of care. There were 392 deaths over this period. 239 surveys were sent out and 41 (17%) surveys were returned. Service improvement had been produced as a result of the survey. This included team based learning on wards in small numbers, with time away from clinical care, using simulation training and role play about communication, piloting reflective discussions about deaths as a ward based exercise 30 mins per month and encouraging consultants to offer / juniors to ask to be present to observe / take over end of life discussions.

The trust's SPCT leads told us they escalated patient stories around end of life care to the board. The relative of a patient had joined the the end of life steering group for a period of time and the hospital were currently seeking another patient/relative representation on the group to embed the voice of the patient in their decision making. Overall it was felt that patient feedback came from compliments and complaints in direct feedback to staff, who incorporated this in to how people were cared for.

The SPCT were engaged with ward staff which enabled better end of life care for patients. We observed that the SPCT had a positive approach to being visible and engaging with the wards. The SPCT staff were accessible and available. They were familiar to ward staff, attended wards to support patients and staff, and also involved with numerous forms ward based teaching when required such as preceptorship, debrief sessions, healthcare assistants' forum, meetings, junior doctors induction, EoLC champions' meeting and the practice development nurses' meeting. We came across end of life care champions on wards. End of life care champions met on a monthly basis for training.

## Learning, continuous improvement and innovation

An end of life care facilitator had been in post for the 18 months. They had improved the education on offer to hospital staff and improved engagement in end of life care among staff. Simulation training had also been provided in communicating with patients during end of life. 1000 staff had had training by the SPCT team this year.

## End of life care

There was an end of life care and bereavement conference at the site. An event called 'Dying Matters' was a nationwide forum and the trust had a stall here. The trust's SPCT leads told us they had 'a huge footfall' at the event. In 'dying matters week' the SPCT introduced signage for side rooms

which showed that people were receiving end of life care, so that staff were sensitive around those rooms such as being quiet, not laughing and shouting. They also introduced special belongings bags. All as part of the compassionate care bundle to support the CCP.

# Outstanding practice and areas for improvement

## Outstanding practice

### Maternity

- The trust had taken significant steps to improve the experience of patients who used the service; for example, utilising the skills of a patient experience consultant to better equip maternity staff in their engagement with patients. Such steps had seen a demonstrable improvement in standards of care, evidenced by positive feedback from those who use the service.
- There was an increased emphasis on improving staff morale and in retaining and progressing those in employment with the trust. Several initiatives had been introduced to enhance the working culture among staff. For example, opportunities for staff to undertake duties in higher bands for a limited time to gain experience, and increased engagement and recognition of staff success. This had improved openness, teamwork and ambition among staff, and had also resulted in improved standards of care.
- The trust was committed to ensuring the service met the needs of the local population and had introduced initiatives accordingly. This included advocates to support the large Bengali population and dedicated Bengali only antenatal classes, and a large amount of Bengali accessible information.

### End of Life Care

- There was an open and engaged approach towards end of life care. We observed teams that were proud of their efforts and ongoing investment in end of life care.
- People from different disciplines and with different skill sets worked alongside each other well to deliver end of life care to patients.
- There was a full time medical examiner in post who carried out reviews of deaths and liaised with relatives. Their duties included categorising deaths, attending serious incident meetings chaired by the Responsible Officer weekly, and feeding back to the SPCT on information regarding the CCP. They also ensured death certificates were completed correctly. Learning from deaths was shared monthly via the trust mortality review group, information from which was cascaded to services via clinical leads.

## Areas for improvement

### Action the hospital SHOULD take to improve

### Maternity

The trust should consider reviewing the scope of training for the ward clerks, with reference to the duties being undertaken for security purposes.

The trust should review the accessibility of extra security presence when required by staff.

The trust should ensure that there is a comprehensive system in place to ensure all policies for staff to access are always in date, and are reviewed as per local recommendation.

The trust should ensure continued investment in the upgrading of the IT systems to facilitate the improvements in governance.

# Outstanding practice and areas for improvement

The trust should ensure that record keeping within the maternity department is always secure and completed.

## **End of Life Care**

Assessments of capacity should be appropriately recorded where DNACPR records indicate that patients lack capacity.

The trust should ensure the system for the loaning out and recovery of syringe drivers is fit for purpose.