Homerton University Hospital

Trust Offices
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Ratings

Overall rating for this hospital	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Good ●
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Overall summary of services at Homerton University Hospital

Outstanding ☆ ↑

The hospital's rating improved. Based on an aggregation of ratings across all of the core services provided from this location, the hospital has been rated outstanding.

Homerton University Hospital NHS Foundation trust is an integrated care trust in Hackney, East London. The trust provides general health services at hospital and in the community. The trust operates acute services from a single site: Homerton University Hospital, which opened in 1986. The trust provides a full range of adult, older people's and children's services across medical and surgical specialties. The hospital has almost 500 beds spread across 11 wards, a ten bed intensive care unit and maternity, paediatric and neonatal wards. Community services are provided by staff working out of 75 partner sites in Hackney and the City of London. The trust has a separate registration to provide continuing health care at the Mary Seacole Nursing Home.

The trust provides some highly specialised tertiary services, including bariatric surgery and the Regional Neurological Rehabilitation Unit. It is one of London's designated perinatal centres and provides a range of highly specialised obstetric and neonatal intensive care services. The trust has 46 neonatal intensive care cots. The total number of births in 2018/19 was 5744.

The trust serves a diverse and changing local population from Hackney, the City of London and surrounding boroughs in East London. Hackney was the 11th most deprived local authority overall in England in the 2015 Index of Multiple Deprivation. The City of London has a growing population and was judged as the 262nd most deprived local authority out of 326. Hackney's population is estimated at more than 263,000 people. Hackney has a relatively young population, with 25% of residents under 20 years old. The proportion of residents between 20 and 29 has grown in the last ten years and now stands at 21%. People aged over 55 make up 18% of the population.

The trust is managed by a board of directors comprising six executive and seven non-executive directors. The board is advised and supported by a council of governors comprised of 14 members of the public, six trust staff and seven people representing interested parties such as the London Borough of Hackney. Responsibility for clinical management and leadership is delegated to the trust management board, comprising the executive directors, associate medical directors and deputy chief nurses. Clinical care is the responsibility of clinical teams divided into three clinical directorates of 1. Surgery and Women's Health Services, 2. Children's Services, Diagnostics, Outpatients and Sexual Health and 3. Integrated and Medical Rehabilitation Services.

This was a focussed inspection that took place on the 28 and 29 January 2020. It covered three core services; medical care, maternity services and end of life care. Our inspection of medical care was focused on older people's care which is reflected in the report. For this reason, medical care is not rated as it did not cover all of the key lines of enquiry related to the core service. Our inspection of maternity services was a follow up inspection to assess whether the trust had made improvements in governance processes since the last inspection in August 2018. We did not inspect all domains but inspected and rated Safe and Well Led only. We inspected and rated all domains in end of life care.

Each core service inspected on this visit are reported on below.

Medical care (including older people's care)

Summary of this service

We carried out a focused inspection of older people's care at Homerton Hospital. This inspection looked specifically at the provision for care of elderly patients within medical care. The inspection was a response to concerns raised by members of the public, and from intelligence coming from stakeholders.

Elderly and frail patients were admitted to the hospital elderly care units (North and South). Each elderly care unit consisted of 28 beds each. This was previously a single 56 bedded ward, which had split since the time of the last inspection.

Patients were admitted to the elderly care units from the acute care unit (ACU), a 35 bedded short stay assessment unit which admitted patients from the emergency department.

Both the elderly care units and ACU were delivered under the division for integrated medicine and rehabilitation services (IMRS), which included the emergency department and community health services.

We visited these wards over two days during an announced inspection from the 28 to 29 January 2020. We also visited and spoke with staff in the discharge lounge.

We reviewed ten patient clinical records and observed care being delivered across the three wards. We spoke with eight relatives and carers, nine patients and 31 members of staff including divisional and local leadership, nurses, consultants, junior doctors, physiotherapists, pharmacists, dietitians, and administrative staff. We also reviewed the performance data and looked at trust policies and pathways for elderly care.

As this inspection was focused on care of elderly patients, the inspection was focused only on relevant Key Lines of Enquiry (KLOEs), and this is reflected in the report. For this reason, the report is not rated.

Care of the elderly wards at Homerton Hospital continued to provide safe care and treatment. Although these services were not rated, we found:

- The service provided mandatory training in key skills to all staff, including dementia awareness and safeguarding training.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Staff supported patients to make informed decisions about their care and treatment. Staff also followed national guidance to gain patients consent.
- The environment on the care of the elderly wards and areas was visibly clean and tidy.
- The service had enough staff with the right qualifications and experience.
- Staff recognised incidents and reported them appropriately. Managers investigated reported incidents and shared lessons learned with the whole team and the wider service.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients and we observed that the MDT supported each other to provide good care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- The service was inclusive and took account of patients' individual needs and preferences, including for elderly patients.

Medical care (including older people's care)

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.
- However:
- On inspection we identified an issue that some patient records did not document falls assessments in care plans. While we noted that patients had been seen by a falls nurse and action had been taken, this was not always reflected in the patient records.
- At the time of inspection, care of the elderly wards did not have a dedicated practice development nurse.
- Where staff had to deliver difficult news, there were communal rooms on the wards and nearby where these conversations could be had. However, these multipurpose spaces were not particularly private and were often in use by staff or for ward activities. Following inspection, the trust stated that the sister's office was the designated space for private conversations on the ward, however some staff were not aware of this.

Is the service safe?

We did not rate safe. This inspection was focused on the key lines of enquiry relevant to older people's care only. For this reason the core service of medical care or any of the domains have not been re-rated.

Is the service effective?

We did not rate effective. This inspection was focused on the key lines of enquiry relevant to older people's care only. For this reason the core service of medical care or any of the domains have not been re-rated.

Is the service caring?

We did not rate caring. This inspection was focused on the key lines of enquiry relevant to older people's care only. For this reason the core service of medical care or any of the domains have not been re-rated.

Is the service responsive?

We did not rate responsive. This inspection was focused on the key lines of enquiry relevant to older people's care only. For this reason the core service of medical care or any of the domains have not been re-rated.

Is the service well-led?

We did not rate well-led. This inspection was focused on the key lines of enquiry relevant to older people's care only. For this reason the core service of medical care or any of the domains have not been re-rated.

Medical care (including older people's care)

Detailed findings from this inspection

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff.

The trust set a target of 90% for completion of mandatory training.

All staff completed Safeguarding Level 1, 2 and 3 (dependent on their roles and responsibilities), as part of their mandatory training. This was repeated 3 yearly. Within this training there were modules relating to safeguarding vulnerable patients as well as relating to the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff working with elderly patients also completed dementia awareness training as part of their core mandatory training. Staff stated they found this training useful in understanding how to best support patients with a diagnosis of dementia.

Mandatory training modules were a mix of classroom delivered training and e-learning. Staff were able to access and complete training modules remotely if needed.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff completion of mandatory training modules was monitored by managers through the trust training system. Staff were informed when training was due to expire, and they were expected to book on to the next available training.

Following inspection, the trust provided a breakdown of compliance for mandatory training courses for staff on care of the elderly wards. The wards met the trust target for training in both safeguarding and dementia training (93% compliant for each course).

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff knew how to identify patients at risk of, or suffering, significant harm, and worked with other agencies to protect them. Staff had a good understanding of when they would need to report safeguarding issues and who they would contact if they had any concerns. This included considerations specifically around the care of elderly and frail patients, including financial abuse and neglect.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All safeguarding referrals were reported via the trust incident reporting system (which was monitored by the safeguarding team) and forwarded to the local authority for investigation when necessary. There were also posters up in the main ward area displaying contact details for the safeguarding team.

We reviewed the hospital safeguarding policy, which detailed what to do in the event of a safeguarding concern and reflected the service's obligations under safeguarding legislation. Staff were also able to provide examples of when they had to contact the safeguarding team or completed safeguarding referrals, and we found these examples complied with the safeguarding policy.

We observed discussions around safeguarding for patients on elderly care wards, which included in discharge meetings. Any safeguarding incidents were also reviewed weekly in the weekly Complaints Litigation Incidents and PALS (CLIP) meetings and appropriate action taken.

Medical care (including older people's care)

At the time of the last inspection, we identified that the role of the adult safeguarding practitioner in the safeguarding team had been vacant for the last six months which had impacted on the delivery of safeguarding training and oversight of safeguarding referrals. On this inspection we found that the resources in the adult safeguarding team had improved, and there was better communication between wards and the adult safeguarding team.

Cleanliness, infection control and hygiene

The environment on the care of the elderly wards and areas was visibly clean and tidy.

Care of the elderly wards were generally clean and well maintained. Signed cleaning schedules were visible on most of the wards indicating when cleaning had been done and when it was due.

Staff followed the trust's infection control policy, for example washing their hands in between attending to patients, using personal protective equipment such as gloves and aprons, and adhered to the trust's 'bare below the elbow' policy. We saw generally good compliance across medical wards for staff hygiene and use of antibacterial hand gel.

Staff used green 'I'm clean' labels to indicate when an item had been disinfected and was ready for use. We saw these stickers in use across wards.

Staff managed waste and sharps safely on the medical wards we visited. We saw that bins on medical wards had the appropriate bags, and sharps bins were not filled above the appropriate line.

Isolation rooms were available on care of the elderly wards for the isolation of patients. We found that staff had appropriately isolated patients in order to protect other patients from infection, or protect patients that were severely immunosuppressed. Where patients had been isolated, staff placed signs on the door indicating what precaution or personal protective equipment (PPE) staff and visitors had to take in line with the hospital's infection control policy and good practice.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe.

Since the last inspection, the 56 bedded care of the elderly ward had been divided into two separate 28 bedded wards (Elderly Care Unit North and Elderly Care Unit South). Staff stated that the change had been driven by the suggestion of the senior sisters for the Elderly Care Unit and the changes made in the last twelve months. Staff stated that the change to the environment had improved the delivery of care in these areas, as the wards were less busy and were more manageable as separate environments.

Emergency equipment such as resuscitation trollies were available on care of the elderly wards. We examined the resuscitation equipment on elderly care wards and found that staff checked equipment daily in line with guidance from the Resuscitation Council.

Entrances to the wards were controlled by key pad access, and visitors were required to identify themselves by using the intercom to staff before being granted entry. Some family members stated that it could take some time to be given access to the ward to visit patients. Staff stated that they responded to provide access as quickly as possible, and that there were volunteers available on the wards who could respond to the entrance bell if clinical staff were busy providing care.

Patients could reach call bells and staff responded quickly when called. Patients and family we spoke with confirmed staff answered call bells in a timely manner. Patients reported they had no concerns for staff response on the wards; even during busier periods they felt staff were very attentive. We also observed the ward sister carrying out checks to ensure call bells were accessible to patients.

Medical care (including older people's care)

Care of the elderly wards had been designed and decorated to ensure they met guidelines for dementia patients. Doors and communal areas had colour coding and signage, which made it easier for patients with dementia to move around the wards. The wards also had accessibility equipment such as hand rails for patient with mobility issues or at risk of falls. Staff stated that each ward had bays close to the nursing station where patients with complex needs could be more closely monitored.

The service had suitable facilities to meet the needs of patients' families. There were armchairs available at each patient bedside for family members to stay, and staff stated that visitors could use the intensive care visitors' room nearby if they needed to be with their relative overnight. Each area had information leaflets on services offered by the hospital to support patients and family members.

Equipment was maintained and checked regularly to ensure it continued to be safe to use, and was clearly labelled with the date when the next service was due. This included mobile electrical equipment that we looked at, which had up to date Portable Appliance Testing (PAT).

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. Staff used the national early warning scores (NEWS2) system to assess and monitor deterioration in patients. We saw the NEWS2 form used by staff to monitor any deterioration in the patient's status, and observed staff discussing the NEWS2 score when deciding on care plans.

Staff knew about and dealt with any specific risk issues. Staff completed risk assessments for each patient on admission and updated them when necessary using recognised tools. Patients were screened on admission and as necessary for sepsis, infection control risks, falls risk, pressure ulcers, and others. We saw consistent evidence of this recorded in patient notes and risk assessment tools in use.

Care of the elderly wards had pathways in place for patients at risk of deterioration. Staff we spoke with were aware of the actions taken when there were signs that a patient was deteriorating, and the pathways were posted on notice boards on the ward. This included pathways for sepsis, resuscitation, and anaphylaxis.

The trust used a venous thromboembolism (VTE) risk assessment tool which was completed on admission to the ward and regularly throughout admission. We saw evidence of patients who had been started on pathways to manage their risk of VTE, which was documented in the patient records. Audits of completion of VTE assessment provided by the trust following inspection showed that between October 2019 and December 2019 98% to 100% of patients received a VTE assessment.

Management of sepsis on the elderly care wards was in accordance with the hospital's policy on sepsis recognition and management. Staff told us that they followed the United Kingdom sepsis guidance on the management of septic patients, and we saw evidence of screening in patient records we reviewed. The 'Sepsis Six' approach was used, sepsis training was mandatory, and the sepsis pathway was visible on notice boards across elderly care wards. Sepsis Six is the name given to a bundle of medical therapies designed to recognise and treat sepsis early and therefore reduce mortality. The trust also had a sepsis lead nurse for the trust who was available to provide advice and training to staff.

Following inspection, the trust provided evidence of sepsis records monthly audit taken throughout the hospital at random (including care of the elderly wards). The audits provided did not provide any areas of concern in process for sepsis screening.

Medical care (including older people's care)

NEWS 2 monitoring was in place to monitor patients at risk of deterioration. Staff on the ward and in A&E had a warning system and escalation flow chart to decide when to make a referral to the critical care outreach team (CCOT). Staff recorded the patient's physiological observations every six hours or more frequently if required.

The CCOT provided an outreach service from 7:30am to 8pm, seven days a week. Staff we spoke to on the ward told us that the outreach team were very accessible and easy to contact for support. Overnight cover deteriorating patients was provided by the additional deteriorating patient Senior House Officer (SHO) who covered medical and surgical wards overnight. This post was in addition to the on-call staff on duty. Junior medical staff were positive about this support from the SHO, who was available on an emergency medical call if needed.

Care of the elderly wards had access to a falls service for patients who were identified at risk of falls, which included a falls prevention nurse specialist. The falls nurse provided advice for staff in managing patients at risk of falls, and also assisted in putting together management plans for mitigating the risk. We saw evidence of input from the falls nurse in patient records. Data provided following inspection showed that care of the elderly wards did not have any falls resulting in harm between November 2019 and January 2020.

Any tissue viability concerns could be reported to the hospital tissue viability nurse (TVN) for support and advice, particularly managing any complex pressure ulcers. TVNs provided some on-ward training in the past to improve skills and provided a weekly walkaround. Staff stated they were able to ask for support in managing pressure ulcers and recognised that pressure ulcer management was an area that the trust was trying to improve. Senior staff stated that the trust was working with NHS Improvement to reduce the number of both pressure ulcers coming from the community and hospital acquired pressure ulcers. As part of this, all grade three approved pressure ulcer reports were discussed within the pressure ulcer scrutiny committee for learning. Data provided following inspection showed that care of the elderly wards had one new pressure ulcer between November 2019 and January 2020.

As part of the inspection we attended daily handovers, discharge meetings, and ward rounds. Each of these meetings included multidisciplinary input, as well as consideration of the individual needs of each patient from each clinical discipline. Discharge meetings included discussion of complex needs such as packages of care in the community, access at home for patients, equipment, medication, and follow up appointments. We also observed that individual patient risks such as mental health, mobility, and dementia were discussed and considered in relation to discharge.

Any delayed discharge of care were followed up by the discharge team and monitored closely with the elderly care wards. The discharge team was supported by the integrated independence team (IIT) which worked across the hospital and the community. The IIT provided support to patients to avoid hospital admissions, but also ensure that when admitted they were supported through discharge from hospital. Staff we spoke with were positive about the role of the IIT in terms of patient care and in managing flow throughout elderly care wards.

The trust held daily multiagency delayed transfer of care (DToC) call to problem solve and escalate any complex discharges which were either already a delay or have to potential to be one. There was also a weekly DToC conference call "huddle" which was attended by senior staff and this looks at themes that may be causing DToCs.

Nurse staffing

The service had enough nursing staff with the right qualifications and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

During our inspection, the wards were well staffed. Senior staff stated that retaining staff on care of the elderly wards had been an ongoing challenge but there were generally able to fill shifts as needed.

Medical care (including older people's care)

Senior staff had recently completed a review of the staffing acuity tool which it used to decide necessary staffing levels. Nursing leadership and ward staff stated that the ward was generally well staffed and they could access additional support if they needed to. Care of the elderly wards provided approximately one nurse for seven patients, depending on acuity.

Nursing staff were supported by healthcare assistants (HCA) on both the day and the night shifts. HCAs could provide support in caring for the patients, but also monitoring of patients with more complex risks such as falls and mental health issues. The Acute Care Unit (ACU) was at the time of inspection piloting an additional HCA on shifts to support communication between wards and floating support for staff.

Managers limited their use of agency staff and requested bank staff where possible. Staff we spoke with stated that the wards used bank staff where possible, instead of agency staff, as they would be more familiar with the hospital processes and could deliver more continuity of care. Managers made sure all bank and agency staff had an induction and understood the needs of patients on care of the elderly wards.

Nursing staff stated they had regular team meetings to review clinical practice and performance, and to review any arising issues. Senior staff stated that there were regular meetings across both elderly care wards, which allowed learning to be shared and consistency of care across both wards. Senior staff stated that the split in elderly care wards also made the daily handover and discharge meetings more manageable, as there were fewer people now involved.At the time of inspection the practice development nurse (PDN) role was vacant, however recruitment had been completed and the successful candidate was due to start in March. Senior staff stated that they had several training needs identified for the wards, which included sessions to improve staff skills in relation to minimising risks.

Medical staffing

The service had enough medical staff with the experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave locum staff a full induction.

Oversight for medical staffing on care of the elderly wards was provided by the clinical lead, and a group of geriatricians providing daily oversight on each ward. Staff we spoke with stated medical leadership and consultant group was visible on the wards and assessible when needed, and that there were regular meeting opportunities for medical staff of all grades. Medical staff on care of the elderly wards worked in groups, with a team of junior doctors supporting a consultant.

Consultants were available on care of the elderly wards every day between 8am and 8pm. The consultant was then on-call from 8pm to 8am the following day. This allowed consultants coming on shift to be familiar with the patients that they would be covering on the ward. This system was extended to cover full weekends (i.e. 8pm Friday to 8pm Monday). Medical staff we spoke with were positive regarding the shift patterns as it provided better continuity of care for patients and oversight for clinicians.

Staff stated there was a positive relationship between the consultants and junior medical staff. Junior staff felt well supported, and consultants were positive about the quality of trainees they worked with. Medical staff on care of the elderly wards also stated they worked closely with colleagues outside the wards, such as the geriatrician assessing patients in the emergency department.

Where elderly or frail patients were admitted to the hospital with both medical and surgical needs, the medical and surgical consultants worked together to provide additional input to manage the needs of elderly patients. Consultants we spoke with stated that there was often joint surgical and medical consultant input for patients that would have complex needs, and that this system worked well.

Medical care (including older people's care)

Doctors completed a formal ward round twice each day and decided on a management plan for each patient. We observed ward rounds on inspection and found them to be well attended by medical staff. Staff we spoke with stated there was regular opportunities throughout the week for bedside teaching during ward rounds.

Medical staff we spoke with were positive about the availability of the critical care outreach team (CCOT) and the deteriorating patient senior house office (SHO). The SHO role was introduced as a pilot role in February 2019 and permanently in August 2019. This role provided additional support for junior doctors out of hours in managing deteriorating patients.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.

The hospital generally used an electronic system for documenting patient care. This included records of treatment, care plans, risk assessments, medicines administration, and patient history.

We reviewed 10 patient records for patients on care of the elderly wards as part of our inspection. The records generally included appropriate care plans for patients, with risk assessments completed throughout and input from each clinician involved in the patients care. Care plans also reflected the individual needs of patients, such as care for dementia, end of life care, and patients with common clinical risks such as falls.

On inspection we identified an issue that some records did not document the falls assessment in care plans that were in place for patients. While we noted that these patients had been seen by a falls nurse and action had been taken, this was not reflected in the records. Following inspection, the trust provided a response that recognised the falls care plans had not been updated, and that learning from this would be collated by the inpatient falls prevention nurse, and shared with staff for improvement.

Care of the elderly wards had access to the Coordinate My Care (CMC), an electronic system which provided patients with access to information about their records, care preferences, and advanced care plans. This included information on care plans, and what the patient may wish to happen if they became less well. The record could also be shared with GPs, care homes, trust community staff, and others involved in the patients care. Staff we spoke with stated that it was standard practice to check if any admission to ECU had a CMC care plan.

Elderly care wards also used a comprehensive geriatric assessment (CGA) in discharge planning for elderly patients. The CGA used 12 subheadings relevant to care for elderly patients and summarised the information so it could be shared with patients, other health care staff, GPs and families in discharge summaries. The elderly care wards undertook a quality improvement project in 2019 to include CGA information under the subheadings of the discharge summary.

Senior staff performed monthly audits of patient records as part of ward performance monitoring app, which the trust provided to us following inspection. Senior sisters used the app to randomly select patient records and reviewed them for completeness. The most recent records audits for care of the elderly wards show records were generally well completed. This included risk assessments, care plans, observations, and evidence of input from other clinicians. Where audits identified any consistent areas for improvement, this was shared with staff in team meetings. However, it should be noted that the records audit had not picked up gaps in falls care plans that we identified on inspection.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

There was an electronic incident reporting system in place and staff knew how to report an incident. Staff told us they also received feedback from incidents reported that were investigated, either through team meetings or by direct feedback. Staff met to discuss the feedback and look at improvements to patient care. Staff stated they were generally well informed about incidents and investigations, as well as serious incidents across the trust.

Following inspection, the trust provided evidence of the three most recent root cause analysis (RCA) relating to care of the elderly wards. We found the RCAs were well completed and included action plans to improve the management of risk on the ward.

Incidents were monitored by senior staff and depending on the type of incident, investigated to identify areas for improvement. The wards and the wider division held monthly governance meetings to share information on incidents and to discuss changes to service delivery from reported concerns. These were minuted for staff who could not attend.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. All staff we spoke with were aware of the duty of candour and knew the circumstances to which they applied it. The trust incident policy reflected the hospital's requirement to be open and transparent with patients when there had been an incident.

Is the service effective?

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. The service was part of the National Audit of Dementia (NAD), which provided benchmarking and standards for dementia services across the UK. Following inspection, the trust provided evidence of the results for the NAD for 2019. The results showed that the trust was regularly above the national average for standards relating to the care of dementia patients. The trust also submitted data for a separate spotlight audit on the use of antipsychotic and other psychoactive medications for dementia patients.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Care of the elderly wards carried out an annual programme of audits to evaluate the quality of care being received by patients and overall performance.

In 2019, the elderly care wards were formally reviewed as part of Getting It Right First Time (GIRFT). The service was visited by the GIRFT programme lead for geriatric medicine in May 2019, which recognised areas of good practice and made recommendations for improvements. These included actions around reviewing the accuracy and coding of data, flow through care of the elderly wards, examining readmission rates, and discharge pathways. Following the report, the trust completed an action plan for addressing areas for improvement.

The elderly care wards had several quality improvement (QI) projects underway. The ECU QI program was led by an MDT of senior clinical staff, which worked closely with central QI Team, and results and outcomes from QI projects were shared throughout the hospital. ECU QI projects included improving the response to deterioration in patients, developing treatment escalation plans, learning from deaths, and a fast track for discharge patients (including end of life).

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. Care of the elderly wards had a regular calendar of weekly and monthly meetings to monitor performance and staffing, as well as twice daily handovers. Care of the elderly wards had joint meetings together to ensure that learning was shared across both wards.

At the time of inspection, the wards did not have a practice development nurse (PDN) in post, due to a vacancy. Recruitment had been successfully completed for a new PDN, and senior staff we spoke to were planning a programme of training for the PDN to roll out when they started. This included training to improve staff skills in mitigating risks to patients, such as falls and pressure ulcers. Staff we spoke with stated they also had weekly training sessions on care of the elderly wards, which had multidisciplinary attendance.

All staff working in the hospital completed dementia training as part of their induction. Staff that worked more closely with elderly and frail patients also completed a study day on dementia and delirium which covered pathways, pain management, end of life care, and supporting the emotional needs of patients and carers. Following inspection, the trust provided information that this course was due to be expanded to two days in 2020.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients and we observed that the MDT supported each other to provide good care.

Care of the elderly wards included the input of consultants and junior doctors, nursing staff, and a range of allied health professionals (AHPs). In clinical areas we observed the different disciplines worked well together collaboratively. This was reflected in conversations with staff, who stated that there was a good working relationship across the disciplines and the teams on the wards.

As part of the inspection we attended daily handovers, discharge meetings, and ward rounds. Each of these meetings included multidisciplinary input, as well as consideration of the individual needs of each patient from each clinical discipline. We reviewed patient records as part of the inspection and found that the daily meetings reflected input from disciplines across the wards.

The wards previously had concerns raised by staff that the nursing handovers were taking too long, leading to delays in medication rounds. This was confirmed in audits carried out by the lead nurse for medicines management. As a result, the trust had devised a safety briefing agenda. It was found that the handovers were taking too long, were too repetitive and also did not always capture the key information required. The agenda devised captured the key information, kept the staff focused and restricted the time in the briefing to approximately five minutes. This had resulted in drug rounds commencing earlier after the safety briefing.

While the care of the elderly wards had been separated, there was still regular opportunities for staff to work together and meet across both wards. Medical staff worked in core groups under the leadership of a consultant but were available across both wards. Nursing staff were allocated to either the Elderly Care Unit North or South, but there were regular team meetings and training across wards to share learning and meet as an overall team.

Where there were elderly care patients in other clinical specialities (i.e. surgery or other medical wards), geriatricians worked alongside their consultant colleagues to provide additional input to manage the needs of elderly patients. Consultants we spoke with stated that there was often joint surgical and medical consultant input for patients that would have complex needs, and that this system worked well. Staff regularly gave the example of orthopaedic patients as a group that may have joint surgical and medical input.

Medical care (including older people's care)

The care of the elderly wards also worked closely with several external organisations in delivering support for elderly patients and their families. For example, a national charity for older patients provided a home and settle service, which was based in the discharge lounge at HUH, patients could be referred from any member of the MDT. The hospital was also part of the City and Hackney Dementia Alliance (a CCG funded alliance of local stakeholders) that had provided funding for some therapies and equipment on the elderly care unit.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We saw that consent was clearly recorded in the patients' records. When patients lacked capacity to give consent this was also recorded in the patient record.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, taking into account the patient's wishes, culture and traditions, as well as input from family members. We attended ward rounds on the elderly care units and observed staff discussing patient capacity.

Staff made sure patients consent to treatment was based on all the information available. Patient information leaflets and records included information that helped patients provide informed consent.

During the inspection, staff told us safeguarding adults' level one training included awareness of the Mental Capacity Act (MCA). Staff also told us safeguarding adult's level two training (available as e-learning) included information on MCA and Deprivation of Liberty Safeguards (DoLS) for all clinical staff working with adults. Refer to Mandatory Training sub-heading for training compliance data.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Managers monitored the use of DoLS and made sure staff knew how to complete them.

Staff could describe and knew how to access policy and get accurate advice on MCA and DoLS. Managers monitored how well the service followed the MCA and made changes to practice when necessary.

Staff implemented DoLS in line with approved documentation. Staff clearly recorded consent to treatment in the patients' records as necessary. We saw examples of mental capacity assessments also completed in the patient records.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff felt that the change to two separate units allowed for better management of older patients as the wards were less busy and they got to know patients better.

During the inspection we saw most staff treating patients with dignity, kindness, compassion, courtesy, and respect. Staff explained their roles to patients (including identifying themselves to patients who were not conscious) and put patients at ease during any interactions.

Medical care (including older people's care)

Since the time of the last inspection the ward had been separated into two separate 28 bedded units (Elderly Care Unit North and Elderly Care Unit South). Staff we spoke with stated they felt this split had made a significant difference in the quality of care that patients could receive. Staff stated that the split allowed staff to work more consistently in one area of the ward and get to know their patients and families better. This meant they could be more familiar with their individual preferences and deliver more consistent care.

Patients said staff generally treated them well and with kindness. We spoke with nine patients on care of the elderly wards during the inspection. Patients spoke positively about the care they received and how they were treated. Patients told us staff were respectful and provided them with space to ask questions about their care. Patients also stated that staff were professional and friendly.

Care of the elderly wards displayed thank you cards on some notice boards that staff received from patients and relatives who had been on the wards. Comments in these cards included: "Thank you for all your support over the years from all the many staff who worked here" and "Thank you for the care you have provided to my dad".

Staff followed policy to keep patient care and treatment confidential. We saw that patient's privacy and dignity was maintained whilst they were on the unit. Staff ensured patients were covered up and supported when moving and received consent to continue before delivering care to the patient. Staff also closed the curtains around the patient's bed space before carrying out any personal care, to ensure they were not exposed while being treated.

Following inspection, the trust provided evidence of patient satisfaction surveys used on the elderly care unit. Survey results from January 2019 to January 2020 showed that 92% of patients were either 'extremely likely' or 'likely' to recommend the elderly care wards. Further survey results from the friends and family test (FFT) found that 92% of respondents answered positively to the questions "Do you feel you have been treated with respect and dignity?" and "Do you have confidence and trust in the staff treating and caring for you?". However, the overall score for "Have you been involved in decisions about your care?" was 82%.

On the care of the elderly wards we saw "You said, We did" boards. These boards identified feedback that had been received from service users or family members, and changes that the ward had made based on this information. We saw examples of these boards on both care of the elderly wards and on the ACU.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for and discussing patients with dementia or diminished capacity. Staff also understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff understood the impact that patients' care, treatment and condition had on their wellbeing. Staff stressed the importance of treating patients as individuals and this was reflected in the interactions we observed. Staff also demonstrated they would be empathetic when having difficult conversations with patients and families.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff provided reassurance and support for patients throughout their care. Staff demonstrated a calm and reassuring attitude to put patients at ease. We observed staff taking time to explain their treatment to patients and asking them if they had any questions about their care.

Should read Staff stated that they would have a conversation for all admissions where appropriate about end of life planning and what to do if the patient required end of life care. Staff stated that while it could be a difficult conversation to have, patients found it useful to do so to have a decision in place.

Medical care (including older people's care)

Patients who were approaching the end of their life or required palliative care could be supported by the palliative care team. The palliative care team worked collaboratively with the care of the elderly staff to manage end of life patients, and staff were proactive in involving the input of the palliative care team. Staff were positive about the availability of support from the palliative care team, and arrangements for palliative patients.

Where staff had to deliver difficult news, there were communal rooms on the wards and nearby where these conversations could be had. However, these multipurpose spaces were not particularly private and were often in use by staff or for ward activities. Neither care of the elderly wards had immediate access to family rooms for having private or sensitive conversations. Following inspection, the trust stated that the sister's office on each ward was the designated space for private conversations on the ward, however some staff were not aware of this.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We spoke with eight family members of patients on the elderly care units. Family members were generally positive about the care the patients received and stated that most staff members were professional and welcoming. Family members also stated they were kept well informed of treatment plans.

Staff supported patients and family members to make informed decisions about their care. There was evidence of discussions of patient care with those close to them in the patient records. We also observed the needs of family members being discussed in the ward rounds and discharge meetings by staff.

There were information leaflets for family members on each care of the elderly ward. These leaflets contained information on visiting times, lead staff, and hospital amenities, as well as managing key risks for elderly patients such as falls.

We saw involvement of family members in end of life care planning for patients. Family members we spoke with stated they were involved in conversations with patients who may require palliative care. Leaflets on how to cope with dying were also available on the wards.

Family members of patients with a learning disability or with a diagnosis of dementia could access a carers passport. The passport allowed carers access to financial support benefits offered by the hospital and allowed them to visit their family members outside of visiting hours and record information.

A carers support group took place fortnightly on the elderly care ward for carers of people with dementia. The group was carer led and provided emotional support to carers and well as information. Staff stated feedback from carers was positive about the group and some carers returned to the group after their family members were discharged from hospital. The wards also had carer involvement in the dementia steering group which allowed service user feedback on how changes to practice could impact on patients and carers.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. They understood patients personal, cultural and religious needs.

The hospital chaplaincy was available to meet the religious needs of patients and their families. The service had multidenominational chaplaincy team and could also provide access to other local religious groups as needed. A duty chaplain was available to respond to emergencies out of normal hours. Staff that we spoke with were positive about the available support from the chaplaincy.

The trust had a multi-faith complex, known as The Sanctuary, which was easily accessible and open 24 hours a day for all faiths. The Sanctuary included access to the chaplaincy office and multi-faith prayer room. There was also a Shabbat room available on-site for Jewish patients. The prayer rooms provided a range of religious texts, necessary for observances.

There was clear signage inside the main hospital building, which meant it was straightforward for visitors to locate the elderly care units and the acute care unit (ACU).

Staff were aware of how to access translation if patients or families were unable to communicate in English. Some staff stated they spoke other community languages so could offer some translation, however also stated that they would use interpreters where appropriate.

Staff stated they could contact security to support them if there were any threats of violence on the ward, towards either staff, patients or visitors. Staff stated they felt the security team would be responsive to keep both staff and other patients safe and were able to give examples of when they had to call for assistance.

Volunteers worked throughout the hospital to support the delivery of care for patients. Volunteers could provide assistance to patients at mealtimes, spend time with patients on care of the elderly wards, and support access to the wards for families. Senior staff stated that volunteers that worked on the elderly care units had completed dementia awareness training.

Care of the elderly wards provided support for patients if necessary upon discharge. The transport services team liaised with the wards to provide support with discharges, which staff stated they tried to arrange for the mornings. Discharge co-ordinators could also access food bank vouchers or supplies and packed lunches that can be given to patients who may have no access to initial food supplies upon discharge.

The trust had an operational dementia strategy to provide more consistent care and therapeutic environments for patients with dementia.

The clinical lead for elderly care was also the trust lead for dementia, and this role was supported by a lead nurse for dementia care. The lead nurse provided advice as well as training for staff to ensure the delivery of consistent care for dementia patients. Staff we spoke with were very positive about the dementia lead nurse.

The lead nurse for dementia was supported by dementia assistants working across the elderly care wards. The lead nurse had developed a therapeutic and social activities timetable which was carried out by dementia assistants (supported by allied health professionals). This included mobility groups, patients dining together, pet therapy, and art activities. The acute care unit was also piloting an additional HCA on the rota to support monitoring and care for patients with dementia.

The care of the elderly wards had an assessment and care pathway for delirium and dementia patients, including the "This is Me" dementia care tool. This included space to identify the individual needs, preferences of each patient, and a pathway of care. Staff stated they could also use a carers passport, to inform staff of patients who had a carer and what support needs they may have.

Care of the elderly wards had plans in place to ensure closer monitoring of patients with dementia and consideration of their needs. 'Forget me not' markers were used in patient records, on whiteboards, and over patient beds to indicate patients living with dementia. We saw evidence of these used throughout elderly care wards. The elderly care wards had also been decorated in line with national guidance on clinical environments for patients with dementia.

Medical care (including older people's care)

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences, including for elderly patients. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Visiting times for family and friends were 12:00 midday to 1:30 pm and 4pm - 8pm. Staff told us visiting times were flexible and visitors could arrange to visit at a time outside the normal hours if discussed with the nurse in charge.

Care of the elderly wards met the needs of patients' dietary requirements. A choice of food was available at each mealtime to meet the patients' needs, including for any religious or spiritual requirements. Patients and family members we spoke with were satisfied with the quality and choice of food on offer. Volunteers were available to assist patients that may have trouble eating by themselves, and these patients could be identified by using different coloured meal trays.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff told us that patients with any communication difficulties would be provided with additional support, and we observed this being discussed on acute care unit and elderly care wards.

Therapy staff supported a specialist falls service for patients who were identified at risk of falls, which included a falls prevention nurse specialist and input from physiotherapists and occupational therapists. A falls prevention steering group also reviewed any incidents involving falls to establish if practice could be improved. We saw evidence of input from the falls nurse in patient records, including plans for mitigating risk.

Appropriate equipment was available to meet the needs of patients with reduced mobility. The facilities on the unit were accessible for people with mobility difficulties. We saw the shower room had a chair and handrails and the toilet was accessible for larger patients or those using a wheelchair.

Elderly care wards had access to a multi-disciplinary team of staff able to support the individual needs of the patients. The ward had access to dedicated pharmacist, and the therapies team for physiotherapy, speech and language therapy, dietician, psychology and occupational therapy. Staff could also refer to specialist care teams such as the pain team or palliative care teams.

Therapeutic staff were involved in developing a number of activities throughout the day to encourage mobility and activity for older patients. These included weekly activities groups which staff referred to as "move, groove, and improve". On inspection we observed some of these activities taking place and found them to be well attended by patients. Staff stated that the patients found the groups useful, and they had the therapeutic benefit of encouraging older patients to retain their mobility.

Staff could also access hospital wide speciality leads (such as for learning disabilities and dementia) to receive advice and guidance on best supporting patients with pressure ulcers, at risk of falls, learning disabilities, or dementia. Speciality leads could also provide ward level training or get involved in care planning for particularly complex cases.

End of life care patients could be supported on the wards by the palliative care team, which was multidisciplinary and provided support throughout the hospital. Staff on elderly care wards were also positive about the role of the end of life care facilitator, who supported liaison and care plans for palliative patients. Staff also stated that they requested feedback from family members following a bereavement, with a view to improving the experience of those using the service.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Medical care (including older people's care)

From October 2018 to September 2019, Elderly Care Wards at Homerton received 14 complaints. Of these, nine related to patient care, four related to admissions and discharges, and one related to facilities. The trust had a target of 30 days to respond to complaints, however was not meeting this target trust wide.

Staff understood the policy on complaints and knew how to handle them. Staff stated they would aim to resolve any patient complaints and concerns immediately. Staff were all aware of the complaints procedure, how to acknowledge complaints, and who had overall responsibility for managing the complaints process.

Managers investigated complaints and identified themes. Any complaints about care of the elderly wards were reviewed and investigated with input from the leadership of the service. Staff were informed of outcomes from complaints investigations individually, in team meetings, and through quality indicators.

Leaflets on how to make a complaint and contact details for the Patients Advice Liaisons Service (PALS) were visible on the wards. The complaints process included information about complaints process and how to contact the Parliamentary and Health Service Ombudsman (PHSO) if needed. Patients and family members we spoke with were confident they would be supported to make a complaint if needed.

Is the service well-led?

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

Both the elderly care units and ACU were delivered under the division for integrated medicine and rehabilitation services (IMRS), which included the emergency department and community health services.

Care of the elderly wards had a clear management structure in place. Responsibility for the wards came under the divisional management team of the Divisions Operations Director, Associate Medical Director and Deputy Chief Nurse, further supported by the clinical lead, Head of Nursing and Matron and with ward level nursing leadership provided by the ward sisters and charge nurses.

Leadership on care of the elderly wards were involved in shaping how the service was delivered. Senior staff we spoke with stated that the proposal to split the 56 bedded ward into two smaller units was first suggested by the ward's sisters, and this had been encouraged by local and divisional leadership. Staff stated that they had also been consulted on the change to the ward and were encouraged to contribute ideas, which the trust provided evidence of following inspection.

Staff knew the management arrangements and their specific roles and responsibilities. Nursing and medical leadership provided clinical support to staff, as well as leadership for the delivery of care and bed management. The nursing and medical leadership teams worked closely together to plan and deliver care, and staff from across all disciplines were positive about the working relationship on the wards.

Staff we spoke with stated that the clinical lead and nursing leadership were visible on the wards and were available to staff when needed. Frontline staff stated that the managers had an open-door policy, and we observed care of the elderly staff interacting well with the service leadership during the inspection.

Junior medical staff said they were well supported by their consultants and medical leadership on the wards. Consultants we spoke with were also positive about the support of their colleagues and stated there was a collaborative working relationship between medical staff on medical and surgical wards.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.

Medical care (including older people's care)

On this inspection we found a good working relationship between doctors, nursing, and allied health professionals (AHP). Staff were very positive about their colleagues and we observed a collaborative working culture in place between the various clinical disciplines.

There was evidence of staff and teams working collaboratively to deliver good quality of care. We observed daily handover and discharge meetings during the inspection and found this to encourage contributions from all staff attending. Care that we observed and meetings we attended showed that staff considered the needs of elderly and frail patients.

Staff were proud of the work they carried out. Staff stated they enjoyed working on the wards and were enthusiastic about the care and services they provided for patients.

Staff we spoke with told us that there was a no blame culture relating to safety and they were encouraged to report incidents. Staff said that they generally felt valued and respected by their colleagues.

Staff demonstrated awareness of the trust values and information on these values was displayed on the wards. Care of the elderly staff stated that the trust values were embedded well on the wards, and this was reflected in conversations with divisional leadership.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a governance framework in place which oversaw service delivery and quality of care for elderly patients. This included monthly divisional governance meetings, weekly CLIP meetings and local quality meetings every two months, led by speciality leads and attended by ward staff. Local care of the elderly meetings fed into the IMRS divisional meetings for further oversight.

We saw records of the governance committee minutes and saw they discussed complaints, incidents, key performance indicators (KPIs), training, staffing levels, audits, and any other clinical issues. Actions to address concerns or outstanding issues were identified and monitored through the team meetings (although were not given deadlines for completion). The meetings were minuted for dissemination to other staff who were not able to attend.

The elderly care units had a weekly meeting, co-ordinated by the ward sisters, that was attended by staff from both wards. This allowed staff to share actions and learning across both wards. This meeting included discussion of ongoing risks on the wards, actions taken to mitigate risk, incidents, complaints, and any other quality issues. Staff stated they attended this meeting regularly and found it useful.

Divisional leads told us that the morbidity and mortality meetings took place monthly and included attendance from medical staff (consultants and junior grades), nurses, therapists, and palliative care. We reviewed minutes from the last three morbidity and mortality meetings and found the meetings were well attended by consultants from care of the elderly wards.

Staff we spoke with were aware of the main clinical risks at the hospital, particularly for elderly patients. The key risks were reinforced to staff through team meetings, in the daily briefing huddle, and was displayed on noticeboards.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Medical care (including older people's care)

The trust established a multi-disciplinary steering group led by a consultant geriatrician in 2018 which met regularly to agree training and discuss policy matters. The group included the lead nurse for dementia, an orthopaedic nurse, therapist and therapy assistants, psychiatrist and a medical ward matron. The delirium steering group produced a training simulation film in 2019 which received positive feedback from the executive leadership and has been used not just for teaching in Homerton Hospital but with staff from the local mental health trust.

Staff across all disciplines were aware of the End PJ Paralysis campaign, which focuses on improving movement and activity opportunities to keep elderly patients active for longer. Nurses, therapists, and medical colleagues were involved in delivering activities that encouraged mobility such as movement groups, and we observed medical and therapy staff encouraging older patients to continue being active where clinically appropriate. The roll out of this project was supported by a project lead.

Outstanding practice

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Areas for improvement

Action the provider SHOULD take to improve

- The trust should improve the documentation of falls assessments and management of falls in patients care plans.

Maternity

Summary of this service

Homerton University Hospital NHS Foundation Trust maternity services delivered care for women who lived in the City of London and the London boroughs of Hackney and the southern part of Waltham Forest. It also accepted women who did not live in the catchment area.

Seven community midwifery teams (Team A-G) were based in GP surgeries, health centres and children's centres and held weekly antenatal and postnatal clinics. Some clinics for women with medical needs were held at Homerton University Hospital, for example, for women with diabetes, high body mass index (BMI), perinatal mental health problems or blood disorders. The hospital offered a fetal medicine service, fertility service and termination of pregnancy for fetal abnormality. We did not inspect the last two services.

The maternity unit in the hospital had a midwifery-led birth centre with four beds and a 14 bedded, consultant-led delivery suite. Two theatres were used for obstetrics. A small maternity triage room had one couch and there was an emergency obstetric unit with two couches, two reclining chairs and one side room. The antenatal ward (Turpin ward) had nine beds, and the postnatal ward (Templar ward) had 27 beds arranged in five bays and five single rooms.

The hospital had a large neonatal unit with 46 cots which was designed and equipped for babies needing extra medical and nursing care.

During our inspection, we visited all clinical areas in the service including the delivery suite, obstetric theatres, clinics, antenatal and postnatal wards. We spoke with 58 members of staff, including midwives, consultants, anaesthetists, senior managers, student midwives, maternity care assistants, discharge coordinators, specialist midwives, housekeepers, administration staff, matrons and support staff. We reviewed 15 sets of medical records and observed a multi-disciplinary team (MDT) handover. We reviewed a variety of hospital data including meeting minutes, policies and performance data.

From October 2018 to September 2019 there were 5719 deliveries at the trust.

This was a follow up inspection to assess whether the trust had made improvements in governance processes since the last inspection in August 2018. We did not inspect all domains but focused on Safe and Well Led.

- All the areas we inspected were visibly clean, tidy, and clutter free. We found some improvements had been made to ensure safety of the service which included the implementation of an acuity tool to monitor activity, increased consultant numbers and improving
- Staff demonstrated understanding of safeguarding processes and awareness on how to escalate and report safeguarding concerns.
- Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Although staffing remained a challenge, the service carried out rolling recruitment every four months and had a buffer to recruit over the requirement.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- We found improvements had been made to the senior midwifery team and maternity dashboard which had strengthened governance systems in operation. Senior leads understood and managed the priorities and issues the service faced.

Maternity

- Staff told us the management changes had resulted in senior leads being more accessible and visible. Staff felt respected, supported and valued. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.
- Although we acknowledged the improvements the service had made with regards to the leadership team, governance processes and the maternity dashboard, progress had been slower than expected to rectify the interface challenges faced due to the use of multiple clinical systems.

However:

- During the last inspection, we found inconsistent compliance with record keeping in the maternity service and interface challenges between the trust's electronic system and the intrapartum data system. On this inspection we found there had been no improvement as the interface issues remained and we found inconsistent compliance with record keeping due to the use of multiple systems. This meant there was the potential risk to have important information being missed as well as confusion on where to record information.
- The interface issues between the trust's clinical systems had been on the risk register since November 2015 and although the service was hoping to finalise their decision as soon as possible, the timelines for decision making and implementation were not clear.
- We found inconsistencies in the completion of growth charts and triage/emergency obstetric unit assessment forms. We showed examples to senior leads who acknowledged the lack of oversight around this and recognised that improvements were required to ensure this was embedded. Although senior leads told us the service was due to change to the Birmingham Symptom-specific Obstetric Triage System (BSOTS), it was not clear when BSOTS would be fully implemented.
- Although the service had improved the completion of modified early obstetric warning score (MEOW) and Newborn Early Warning Trigger and Track (NEWTT) observations with reduced variation in compliance, further work was required to ensure documentation included the time of NEWTT observations and if escalation had taken place. Similarly, we found where MEOWs intervals were not always adhered to, there was no documentation to explain non-compliance.
- Although the service provided mandatory training in key skills to all staff, further improvement was required to ensure medical staff compliance rates met the trust target for the mandatory training modules.
- During our last inspection, we found inconsistent hand hygiene amongst midwives and doctors as they moved around the unit. On this inspection, although hand hygiene practice was consistent at the bedside, we observed poor hand hygiene practice amongst staff at entry and exit into wards. We raised this with senior leads who acknowledged that the trust's policy and hand hygiene audit did not take into consideration hand hygiene at entry and exit into wards.
- During the last inspection we found there was limited understanding regarding the purpose of the World Health Organization (WHO) Five Steps to Safer Surgery checklist amongst some of the staff. On this inspection, although we found some improvements in staff awareness further improvement was required in compliance. The 2018 audit showed 55% compliance, and this had improved to 77% in 2019.
- Although the service had improved staff awareness of the risk register, we found some risks that staff told us about, were not recorded on the risk register. For example, IT in community was not recorded.

Following the inspection, we issued one requirement notice that the trust must put right. We identified 6 areas that the trust should make improvements. Details are at the end of the report.

Maternity

Is the service safe?

Requires improvement

Our rating of safe went down. For further information please see detailed findings.

Is the service well-led?

Good

Our rating of well-led improved. For further information please see detailed findings.

Detailed findings from this inspection

Is the service safe?

Mandatory training

Although the service provided mandatory training in key skills to all staff, further improvements were required to ensure medical staff compliance rates met trust target.

The trust set a target of 90% for completion of all mandatory training courses. These included conflict resolution, infection prevention and control level one and two, adult basic life support, health, safety and welfare, safeguarding adults' level two, fire safety, information governance and data security and equality, diversity and human rights. Staff told us the training was delivered via e-learning and some modules were face to face.

Data between April and September 2019 showed nursing and midwifery staff met most of the modules except for health, safety and wellness (88%) and fire safety (72%). However, medical staff failed to meet the trust target for any of the modules in the same activity period with the lowest compliance in infection prevention and control level two (51.1%), fire safety (62.2%) and information governance (51.1%).

We raised this with the senior leadership team who told us the data was not correct as despite training being completed, there was a delay in updating the system to reflect this. The service monitored compliance for core training and worked with the medical education team to improve compliance. For example, the service arranged face to face group training sessions for medical staff when no clinics were running to facilitate attendance and the next batch of training was booked for February. Senior leads told us medical trainee staff completed their core mandatory training at induction. In response to our feedback, the trust put in place an action plan to achieve mandatory training compliance. This included writing to medical staff who had outstanding training and instructing them to complete the online training by 14 February 2020.

After the inspection, the trust submitted the current compliance rates as of 31 January 2020 for medical staff. Although the data showed that medical staff still did not meet the trust target for any of the modules, improvements had been made in compliance rates. For example, infection prevention and control level two had improved from 51.1% to 73.2%, fire safety had improved from 62.2% to 80.1% and information governance had improved from 51.1% to 78.1%.

The service had two practice development midwives (PDM) who organised training for staff, for example, cannulation refreshers. Champion midwives provided maternity specific manual handling training which covered the use of nets and hoists and management of birth pools including evacuation procedures.

Each month there was a mandatory training week where staff received protected time to complete all outstanding mandatory training. Managers and staff received email reminders and in safety huddles. Staff received updates regarding the risk register, governance and Practical Obstetric Multi-Professional Training (PROMPT) during this time.

Staff told us PROMPT skills and drills included obstetric emergencies such as major obstetric haemorrhage, pre-eclampsia and sepsis. The PROMPT sessions were led by an obstetrician and included attendance from medical and midwifery staff. The current compliance rates for PROMPT training was 94% in midwives and 91% in senior house officers and registrars.

Midwives and medical staff were trained in undertaking cardiotocography (CTG) where the fetal heart rate was monitored. The CTG training was led by an obstetric consultant followed by an assessment after the session. Trust data as between January 2019 and January 2020 showed 98% compliance in midwives and medical staff. Although the remaining 2% of staff had withdrawn from the training due to other clinical priorities in January, the trust told us that the remaining staff had received a subsequent training date.

The maternity service had weekly 'hot drills' either on the birth centre or delivery suite. Staff told us the recent drill was on haemorrhage and described how they were assessed on their estimations of various blood losses. Individual staff feedback was provided at the end. Staff told us the annual simulation training was filmed in the education centre and feedback was provided.

Although the service had weekly case review and educational sessions, staff were not always able to attend due to clinical workloads.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Safeguarding training was incorporated into staff's mandatory training and included Safeguarding Adults (level one and two), Safeguarding Children (level two and three) and preventing radicalisation awareness. Safeguarding Adults Level one training was undertaken during staff induction and level two was completed by all clinical staff working with adults. Level three training was available for all staff who may, as part of their duties, undertake safeguarding investigations and training was delivered using a combination of class room based teaching and e-learning.

Compliance with all levels of safeguarding training was monitored by the trust's education and training department and reviewed at the trust's safeguarding committee. The trust set a target of 90% for completion of safeguarding training. Data between April and September 2019 showed nursing and midwifery staff met most of the modules except for preventing radicalisation awareness (73.3%). However, medical staff only met the trust target for one of the modules in the same activity period with the lowest compliance in safeguarding children level three (54.8%) and preventing radicalisation awareness (40.9%). The service had plans to arrange classroom based safeguarding training on a quarterly basis to ensure staff achieved training compliance. Levels of compliance were reported on a quarterly basis to external agencies such as the Clinical Commissioning Group (CCG) and local authority.

Staff had access to the trust's adult and children's safeguarding policies and procedures via the staff intranet. We found the policies included information on individual responsibilities and the process to follow for reporting and escalating concerns about a patient's welfare. The service incorporated information about female genital mutilation (FGM) in their procedures. All the staff members we spoke with were able to identify abuse and demonstrated consistent awareness of FGM.

The service had introduced a fortnightly midwifery clinic for FGM victims in a local maternity centre from December 2019. The clinic focussed on providing psychological support, assessment of FGM and safeguarding risk. The clinic included assessment and if treatment was needed, the same midwife would attend the 20 week appointment with the expecting mother for support.

The trust's safeguarding team included a safeguarding lead, named doctors, named nurses, named midwives and learning disabilities lead. The safeguarding adult's team was available for help, advice and support related to adult safeguarding concerns and could be contacted via landline or mobile telephone, Monday to Friday 9am to 5pm. Evenings and weekends cover was provided by the clinical site managers. Staff could access contact details on the adult safeguarding page on the intranet.

The service had specialist midwives for perinatal mental health and substance misuse. Women with mental health needs had the same consultant and midwife for continuity. Staff also received enhanced training on how to have difficult conversations with women.

Staff received training on domestic violence and were encouraged to use the Duluth Power and Control Wheel tool. This tool helped explain the different ways an abusive partner can usepower and controlto manipulate a relationship.

Staff discussed mental health with women at each appointment and had access to guidance and tools to help determine where a referral to the GP, perinatal team or Improving Access to Psychological Therapies (IAPT) services was needed.

The trust was part of the child protection information system (CP-IS) which allowed sharing information with the local authorities who had signed up to the scheme. Shared information included child protection plans and who to contact in the relevant local authority. The scheme also flagged children if they had unscheduled visits to the emergency departments.

Women living with learning disabilities were referred to the vulnerable women's team. The service had started a recent pilot in January 2020 of introducing a learning disability maternity champion to address cases of postnatal undiagnosed learning disability of borderline assessments.

The service had started a project called Trauma Informed Care with the aim to ensure all care was psychologically safe. Staff received training to help them identify women's' needs throughout the pathway whilst maintaining patient safety. The training helped staff understand what trauma was and how it impacted on healthcare processes.

Cleanliness, infection control and hygiene

Staff kept equipment and the premises visibly clean. Although staff adhered to hand hygiene practice consistently at point of care (at the bedside), we found poor hand hygiene practice amongst all staff groups at entry and exit into wards.

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The trust's infection prevention and control (IPC) team were available Monday to Friday 9am to 5pm with access to the on call microbiologist during out of hours and weekends. Staff told us they could contact the IPC team easily but would usually contact the IPC midwife.

The trust had a service level agreement with an external contractor to provide cleaning services. We saw the domestic service provision was displayed in all areas. Staff told us two domestic cleaners came in the morning and one in the evening with the facility to request additional cleaners if needed.

The IPC team completed annual environmental audits which included IPC arrangements, general environment, hand hygiene, sharp safety, equipment, food and hygiene, isolation, waste and PPE. The trust provided the November 2019 environmental audit report which detailed recommendations for each area where appropriate. The service completed a follow up audit in February 2020 to ensure the recommendations had been actioned. The trust provided average audit scores for January 2020 which showed the delivery suite achieved 98.5% (against target 98%) and Templar ward achieved 96.7% (against target 95%).

Maternity

During our inspection, we reviewed patient areas across the wards including utility rooms and treatment rooms. All areas we checked were visibly clean with no clutter in the corridors despite the ongoing refurbishment. The service used 'I am clean' stickers to identify equipment that had been cleaned and was ready for use. All the equipment and stickers we sampled were clean and the date was recorded.

We found curtains were in date and the cleaning schedules for equipment were up to date and fully completed. For example, we saw staff regularly completed checks on birthing rooms and pools in the birthing centre. We inspected various items of equipment such as baby scales, infusion pumps and ultrasound machines and chairs and found a good level of cleanliness. We saw the daily cleaning checklist in the fetal medicine unit was completed without omission and included the patient scanning couch, ultrasound machine, treatment trolley, storage cupboard, disposable gloves holder and emergency bell.

On the fetal medicines unit, we reviewed one of the ultrasound rooms and found the cleaning checklist had been completed daily without omission and included probes, cables, ultrasound machine, couch and oxygen and suction pipes.

The maternity service provided staff with access to personal protective equipment (PPE) which included sterile gloves in different sizes and aprons. The service had numerous alcohol dispensers in most areas including at the bedside. Handwashing facilities with posters for cleaning your hands were seen throughout the service. Staff we observed were compliant with the trust's policy and were bare below the elbow (BBE) and adhered to infection control related aspects of the uniform policy.

The service monitored hand hygiene compliance monthly and had identified hand hygiene champions for both midwifery and medical staff. Trust data between April 2019 and December 2019 showed that Templar ward consistently achieved 100% compliance (against trust target of 98%). The fetal medicine unit achieved 100% compliance except for November 2019 where no data was returned by the required deadline. The antenatal clinic achieved 100% compliance for April, May, July and October; no data returned for November and December and 98% for June, august and September. The delivery suite achieved 100% compliance between April and July 2019, September and October 2019 with no data returned for august 2019, 92% in November and 98% in December. Data for January 2020 showed that the delivery suite, Templar ward and fetal medicine achieved 100% and the antenatal clinic achieved 98%.

During the last inspection we found inconsistent adherence to good hand hygiene practice amongst some midwives and medical staff as they moved around the unit. On this inspection, although we found staff adhered to hand hygiene practice consistently at point of care (at the bedside), we found poor hand hygiene practice amongst all staff groups at entry and exit into wards.

During a 15 minute observation outside the Turpin/Templar wards reception desk, we observed 15 staff members entering and leaving the wards without using the alcohol gel. Of these, four staff went from the wards to the neonatal unit but did not use the alcohol gel on exit from the wards or on entry to neonatal unit. We found that staff did not encourage visitors/patients to use the alcohol gel at entry/exit from wards. We also observed the entrance to the ward had two alcohol dispensers on entry to the ward and none on exit.

We raised this with the IPC lead who told us the trust policy and hand hygiene audit only assessed hand hygiene at point of care (at the bedside) and did not include entry or exit from the wards. We raised this with the senior leadership team who acknowledged the gap in the trust wide audit tool and told us the audit tool would be revised to include ward entry and exit. Senior leads told us the leads in each area would audit a different area to provide objectivity. We queried the location of the alcohol dispensers near the entry and exit and found that on day two of the inspection, an alcohol dispenser had been installed on the exit side of the door. Although we observed that staff were reminded about hand hygiene on entry and exit during the multidisciplinary handover, further improvements were required to ensure consistent hand hygiene was embedded which included updating the trust wide policy and hand hygiene audit.

The trust had an Infection Prevention and Control policy for Carbapenamase producing Enterobacteriaceae (CPE) and most staff we spoke with, demonstrated awareness of it.

Staff carried out appropriate checks for cannula care in line with trust policy. Staff told us the cannula site was checked as part of the hourly observations and the visual infusion phlebitis (VIP) score was completed every eight hours and recorded on the electronic patient record system.

Bathrooms including showers and toilets were cleaned and checked twice a day. We checked a sample of bathrooms/ toilets in each area and saw that although the areas were found to be visibly clean, no checklist was displayed. We raised this with ward staff on Templar ward who told us they would address it. Staff told us the contractor was responsive to additional cleaning requests.

Waste management and removal, including those for contaminated and hazardous waste was in line with national standards. There were waste disposal bins in appropriate locations on the ward and those we checked were not overfull.

The trust confirmed that there had been zero incidences of hospital-acquired methicillin-resistant Staphylococcus aureus (MRSA), clostridium difficile (C. diff) and methicillin-susceptible Staphylococcus aureus (MSSA) within the maternity department.

Isolation procedures were in place for women with infections by using the side rooms. Staff told us that in event of a patient being isolated, the side room would be marked clearly to alert staff and visitors with instructions of the precautions to take prior to entering the side room.

The service used safety bundles such as for urinary catheter and vascular access which was in line with National Institute of Health and Care Excellence (NICE) Infection prevention and control quality statements 4 and 5.

The service offered a walk in service for whooping cough vaccinations in pregnancy (from 20 weeks) in line with Public Health England guidance. The service also offered flu vaccinations.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

The maternity service had CCTV in operation and each area had a reception area with restricted access. We observed visitors requesting entry via the buzzer on the intercom.

The delivery suite had one birthing pool in one of the rooms and the birth centre had four individual birthing rooms with ensuite bathrooms and a birthing pool. We saw evidence of the birth pools being checked by midwives.

The fetal medicine unit opened four years ago and was designed by the lead consultant. The unit was situated next to the antenatal clinic and had its own reception area with two waiting rooms which had suitable toys for children, a television at a suitable volume and baby changing facilities. All the clinic rooms had keypad entry and general ultrasound was available in four of the eight clinical rooms and the unit had its own phlebotomy on site. There were dedicated clinical rooms for complex cases in the quieter end of the unit to provide privacy and two quiet rooms to have sensitive conversations.

We saw evidence that equipment was routinely, and regularly serviced and calibrated. The equipment store rooms were organised and clean with secure access. We checked various items of equipment such as defibrillators, blood pressure monitors, infusion pump, syringe driver, hoist, ultrasound machine and found they had been safety tested and were all within service date.

Needle sharps bins were available throughout the wards and within the medication preparation area. The bins we inspected were correctly labelled and none were filled above the maximum fill line.

Maternity

During the last inspection, further improvements were required in the systems used for checking all emergency equipment, including emergency boxes for postpartum haemorrhage (PPH), asthma and diabetic emergencies. On this inspection, we found improvements had been made. The triage midwives were allocated to check all the different trolleys daily between 6am and 9am after which a compliance check was completed at 10am to ensure all the checks had been completed. These included the major obstetric haemorrhage (MOH) trolley, resuscitation trolley, difficult airway trolley, sepsis trolley, instrumental trolley and pre-eclampsia equipment. The neonatal team checked the neonatal trolleys and the anaesthetic team checked the epidural trolley. We checked the trolleys in each area and found that trolleys were organised, and checklists had been completed without omission and the contents were in date.

Emergency medicines were stored on the resuscitation trolley throughout the maternity service. We checked the resuscitation trolley in each area and found all the trolleys were adequately stocked with all items on the checklist present and in date. We saw evidence of daily checklists being completed without omissions. For example, the checklists for the resuscitation trolley in theatres had been checked between October and December 2019 without omission, with no omissions for January 2020. Staff told us the contents of the trolleys were checked weekly whilst the daily checks ensured the tag was intact. The tags were numbered and if the tag was not intact or had been tampered with, staff would open the trolley and check the full contents.

We asked staff to open the resuscitation, PPH and MOH trolleys on the delivery suite. We found the trolleys were neatly organised and the contents were in date. This included single use items such as airway equipment, face mask and oxygen tubing. We found the anaphylaxis treatment box and emergency drugs were all within expiry date.

The resuscitation trolley stored the EZ-10 kit which the trust had implemented six years ago. Kits were available on the delivery suite, in recovery and in the emergency department. The anaesthetic team were trained to use the kit. The kit allowed intravenous access via the bone for women whose bodies had shut down.

Fire extinguishers were stored securely and in date throughout the service. The service displayed notices advising staff what to do in event of emergencies which included fire.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and removed or minimised risks.

During the last inspection we found further improvements were required with the completion of baby observations. On this inspection, we found improvements had been made with reduced variation in compliance. Between October 2018 and September 2019, the Newborn Early Warning Trigger and Track (NEWTT) compliance ranged between 93% and 100% except for April 2019 and July 2019 where compliance dipped to 76% and 80% respectively.

The maternity service used the modified early obstetric warning score (MEOWS), designed to allow early recognition and deterioration in pregnant and postnatal women by monitoring physical parameters, such as blood pressure, heart rate and temperature. Between October 2018 and September 2019, MEOWS compliance was consistently 100% except for December 2018 and January 2019 where compliance was 97%. Staff told us where women had a MEOWS score of three, the registrar would be called and transferring the patient to the delivery suite was easy to do. Staff told us the introduction of Perfect ward had helped to improve compliance as it included checks on the completion of MEOWS and NEWTT. Trust data showed that between October 2019 and December 2019, MEOWS compliance was 100%.

However, further improvements were required in documenting the time of NEWTT observations and recording where escalation had taken place. Senior leads told us that although it appeared the first hour NEWTT observations had been missed, this wasn't the case as it had been completed but staff had not manually change the time to reflect this. Similarly, MEOWs intervals were not always adhered to and there was no documentation to explain non-compliance.

Maternity

Data for NEWTT and MEOWS showed that the frequency documented in a timely manner (i.e. within 30 minutes of when the observations was taken) ranged between 90% and 100% except for May 2019, July 2019 and December 2019 where compliance dipped to 80%. Trust data showed that for the 'appropriate action taken' indicator for NEWTT observations, the service achieved 83% for October 2019 and December 2019 and 100% for November 2019.

The service used 'Perfect ward' which was an online inspection tool aimed at continuous quality improvement. This included appropriate escalation of modified early obstetric warning score (MEOWS), completion and escalation of newborn early warning trigger and track (NEWTT) and compliance checks which included equipment and emergency medicines. The trust told us that identified issues would remain on the report until it had been resolved. Trust data for December 2019 showed the delivery suite achieved 95%, emergency obstetric unit achieved 98% and the birth centre achieved 92%.

Midwives trained in newborn and infant physical examination (NIPE) and nursery nurses completed baby observations. The service had 37 midwives who were qualified to perform the NIPE checks, of which six midwives were on maternity leave and one on long term sick leave. Staff told us that NIPE checks were completed by doctors on babies receiving intravenous antibiotics, phototherapy or if there were other complications. During the inspection, we observed a NIPE check and found the checks to be thorough, with a good technique and compliant with hand hygiene practice.

Women who arrived by ambulance had an immediate 'meet and greet' by the triage/EOU midwife with a handover from the ambulance crew. The delivery suite coordinator was informed of all women arriving by ambulance by the external provider. The reception desk which covered the delivery suite, EOU and triage was staffed 24 hours a day. There was one triage room where the midwife completed assessments to decide if the woman required EOU or the delivery suite. There were three levels of priority in how women were seen: level one (red) women immediately went to the delivery suite, level two (amber) women were seen within 15 to 30 minutes either on EOU or delivery suite and level three (green) women were seen within 60 minutes either in EOU, delivery suite or the wards.

We observed a transfer of a woman in labour from the community to the delivery suite. Although the environment was open plan which meant there was little privacy for conversations, we found staff discreetly discussed the woman and a thorough handover was provided.

Basic life support (BLS) was part of the mandatory training programme. Midwifery staff met the 90% trust target for BLS training and medical staff achieved 80.5%. The trust told us that intermediate life support (ILS) training was not currently delivered and advanced life support (ALS) training was not a requirement for midwifery staff. Although foundation doctors (FY2) were required to complete ALS at the end of their year, the service did not hold any records for ALS training for doctors as it was not a mandatory training requirement. During the inspection, we saw the emergency buzzers were working and connected to the delivery suite. Staff told us that major obstetric haemorrhage (MOH) triggers went to the obstetrician, anaesthetist and haematologist.

The service had plans to introduce a high dependency unit in one of the rooms on the delivery suite as part of a quality improvement project. The aim was to upskill staff to manage high risk women and for staff to receive enhanced maternal care training with anaesthetists.

Safety huddles took place twice daily at 8am and 4pm on the delivery suite. Attendees included the manager on call, representation from the obstetric team, anaesthetic team, sister for postnatal ward and delivery suite. The focus for the huddle was safety, acuity and staffing in each area. Key announcements and teaching updates were also shared with staff. After each huddle, the maternity safety huddle checklist was completed and signed by the huddle lead. We saw evidence that the checklist was completed regularly.

Staff recorded cardiotocographys (CTG) on the electronic system every hour with a system of 'fresh eyes' in place every two hours to check the interpretation was correct. This was in line with national recommendations (NHS England Saving Babies' Lives: A care bundle for reducing stillbirth, 2016). We saw evidence of good CTG traces in documentation. Fetal wellbeing midwives helped complete the CTG traces at night. We saw evidence of using 'fresh eyes' in a case discussed at the safety huddle we observed.

SBAR (situation, background, assessment and recommendation) is a structured method for communicating critical information that requires immediate attention and action, contributing to effective escalation and increased patient safety. The service used a SBAR handover notice board which included details such as which stage (antenatal/ intrapartum and postpartum), age, body mass index (BMI), MEOWs scores, allergy, gestation, CTG, management plan and progress in dilation if the woman was in labour. Staff told us the EOU away day included practising SBAR handovers and the PDMs tested midwives on mock SBAR handovers when visiting the maternity areas.

We attended a multidisciplinary handover and found attendees included midwives, gynaecology doctors, medical students, anaesthetists, consultants, manager on call, matrons, clinical placement coordinator, student midwives and preceptors. We observed the SBAR handover notice board was used and discussions included night activity, any incidents of major obstetric haemorrhage, safeguarding, bed capacity in all areas, medical and midwifery staffing in all areas and summary of each patient with plan of care. The handover included a CTG review of a case and importance of human factor and communication with the patient and their family.

The maternity service had sepsis trolleys which contained all the required equipment to speed up the response to managing patients with sepsis. The trolleys were secured with a keypad lock and were checked daily by midwifery staff. We saw evidence of sepsis protocols on display for staff, for example, we saw posters on 'Sepsis 6' in the delivery suite. The intranet had information on sepsis screening and treatment for staff to access.

The trust was previously part of a cluster randomised controlled trial which evaluated the effect of the Growth Assessment Protocol (GAP) programme. During the trial, the trust had put processes in place to compensate for the fact that they were part of the trial and to give them the necessary assurance around compliance. The maternity service implemented fetal growth assessment (Intergrowth) charts in July 2019 to help identify babies who were not growing as well as expected. The service carried out spot checks in August and September 2019 and having found good compliance, the project for implementing the chart was marked as completed in three months. However, during our review of records, we found inconsistencies in the completion of the symphysial fundal height (SFH) results being plotted on growth charts. We showed examples of incomplete growth charts to senior leads who acknowledged the lack of oversight around this and recognised that improvements were required to ensure this was embedded. We requested audits for SFH chart compliance which was not provided as the service had started auditing compliance in January 2020.

The service completed venous thromboembolism (VTE) risk assessments (used to determine a patient's risk of developing a blood clot), in line with national recommendations. In the 15 patients' notes reviewed, we found staff completed VTE risk assessments. We requested the most recent VTE audit results. The trust provided us with a retrospective case review of 200 antenatal notes between June 2016 and December 2016 which found 100% of women had VTE assessments at booking.

During the last inspection we found there was limited understanding regarding the purpose of the World Health Organization (WHO) Five Steps to Safer Surgery checklist amongst some of the staff we spoke with and compliance audits did not include briefing and debriefing aspects of the checklist. On this inspection we found some improvements had been made as all the staff we spoke with were aware of the three stages of the WHO checklist. Staff told us debriefs took place at end of the list and the theatre coordinator would take forward any issues. Senior leads told us the 2018 audit showed 55% compliance and this had improved to 77% in 2019. Although, the service audited the WHO checklist annually and monitored compliance, we were not provided with monthly compliance data.

Maternity

NHS England collects data on nine key performance indicators (KPIs) for screening. These KPIs included the number of women: tested for HIV, sickle cell and thalassaemia; referred for Hepatitis B specialist assessment; completed laboratory request forms for Down's syndrome screening; tested by 10 weeks gestation; the number of laboratory requests with completed Family Origin Questionnaire and avoidable repeats for new born blood spot test and the number of babies having a newborn and infant physical examination (NIPE). Current trust data showed the service either met or were close to meeting the acceptable threshold for most of the KPIs.

The service had an obstetric query line which provided staff with easy access to consultants, anaesthetics, seniors nurses and there was a maternity helpline, staffed by midwives to provide advice to women.

The service used two identity labels (one on the arm and one on the leg) to ensure babies were correctly identified. Staff told us the identity labels were applied on the delivery suite prior to transfer to the wards with a midwife, who would then handover the care to ward staff who would recheck the tag. If a baby was found without an identity band, all the babies on the ward were checked before replacing the missing band for that baby. The baby identity bands were checked during the daily newborn checks and prior to any assessment, investigation or treatment. We requested audits for baby identity checks which were not provided. Although the trust informed us that the service would include this as part of the weekly perfect ward compliance audits, no details of when this would start was included.

The service carried out baby abduction drills annually and as a result of the 2019 drill, additional posters on tailgating had been displayed. The main exit from the wards and the delivery suite was controlled by reception only. This enabled staff to control entry and exit. Visitors were given badges and staff told us that high risk women were placed in high visibility beds and high risk partners would be asked for identification and could be restricted from visiting where applicable.

Security staff visited the maternity areas daily and staff told us they were responsive when called. During the inspection, we observed security staff outside the postnatal/antenatal door whilst the lock was being fixed.

The trust had lone working arrangements for community midwives which included work mobiles, access to diaries and panic alarms. Although women were generally seen in clinics held at GP centres or health centres, staff would go in pairs for home visits if needed.

Women with more complicated pregnancies were offered specialist antenatal services and clinics. For example, the fetal medicines team provided specialist scanning for women with complex pregnancies or additional scans for women who had had miscarriages. Scans were carried out at 12 weeks, 16 weeks and 20 weeks for anomalies and abnormalities. Alongside the specialist service, women still had their own named midwife. The team also offered vaccinations at the same time. Examples included the flu vaccine or the whooping cough in pregnancy vaccine.

The Early Pregnancy Assessment Unit (EPAU) was located in the Women's Health Centre on Tuke Ward. The EPAU was a nurse-led specialist unit which was supported by sonographers and the on-call gynaecology team.The unit managed early pregnancy problems in the first 18 weeks of pregnancy such as vaginal bleeding and abdominal pain. After 18 weeks, women were seen in the Emergency Obstetric Unit (EOU) or in the delivery suite. The EPAU came under gynaecology and so has not been included in this report.

Midwifery and nurse staffing

Although midwifery staffing fluctuated, the service ensured there were enough midwifery staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

During the last inspection, the maternity service did not use an acuity tool to monitor activity on the delivery suite. On this inspection, we found this had improved as the service had fully implemented a national acuity tool (Birthrate Plus) on the delivery suite with plans to introduce the tool on the postnatal ward in February 2020.

Maternity

Senior leads told us the service had a vacancy of four whole time equivalent (WTE) midwives. The service carried out rolling recruitment every four months and had a buffer to recruit over the requirement. The service had a preceptorship programme which helped address skill mix and included rotations around the unit including the community after one year. The service was able to recruit Band 5s more easily than Band 6s and senior leads told us that delays often occurred when newly qualified midwives were waiting for their registration to be processed.

Between October 2018 and September 2019, data showed that 9% of shifts were filled by bank, 1% were filled by agency and 4% were unfilled. Between October 2018 and September 2019, the annual sickness rate for midwifery and nursing staff was 2.7% (against trust target of 3%). During the same activity period, the annual turnover rate was 0% (against trust target of 11%). The ratio for birth to midwife and senior midwives to midwives were both similar to the national comparison and had remained stable from the previous period.

Between April 2019 and September 2019, the maternity dashboard showed that the delivery suite coordinator was consistently supernumerary. Staff told us the shift leader on the wards was supernumerary and coordinated the discharges.

Staffing rotas were completed and approved six weeks in advance. Staff told us the service used bank staff to cover any gaps and agency staff were only used to cover last minute sickness. Staff we spoke with told us the unit could do with more staff. Senior leads also acknowledged that additional administration support was needed.

The maternity service offered mixed shifts to support flexible working across each area. Most midwifery staff worked long days (8am to 8.30pm) and night shifts (8pm to 8.30am). Whilst some staff worked either early shifts (8am to 4pm) and late shifts (12.30pm to 8.30pm).

On Turpin (antenatal) ward, there were two midwives during the day and two midwives at night. On Templar (postnatal) ward, there were five midwives, two maternity support workers, one nursery nurse and one ward clerk during the day. During the night, there were four midwives and three MSWs.

The nursery nurses worked long days Monday to Sunday but did not cover night shifts. They supported midwives by completing high risk baby observations. However, with only one nursery nurse on a shift, the service discussed workloads in the morning huddle.

The EOU had two midwives and one midwife support worker (MSW) in the daytime and at night, had one midwife and one MSW at night. Triage had one midwife for the day shift and one midwife for the night shift.

The delivery suite had 10 midwives and two MSW during the day shift and the same provision for the night shift. The birth centre had two midwives and one MSW during the day shift and two midwives for the night shift. Staff told us that staffing on delivery suite was frequently short and the community team were often pulled in to cover the staff shortages.

The service had introduced a twilight role between 10pm and 6am to provide support with staff breaks during at risk hours in the EOU and triage. Thereafter, the priority would be to support staff in the delivery suite with breaks.

The reception desk at the entrance to the wards was staffed between 8am to 8.30pm. However, as the desk was not staffed at night, visiting was restricted after 10pm although partners were welcome 24 hours a day.

The service had specialist midwives in the following areas: public health, research, clinical governance, digital, audit and guidelines and bereavement. The service had a fetal wellbeing midwife which was in line with the NHS England Saving Babies lives care bundle recommendation.

The antenatal clinics took place Monday to Friday with occasional Saturday clinics to accommodate the overspill of patients. However, the service was offering reduced clinics due to staffing issues because of long term sickness. Senior

leads reviewed the service needs and discussed flexible working with human resources (HR) to mitigate the staffing issues. Staff were able to work remotely from home as a result. For continuity, midwives who completed the booking process, informed women that they may not see the same midwife in event of staff sickness, annual leave or training. Senior leads told us there were plans to request an uplift of two WTE in April.

The community midwives were managed by the public health team leaders and had no vacancies. The team leaders had their own caseloads which they described as fluctuating. Although a limit for caseloads had been set, there were often occasions when caseloads exceeded the set limit. However, the introduction of the community midwifery team coordinator role provided support with management and administration. The community teams had a buddy system to cover sickness and annual leave. The homebirth team had six midwives who had their own caseloads which included provided postnatal care.

Medical staffing

The service had taken steps to ensure there were enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment.

During the day time, medical cover included a consultant from 8am to 10pm and two senior registrars and two senior house officers (SHO) supported the consultant obstetrician on duty. After 10pm, the on call consultant was either on site or provided remote cover from home until 8am. Senior leads told us that all the consultants lived within the statutory distance to the hospital in cases of emergency. Junior doctors told us they could easily contact the on-call consultant obstetrician who would come on site to support if needed.

During the day shift, there was a designated specialist registrar (SpR) who covered the emergency obstetric unit (EOU), triage and Turpin ward. During the night time, the EOU had cover from a gynaecology registrar. As EOU and triage was located next to the delivery suite, staff could access the medical team covering the delivery suite when needed.

On the delivery suite, the ward rounds were completed twice daily by the senior house officers (SHO), registrar, consultant obstetrician and anaesthetist. The senior registrar completed ward rounds daily and staff told us the consultant joined the ward rounds three times a week.

Between October 2018 and September 2019, the average number of hours per week of consultant presence on labour wards was consistently 98 hours.

During our last inspection, we found that consultant numbers were lower than expected for a unit of this size. This meant there were not always consultant led elective caesarean sections or ward rounds, and gaps in middle grade doctor's rotas meant locum and agency staff were used. On this inspection, we found improvements had been made as the trust had increased consultant numbers following a workforce review from 12 to 16. Senior leads told us the service had recruited the additional consultants who were currently going through the HR process.

Although senior leads told us the recruitment of consultants would remain on the risk register until the consultants had passed their probation period, the level of risk had been reviewed and reduced further to the additional consultants being appointed. Senior leads told us the structure for medical staff was also being reviewed in line with the additional consultants to ensure there was an obstetric consultant dedicated for the Turpin and Templar ward.

Trust data showed that between January 2019 and December 2019, the annual sickness rate for medical staff was 0.01% and the turnover rate was 0%.

Junior doctors found the workload manageable and reported good working links with midwives and discharge coordinators. Junior doctors told us the rotas were managed better than before and any gaps on the rota were covered internally.

There were two obstetric theatres staffed by a dedicated theatre team who provided 24-hour cover. The team included theatre nurses, recovery nurses, consultant, senior registrars, operating department practitioners (ODP) and a team of scrub nurses. The unit was supported by a level three neonatal unit on site. The service had a dedicated anaesthetist for elective lists and if the theatres were needed out of hours, the ODP and staff from the main hospital would be called. Therefore, the obstetric theatres were therefore not reliant on the delivery suite staff.

Records

Although records were stored securely, we found inconsistent compliance with record keeping due to the use of multiple electronic systems.

During the last inspection, we found inconsistent compliance with record keeping in the maternity service and interface challenges between the trust's electronic system and the intrapartum data system. This meant manual data cleaning was required to remove multiple errors and work had been ongoing since October 2016 to improve this. On this inspection we found there had been no improvement as the interface issues remained and we found inconsistent compliance with record keeping due to the use of multiple systems.

The maternity service used a mixture of paper and electronic records. The emergency obstetric unit (EOU) used paper based triage forms as well as one of the electronic record systems. However, the rest of the service used two different electronic record systems. We reviewed 15 maternity records for women at different stages of the maternity pathway and found inconsistent compliance with record keeping. For example, although we found risk assessments had been completed and entries were dated and signed, the use of multiple systems resulted in difficulty finding information as it wasn't clear which system it would be recorded in. The inspection team struggled to piece together the information between the two electronic systems after which the team reviewed some records with the deputy head of midwifery and one of the digital midwives.

Staff told us the interface challenges between both systems was an issue as the delivery suite records was on a different system to the wards. This meant there was the potential risk to have important information being missed as well as confusion on where to record information. For example, we found there were documentation gaps where escalation would have taken place and although staff told us escalation had taken place, we could not find evidence of this recorded in either system.

On day one of the inspection, we observed a woman who was not booked at the hospital attend the EOU with concerns around reduced fetal movements. This meant the patient was not known to the service. We followed up on this with staff on day two of the inspection to determine what the outcome was. Although staff had taken appropriate action by contacting the hospital where the patient was booked, we found the notes did not evidence the action taken. For example, the patient had been referred to the safeguarding team but there was no record of this in the written notes or the electronic system and staff members completed this retrospectively.

Although the delivery suite could access the system used on wards, the wards could not access the system used on the delivery suite. Staff told us they received print outs from the delivery suite as part of the handover. Staff we spoke with also raised their concerns with using two electronic systems which didn't interface with each other. Senior leads told us funding was being sourced to secure a computer terminal to provide the ward staff access to the electronic system used on the delivery suite. During the factual accuracy process, the trust told us they had plans to install a computer terminal on the maternity ward in May.

We raised this with senior leads who acknowledged the challenges and told us work was ongoing to address this and the issue was on the risk register. Senior leads told us no themes had been identified in incidents to suggest any concerns around managing deteriorating women or related to issues with records. Although the senior leadership team recognised the issues caused from using multiple systems in addition to paper records, the service was yet to decide on the new system to address the interface issues. However, we were not provided with a definitive timescale to achieve this.

Maternity

The maternity service had implemented triage/emergency obstetric unit assessment forms (also known as OTAS forms) to use a traffic light system to flag priority for assessment (RAG rating). However, we found four examples where the assessment forms were poorly completed with missing information such as date and time of transfer, priority and RAG rating. We noticed the form had limited space for the transfer midwife to document this information. We raised this with the deputy head of midwifery and matrons who acknowledged the forms were poorly completed and told us the service was changing to the Birmingham Symptom-specific Obstetric Triage System (BSOTS). The system was based on established triage systems in emergency medicine and used an assessment with clinical prioritisation of the common reasons that present within maternity triage. BSOTS can also be integrated electronically and provide the information visually. Although senior leads told us staff training was ongoing, it was not clear when BSOTS would be fully implemented.

The maternity triage guidelines had a target of 90% of women having their first assessment within 15 minutes. Although senior leads told us the OTAS forms were audited, they were not sure if the audit included form completion. The trust provided the June 2019 audit results showed that since the service had introduced a Meet and Greet system in December 2018, 92% of women had their Meet and Greet within 15 minutes. This was an improvement from 66% in December 2017. However, the audit did not review form completion.

The service had two digital midwives who reviewed records on both electric systems and cross checked for accuracy and ensured discrepancies were corrected. Findings were shared with the team or where appropriate, with the individual staff member. The service told us that midwives reviewed an average of 10 to 15 records at the monthly midwifery mandatory training (MMT) sessions. We requested a recent records audit, and this was not provided. Instead, the trust provided us with the January 2020 peer review documentation audit which was carried out in response to CQC. The audit provided looked at the records reviewed in the MMT sessions between January 2019 and January 2020 retrospectively. Although the audit found there was good documentation in some areas, the audit also highlighted documentation gaps as the use of two different electronic systems made it difficult to follow the continuity of care.

Women carried their own handheld pregnancy records, which they were advised to bring to each antenatal appointment and any occasion when they attended the hospital. Senior lead told us handheld records had been expanded to include personalised care plans.

The personal child health record (also known as the ‘red book’) was given to mothers on discharge. The red book is a national standard health and development record and is used to monitor growth and development of the child, up to the first four years of life.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. Access to treatment rooms was restricted via keypad access and we found all the cupboards were locked. We found the intravenous (IV) fluids were stored securely and neatly. In the delivery suite, the keys for the drug cupboards were kept in a safe in the treatment room. Staff told us the safe was due to be replaced and we saw this had been completed during the inspection.

Although we found that Oxygen and Entonox cylinders were in date and appropriately stored in most areas within the service, we found space limitations presented challenges in some areas. For example, on Turpin ward we found two large Entonox cylinders and one large Oxygen cylinder stored near the fire exit door and toilets. Staff told us they were advised to keep the large cylinders there due to space limitations. We raised this with the matron as this could be a possible health and safety risk especially if women were visiting with children. Staff reviewed the area and decided to change the sizes of the waste bins and in doing so, were able to store the cylinders neatly near the fire door in a less cluttered way and without causing any obstruction.

The home birthing team received training on how to store and transport Entonox in their cars. Two members of the home birthing team attended visits and one midwife stayed with the medicines and records, whilst the other staff member provided care.

Stock management was consistent across all maternity areas. We randomly checked five drugs in each area and found the medicines were in date. Staff told us the pharmacy technician ensured medicines stock was topped up as needed.

The service had a dedicated pharmacist who screened prescription charts and staff we spoke with, reported a good relationship with the pharmacy team. Staff also told us the computer system informed staff where to locate emergency medicines during out of hours.

Controlled drugs (CD) management across all maternity areas was good. CDs were stored in a lockable, wall-mounted units and the keys were kept with the midwife in charge or the delivery suite coordinator. CD balance checks were completed daily by two midwives and the CD book was neatly and accurately completed, and there were no missing entries or signatures. During our inspection, we checked a sample of CDs in each maternity area and found quantities matched the CD register and the medicines were in date. We found that when the CD cupboard was open in the recovery area, an orange light outside the recovery area came on to indicate the cupboard was open. Trust data for November 2019 showed that the delivery suite and Templar ward were compliant with the CD checklist.

Medicines that needed to be kept below a certain temperature were stored in locked fridges. Although staff checked the fridge temperature daily which we saw evidence of, staff told us fridge and room temperatures were monitored centrally. If the temperatures went out of range, the pharmacy team were notified. The fridge in the recovery area stored vaccinations and we checked a sample and they were all in date.

The Perfect ward rounding incorporated compliance with safe storage of medicine including IV fluids, drug fridge checks, daily CD check, completion of resuscitation trolley checklists and emergency boxes.

Between January 2019 and January 2020, there were 40 medication incidents reported, of which 38 incidents caused no harm to patients and two incidents caused low harm.

We found ‘to take away’ (TTA) medicines were kept securely in locked cupboards and included pain relief, antibiotics, contraception. We checked a random sample of TTA medicines in the delivery suite and found all items were in date.

The delivery suite had grab bags for paediatrics which were checked weekly and provided the emergency drug boxes. This included a grab bag for paediatrics under 10kg, over 10kg and a patient transfer bag. We checked the hypoglycaemia kits (Hypo box) in the delivery suite and found all the checks had been completed and the contents were in date.

We reviewed 15 prescription administration charts and found they were all signed, dated and legible. We found that patients’ allergy status was documented appropriately which was essential to avoid serious medication errors from being made. Antibiotics were prescribed and reviewed regularly and ‘when required’ (PRN) medicines for pain and nausea were included.

Patient group directions (PGDs) allow some registered health professionals (such as midwives) to give specified medicines to a predefined group of patients without them having to see a doctor. The service used PGDs, for example, midwives could provide pain relief for the latent phase of labour. We saw evidence that midwifery staff in the delivery suite and emergency obstetric unit had signed variance sheets and the PGD included information on inclusion criteria, exclusion criteria, referral arrangements and what to do if treatment is declined.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women honest information and suitable support.

Maternity

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. There were no never events reported at Homerton University Hospital within maternity between April 2019 and September 2019. (Source: Strategic Executive Information System (STEIS). Senior leads told us there had been zero never events in the last 12 months.

From April 2018, the HSIB became responsible for all patient safety investigations of maternity incidents occurring in the NHS which met the criteria for the Each Baby Counts programme. Each Baby Counts is the Royal College of Obstetricians and Gynaecologists (RCOG) national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour. For these incidents HSIB's investigation replaced the local investigation and the trust remained responsible for Duty of Candour and actioning any safety recommendations made following these investigations.

Staff were aware of their responsibilities for reporting incidents and able to explain how this was done. Staff told us they received individual feedback for incidents they had reported and after investigations had been completed. The trust had three Professional Midwifery Advocates (PMA) who supported staff post incidents. The maternity service had 30 members of staff who had completed the root cause analysis (RCA) training.

There were six recorded serious incidents between October 2018 and September 2019 for maternity, all of which occurred in the hospital. Three of the incidents were being investigated by Healthcare Safety Investigation Branch (HSIB). However instead of waiting for the HSIB recommendations which caused delay, the service completed 72 hour reviews so that immediate action could be taken where needed to ensure patient safety. Although we requested the RCAs from two recent serious incidents, the trust provided two HSIB investigation reports as this replaced local investigations.

The trust contributed data to the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK (MBRRACE-UK). MBRRACE is a national programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths. Senior leads told us that as the hospital provided level three support for neonates which generated a lot of referrals, the MBBRACE data had been adapted to factor this in. The service used the perinatal mortality review tool (PMRT) which had been designed as a review tool to assist units in completing a structured, standardised and thorough review. Bereavement midwives were involved with MBBRACE and audit findings.

PMRT meetings took place weekly to review deaths, stillbirths and late miscarriages. Attendees included obstetricians, the neonatal team, bereavement midwives, matrons, quality improvement leads, the governance team and external midwives/consultants who worked at other NHS trusts. We reviewed three sets of minutes for January 2020 and found each case discussed had named leads and actions.

Key messages and lessons learnt from incidents were discussed with staff during handovers, ward meetings, topic of the week, newsletters, safety huddles and in the divisional complaints, litigation, incidents, PALS (CLIP) meetings. The weekly CLIP meetings included a breakdown of incidents and we reviewed three sets of minutes for January 2020 and found the meeting summaries included a list of attendees and an action log with identified leads, action required and date for feedback.

Staff also received monthly thematic review of incidents via email and other platforms such as tips of the fortnight, topic of the week, team meetings and safety huddles.

Senior leads told us weekly meetings took place with the midwifery team, neonatal team and obstetric team where three cases were presented to review care at each point for example, antenatal, intrapartum, postnatal and baby checks. The bereavement midwives attend the monthly morbidity and mortality meetings that included discussion of stillbirths.

Perinatal mortality and morbidity meetings took place weekly and attendance included obstetricians, neonatologist, midwives, nurses, student midwives, medical students, fetal wellbeing midwife, matron and governance midwife and risk manager. Cases were identified from incidents or by the neonatologists. We reviewed the minutes for January 2020 and found discussions included synopsis, areas of good practice, areas where practice can be improved and grading.

Staff were aware of their responsibilities in relation to the duty of candour. All staff we spoke with were aware of the principles of openness and accountability when things go wrong. Senior leads told us that mandatory training included duty of candour.

Safety Thermometer (or equivalent)

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, women and visitors.

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

Data collection took place one day each month – a suggested date for data collection was given but wards can change this. Data must be submitted within 10 days of suggested data collection date. The service did not display the safety thermometer.

The Maternity Safety Thermometer is a measurement tool for improvement that focuses on: perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. The tool allows maternity teams to take a temperature check on harm and records the number of harms associated with maternity care, but also records the proportion of mothers who have experienced 'harm free' care. The Maternity Safety Thermometer was introduced on Templar ward in April 2019 and on the delivery suite in June 2019.

We reviewed the Maternity Safety Thermometer for November 2019 for the birth centre and the delivery suite which showed there were zero incidences of maternal infection, zero babies with an Apgar score of six or less at five minutes, zero patients where there was a blood loss over 1000ml and all patients had a positive perception of safety. For Templar ward during the same month, there were zero maternal infections, two babies with an Apgar score of six or less at five minutes, one patient where there was a blood loss over 1000ml and all patients had a positive perception of safety.

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and staff.

The maternity service was part of the Surgery, Women's and Sexual Health (SWSH) clinical division. The senior midwifery team was restructured in 2018 and now included a quality improvement lead midwife, named midwife for safeguarding, additional matron, deputy head of midwifery, new clinical lead and associate medical director for women's health. Staff told us the management changes had resulted in senior leads being more accessible and visible. The head of midwifery carried out monthly breakfast rounds and told us this helped senior leaders stay connected with all staff including housekeeping.

The maternity service was led by a triumvirate team that included the head of midwifery, divisional operations director and the clinical lead. We interviewed the senior leadership team who demonstrated an awareness of the performance within the maternity service along with its challenges.

Staff we spoke with told us that managers were supportive and approachable, and felt their concerns were listened to. Both midwifery and medical staff of all grades spoke of good teamwork and development opportunities.

Maternity

During the inspection, we were made aware that the head of midwifery was leaving the trust. Although staff we spoke with were sad to hear this, senior leads and staff told us they were confident that the changes made were embedded and would remain. However, during the factual accuracy process, the trust told us the head of midwifery had decided to continue their role and was no longer leaving the trust.

Each maternity area had monthly staff meetings. We reviewed the team meeting minutes for Templar and Turpin ward for October 2019, December 2019 and January 2020. We found there was consistency in the format and structure of the meetings. Meetings included staff reminders for compliance checks, complaints, NEWTT and MEOWS charts, VTE, welcome for new staff and any key updates.

Vision and strategy

Senior leaders told us they were proud of the service and that they were delivering good care.

The trust's strategy, 'Achieving together', outlined three key priorities to respond to the changing demands and pressures in local health care. The key priorities included quality services, promoting integration and sustainable growth.

The maternity strategy was introduced in September 2017 and identified seven main priorities to be delivered over a three year timescale. The seven priorities included women centred personalised care that takes into consideration the needs of her family, collaborative working, co-production of services with women and families, sustainable work force, compassionate postnatal care, working with partners to provide good preconception care and promote good maternal, physical and mental wellbeing. The maternity strategy was due for renewal in April 2020. The senior leadership team had a maternity strategy action plan and told us they were keen for the staff to take ownership and for the focus to be on future proofing the workforce. The maternity voice partnership (MVP) would provide public engagement.

Senior leads told us the trust's values were integrated into the appraisal process and were displayed throughout the maternity service for both the public and staff to see. The trust values included four key areas: safe, personal, respectful and responsibility. Staff were required to include examples of how they demonstrated the values in their appraisals.

During the inspection, the service was filming the 'lived experience video' which showed the experience of seven women who received pregnancy care at the hospital. Women from different ethnicities were selected to ensure true reflection of the diverse population and an independent person engaged with women to remove any bias. The video promoted the service and would be used for staff training.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

They said it was a friendly team and they felt listened to if they raised concerns. Staff commented that the team was like a family with no hierarchy and they prided themselves on good teamwork. Junior doctors said they felt well supported by consultants and described the culture as positive. Staff described the environment as supportive to newly qualified staff with good team work ethic.

Senior leads were proud of their staff and told us several staff members had been working in the trust for years. Senior leads told us there was an atmosphere of togetherness especially during difficult times. Despite the staffing challenges in delivery suite, senior leads described the culture as stable.

Staff told us there had been a massive shift in management praising staff. The maternity service had implemented a 'star of the month' staff recognition award and displayed 'star of the month' certificates with staff photos. Staff were awarded with a voucher and a star of the month certificate.

As part of the trust's work on diversity and equality, the trust had staff networks for disability, black and minority ethnic (BAME), lesbian, gay, bisexual, and transgender (LGBT) and ability and wellbeing. In addition, the chaplaincy catered for the religious needs of staff communities. Staff we spoke with told us they had not witnessed any bullying or harassment in the department.

There were processes in place to support staff during challenging circumstances. Staff told us they had access to debriefing sessions to facilitate reflective practice and talking about their feelings. The professional midwifery advocates (PMA) provided staff with restorative supervision as part of the mandatory training. Although senior leads told us the intranet had information on freedom to speak up guardians, we found staff had inconsistent awareness of them.

Governance

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a clear governance structure for the service and staff at all levels were clear about their roles and understood their responsibilities. Staff were aware of how to complete incident reports and were encouraged to do so. Most staff we spoke to had completed incidents and received feedback from managers.

The monthly maternity risk management review (MRMR) meeting was chaired by the divisional operations director and had multidisciplinary attendance from matrons, consultants, midwives, head of midwifery, governance team, clinical placement facilitator, screening teams and clinical leads. The MRMR meetings fed into the monthly divisional (SWSH) board meeting which were attended by the maternity triumvirate team. This meeting included monthly speciality presentations which meant each speciality would present at least two to three times a year. The monthly performance review reports were presented at the Trust Management Board (TMB) meetings where each division provided a performance report of the previous quarter.

The trust's management board met monthly to discuss quality and operational assurance. We reviewed the minutes for July, August and September 2019 and found there was consistency in the format and structure of the meetings. The meeting agenda included discussion on outstanding risks, serious incidents, operational performance management and service delivery from each division, policy and service development and committee and meeting reports.

The service had bi-monthly joint meetings between midwifery obstetricians and anaesthetic team. Although minutes were not taken for these meetings, the trust provided summaries for October to December 2019, which showed the agenda included clinical governance, education and an action plan for next steps.

During our last inspection we found the parameters on the reporting dashboard were not standardised which meant benchmarking activity against regional or national performance measures was not possible. On this inspection, we found the service had reviewed the maternity dashboard and made improvements. The maternity service used a clinical performance dashboard to monitor activity, outcomes, performance and helped identify patient safety and quality issues. This was in line with national recommendations (RCOG Maternity Dashboard: Clinical Performance and Governance Score Card, Good Practice No.7, 2008). The dashboard tracked monthly performance against locally agreed performance measures. A traffic light system was used to flag performance against agreed thresholds. The service introduced a dashboard guideline in June 2019 which provided information regarding each field's data definition, rationale and threshold. The maternity dashboard was regularly discussed at departmental, divisional board meetings, trust board and with the Clinical Commissioning Group (CCG). Senior leads told us the improvements had been recognised by the CCG.

Each maternity area had a governance board which highlighted the updated guidelines, duty of candour, maternity risks on the risk register and a summary of maternity activity for the previous year. For example, in 2019, there were 5672 births, 100% of women received one to one care, 115 homebirths (2% of all births) and 935 births at the birth centre.

Maternity

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively.

Senior leaders and managers of the maternity service had a good understanding of most risks to the service and these were appropriately documented in risk management documentation with named leads and actions. The senior leadership team told us they had reviewed the register to ensure mitigations were more robust.

During the last inspection, we found variations in how risks were managed across the services as some risks that staff told us about, were not recorded on the services risk register. On this inspection, although we found improvements had been made on sharing the risks with staff, we found isolated risks that staff told us about, had not been recorded on the risk register.

For example, we saw that most risks identified on inspection were on the risk register, including the interface issues with the electronic system and lack of middle grade obstetric doctors. However, the risk register did not include Information Technology (IT) systems in the community (refer to subheading managing information).

Although the risk register had included the interface issues between the trust's electronic record systems since November 2015, senior leads told us the risk score was 10 due to the mitigations in place. The risk register stated the lack of interface meant there were frequent documentation errors which resulted in the informatics lead undertaking a significant amount of daily data 'clean-up' to mitigate this. During this inspection, we found the use of multiple systems had the potential to create possible confusion as to what information was recorded where, resulting in documentation gaps and inconsistency. However, the description of the risk in the risk register did not mention this.

Although senior leads told us there had been no incidents relating to documentation or deteriorating patients as a result of documentation gaps, senior leads acknowledged the challenges faced when using multiple systems and told us they were in the process of sourcing an alternative provider. Although the service was hoping to finalise their decision as soon as possible, the timelines for decision making and implementation were not clear.

Senior leads told us they had reviewed whether compliance rounds should be recorded on the risk register but identified that no agreed set of principles were in place to achieve consistency. Therefore, the first step was to agree a set of principles which the service had completed and were monitoring.

The risk register was reviewed monthly in the maternity risk management review (MRMR) meeting. We reviewed the MRMR meetings for October to December 2019 and found there was consistency in the format and structure of these meetings. The meeting agenda included introductions and apologies, review of previous minutes, actions from the action table, maternity clinical governance dashboard which included current and new risks, serious incidents, trends reports, policies and guidelines, maternity strategy action plan, maternity dashboards (reporting by exception), committee reports and audit feedback. Staff also received updates on the risk register during mandatory training which helped staff understand the risks for the service and the mitigations in place.

The maternity service had revamped the Maternity Risk Newsletter (Maternity Pulse) in April 2019. The newsletter was published quarterly and included the latest maternity risk changes, challenges and improvements. We reviewed the July 2019 edition which included information on star of the month, clinical governance, incidents, root cause analysis, serious incidents, HSIB investigations, spotlight dashboard, audits and guidelines, practice development, multidisciplinary in-situ simulation and mandatory training.

The trust had a major incident plan policy, which we reviewed and found to be up to date and comprehensive. For example, the policy covered the protocol for deferring elective activity for emergencies and major incidents.

Maternity

Maternity safety is an important issue for all members of the Clinical Negligence Scheme for Trusts (CNST) and the scheme incentivised ten maternity safety actions. Trusts that demonstrated they have achievedall thetensafety actions would recover their contribution to the CNST maternity incentive fund and would also receive a share of any unallocated funds. The service had achieved the CNST maternity incentive scheme for two years.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. However, the lack of interface between the trust's electronic system presented challenges.

Computer stations were available so that staff could access the intranet and internet. Staff were aware of how to use and store confidential information. We found paper records were stored securely. During our last inspection, we observed staff leaving computer screens unattended and displaying patient information. On this inspection, we found this had improved as the service had installed privacy screens on computer monitors and most staff locked computers preventing unauthorised access.

During our last inspection, we found the lack of interface between the trust's electronic patient record systems presented challenges. Although the trust had a working group who were working with the Information Technology (IT) provider to develop the interface since 2016, on this inspection, we found the interface issues remained. With the lack of interface and navigation difficulties, we reviewed some patient records with one of the digital midwives and the deputy head of midwifery. They both acknowledged the examples we showed had documentation gaps due to the interface challenges. Staff we spoke with also told us they wanted one system to ensure all the information was in one place. Refer to Records subheading for more information.

Staff told us that IT in the community also presented challenges as laptops needed to be updated and Wi-Fi signal was intermittent. Although Band 7 midwifery community staff had smart phones, Band 6s did not have smart phones which meant they could not access their emails on their phones. We raised this with the head of midwifery who told us funding had recently been agreed for all midwifery community staff to have smart phones and for aged laptops to be replaced. However, we were not informed when this would be achieved by. We noted that the IT issues in community were not recorded on the risk register.

Most staff were able to access policies and guidelines on the intranet although staff told us the search function did not always find the requested document. However, we found there were several guidelines that were out of date with poor documentation of version control. Examples included Brachial plexus injury (August 2019) and Care of women in labour and in the immediate postnatal period (January 2019). We raised this with senior leads who told us the service had a dedicated audit and guidelines midwife who kept a spreadsheet of all the guidelines. Four months prior to a guideline expiring, the author would be contacted to review the guidance and where the original author was not available, the task would be assigned to an appropriate person. The spreadsheet showed 17 guidelines were in the process of being updated. The status for each guidance was documented to indicate where the guideline was in the ratification process. For example, the spreadsheet showed that the Brachial plexus injury guideline was under author review.

The service submitted data to external bodies as required such as MBRRACE-UK, which enabled the service to benchmark performance against national outcomes.

Staff notice boards included information on what's on the risk register, message of the week and duty of candour. Staff received communication through huddles, handovers and newsletters. The service had several social network groups which helped share communication; for example, sharing additional shifts.

Noticeboards in maternity areas displayed a vast range of information for women and their families. For example, the reception area in the delivery suite displayed the photographs of the leadership team, the previous CQC ratings and helpline details for women if they were concerned with baby's movements. Information boards were displayed in each area which included the planned versus actual staffing for each shift that day.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff gave the friends and family test (FFT) forms to women at the point of discharge so that they could give feedback in relation to the care they had received. The service had moved to a text message service in July 2019 to improve response rates. Between August 2019 and January 2020, the average response rate across the service was 15% with an overall satisfaction rate of 89%. Although the introduction of the text service had increased response rates, further improvement was still required. Feedback was also collected through social media forums such as NHS Choices, Facebook, Instagram and Twitter. Women who used maternity services were encouraged to give feedback on the quality of service they received. Between April 2019 and September 2019, the maternity dashboard showed that the service mostly met the 95% target for percentage of women who recommended the service to family and friends.

Obstetricians organised birth reflections clinic with women who had used the maternity service and the Professional Midwifery Advocate (PMA) shared the themes identified with staff. The PMAs held ad hoc listening clinics with women to help get a better understanding of patient experience.

The service had developed strong links with the local Maternity Voices Partnership (MVP), which was an independent multidisciplinary committee made up of user representatives, maternity professionals and other stakeholders such as Clinical Commissioning Groups (CCGs). The service worked closely with the Local Maternity System (LMS) and senior leads described the LMS in East London as strong. The trust had worked with neighbouring NHS hospitals and reviewed their self-referral and GP referral forms.

The service used patient feedback to make improvements to the service provided. For example, further to patient feedback about the noise levels on the wards, women were given ear plugs. The trust had a patient panel called 'Walk the patch' where women who had used the maternity service, shared their experience.

The staff survey in 2018 highlighted that there wasn't enough recognition of their work from management. In response, the trust implemented 'star of the month' and we saw noticeboards display the winners for December 2019 during the inspection. Staff received a certificate and vouchers for star of the month and staff could nominate their peers via the internet and paper. Staff told us they felt recognition from management had improved which had improved morale.

Staff also wanted a forum with the head of midwifery to raise concerns informally. Senior leads told us drop in sessions had been set up with the head of midwifery but following poor attendance, an email address was set up to allow staff the opportunity to raise concerns. The head of midwifery also carried out monthly breakfast rounds for staff.

Staff also highlighted the need to have improved methods of communication. The maternity service kept staff up to date through several newsletters such as 'Tips of the Fortnight', 'Topic of the week' and 'In The Loop' which provided key updates. For example, 'Tips of the Fortnight' included recommendations from morbidity/mortality meetings, case reviews, guidelines updates and changes in practice. The information was then discussed at the daily safety huddle and once staff had read and understood the information given, staff signatures were obtained to evidence the learning.

We reviewed the 'In The Loop' newsletter for June, September and December 2019 and found they included information on new appointments, star of the month, celebrating successes, quality improvement update and what's in the pipeline. The trust archived newsletters within shared folders, so staff could readily access them.

Maternity

In August 2019, the service requested staff to complete a survey monkey to ascertain how successful the changes implemented to date had been. A total of 79 maternity staff responded with most staff reporting positive feedback.

The service organised a craft club where staff got together and made personalised items for bereaved mums. Senior leads told us the club was successful and that they planned to run the club quarterly.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The maternity service was a pilot site for the borough-wide Making Every Contact Count (MECC) project. MECC is an approach to behaviour change that utilises the millions of day to day interactions that organisations and people have with other people to encourage changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and populations. Staff training was scheduled in February 2020 and included a competence on culture.

The maternity unit was invited to participate in the PReCePT programme by NHS England as part of the Maternity and Neonatal patient safety collaborative. A multidisciplinary team of doctors, midwives and administration staff were resourced with protected time to deliver the programme. The trust's Academic Health Science Network (AHSN) provided the team with tools and resources to support implementation.The national target was 85% and the trust's compliance was 80% in September 2018. Data provided by the trust showed the maternity service had achieved 100% (against the stretch target of 95%).

The fetal medicines unit was involved in several research projects and the team were co-located with the research midwives.

Outstanding practice

- The service had started a project called Trauma Informed Care with the aim to ensure all care was psychologically safe. Staff received training to help them identify women's' needs throughout the pathway whilst maintaining patient safety. The training helped staff understand what trauma was and how it impacted on healthcare processes.

Areas for improvement

Action the provider MUST take to meet the regulations:

- The trust must address the interface challenges between the trust's electronic patient record system to ensure there is consistent record keeping with no documentation gaps. This includes ensuring the emergency obstetric unit/ triage assessment forms and symphysial fundal height (SFH) growth charts are completed in full. Please see requirement notices for further information.

Action the provider SHOULD take to improve

- The trust should continue taking steps to ensure consistent compliance with hand hygiene practice amongst staff and visitors at entry/exit into ward areas. This includes reviewing the trust wide hand hygiene audit and policy to include this.
- The trust should continue taking steps to improve the medical staff compliance rates for mandatory training to ensure the trust target is achieved.
- The trust should continue taking steps to improve their WHO checklist compliance.

Maternity

- The trust should continue taking steps to ensure staff consistently complete MEOWS and NEWTT observations and where appropriate, the records should include any narrative to explain non-compliance and where escalation has taken place.
- The trust should continue taking steps to ensure the service had enough midwifery staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm.
- The trust should continue taking steps to improve response rates for Friends and Family feedback.

End of life care

Good

Summary of this service

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

The specialist palliative care team are a multidisciplinary team that work across the wards and alongside ward staff and doctors as an advisory team and in the delivery of direct patient care. It is comprised of a senior nurse, lead nurse, a palliative consultant, clinical nurse specialists, a social worker and an end of life care facilitator. The role of the team includes assessment and care planning for patients with complex palliative care needs, treatment, medication, symptom control and emotional and psychological support for patients and their relatives and loved ones. They provide a five day a week face to face palliative care and end of life care service for patients and support to staff. A 24-hour telephone advice line is available from a consultant in palliative medicine. The team carry out holistic assessments in partnership with nursing and medical teams. The trust use an individualised care plan to tailor care for dying patients in the last weeks or last days of life.

During 2018/19, there were 436 patient deaths at the hospital. Current data showed that 65 to 70% of patients who died in the hospital were seen by the SPCT. There are no inpatient palliative care beds. The SPCT received 561 referrals in 2019.

We spoke with a total of seven patients and relatives. We also spoke with 37 members of staff, which included ward managers, nurses and healthcare assistants, ward doctors and specialist support staff such as occupational and physiotherapy staff. We also spoke with senior managers, mortuary staff, chaplaincy, bereavement coordinators and all members of the specialist palliative care team, end of life care team and key senior managers at the trust.

We observed care and treatment within the wards and reviewed 26 care records that included 11 Do Not Attempt Cardio-Pulmonary Resuscitation forms.

At the last inspection we found patients received safe end of life care and there were systems in place to ensure patients were kept safe. People were given information and support to make decisions about their care as inpatients and they were involved in discharge planning. Staff received appropriate training and support and understood the good practice guidelines and pathways in place. The service was well led by an experienced palliative care team that was respected and valued by medical, nursing and other colleagues in the hospital.

We rated it as good because:

- All members of the specialist palliative care team demonstrated appropriate awareness and understanding of safeguarding processes. Staff used equipment and infection control measures to protect patients, themselves and others. Equipment and the premises were kept clean. Risk assessments considered patients who were deteriorating and in the last days or hours of their life. The use of electronic patient records was fully embedded and records we saw were up to date and accessible. All members of the specialist palliative care team had a specialist understanding of medicines used for symptom control.
- The service provided effective care and treatment. It was based on national guidance and evidence-based practice. Patients had enough food and drink and were assessed and monitored regularly to see if they were in pain. We encountered positive multidisciplinary working for the benefit of patients. We reviewed 11 DNACPR forms that were in place at the time of our visit and found them completed to a high standard.

End of life care

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support to patients, families and carers to minimise their distress. The service understood patients' personal, cultural and religious needs. Patients, families and carers supported to understand their condition and involved in making decisions about their care and treatment.
- The specialist palliative care team's assessments and daily handovers considered patient risk and the holistic needs of patients. The team worked closely with community teams, the community palliative care team and maintained good links with the local hospice. The mortuary and bereavement teams understood patients' cultural needs after death and the bereavement office was co located in the mortuary suite, enabling good access to services for relatives. The borough registrar was located in the hospital two full days and three half days a week, thus better facilitating the process for prompt funeral arrangements.
- There was a leadership structure and clear lines of accountability in place for different aspects of end of life care. There were governance structures in place to manage the performance and risks of the service. There was a positive drive to improve the culture of the hospital and make end of life care everyone's business, which was linked to the end of life care strategy.

However:

- The service did not have enough palliative medical staff to provide the right care and treatment in line with Royal College of Physicians guidance. The anticipatory drug chart identified four of the five symptoms recommended in NICE guidance but had omitted breathlessness from the chart. Space was provided for 'other' symptoms to be added which meant inclusion was down to user initiative. Although currently in working order, the mortuary fridges and freezers were 33 years old and consequently past their expected life span. There were no current plans for their replacement and the issue was not included on the trust risk register.
- Where DNACPR forms indicated that patients lacked capacity, a mental capacity assessment was not always completed. We were told that an audit of DNACPR had not been undertaken but data the trust extrapolated from other audits showed a low compliance rate. The palliative care service was a Monday to Friday service whereas guidance states the hospital service should be provided on site seven days a week. Plans for Saturday working were at the planning stage.
- Work was currently underway to improve the continuing healthcare fast track pathway where delays to discharge had been identified. Preference for patients' preferred place of care and preferred place of death was being recorded. However, audits of these were not taking place. Nurses received training in dignity after death which we were told, had so far been ad hoc and the end of life care facilitator had been tasked with improving this. The trust had recently purchased a component for their electronic incident reporting system that could draw out themes relating to end of life and palliative care to improve learning. However, this was not yet embedded.
- There was a lack of spaces on wards to meet with relatives and patients for private or sensitive conversations. Chaplaincy provision, including office, multifaith prayer room, ablution room and resource area were all being provided from one small space. It was not possible to establish whether the number of chaplaincy hours allocated per week were in line with the NHS Chaplaincy Guidelines 2015 of 3.75 hours per week of chaplaincy care for every 35 patients.
- There was an aim to implement the Swan model of end of life and bereavement care by 1 April 2020. Most staff we spoke with had heard of its imminent introduction. However, at the time of inspection only one ward had been piloted and it was not clear how progress was being measured. The swan symbol featured on the cover of the strategy booklet. However, explanation of the Swan model of care for end of life or its implementation was not referred to within the strategy.

End of life care

Is the service safe?

Good

Our rating of safe remained the same. For further information please see detailed findings.

Is the service effective?

Good

Our rating of effective remained the same. For further information please see detailed findings.

Is the service caring?

Good

Our rating of caring remained the same. For further information please see detailed findings.

Is the service responsive?

Good

Our rating of responsive improved. For further information please see detailed findings.

Is the service well-led?

Good

Our rating of well led remained the same. For further information please see detailed findings.

Detailed findings from this inspection

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The trust set a target of 90% for completion of mandatory training. Within staff groups that provided end of life care, 100% was achieved in all but two instances. Five of six staff in the specialist palliative care team (SPCT) had completed safeguarding children level 2 training, and in chaplaincy where one of two had completed safeguarding children level 2 training.

End of life care

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

All members of the SPCT demonstrated appropriate awareness and understanding of safeguarding processes and procedures. We were given appropriate examples of when a safeguarding referral might be required. The team were able to identify who the trust safeguarding leads were for both adults and children. The contact details for the safeguarding leads were on display in the SPCT offices.

All team members had attended mandatory training for safeguarding level 1 and 2, which also covered mental capacity and deprivation of liberty safeguards. The trust set a target of 90% for completion of safeguarding training. Safeguarding training completion rates from April 2019 to September 2019 showed the target was met for three of the four safeguarding training modules for which qualified nursing staff were eligible.

Cleanliness, infection control and hygiene

Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. Staff used infection control measures when visiting patients on wards and transporting patients after death.

We observed staff entering and leaving wards were adhering to hand hygiene protocols. All ward areas we visited were clean. All staff we observed were in compliance with bare below the elbow policy.

Each ward had a syringe driver and additional drivers were available from the equipment library. It was the responsibility of ward staff to ensure that all syringe drivers returned to the equipment library were clean. Returns were not accepted if they were not clean and without a decontamination certificate attached.

The mortuary and viewing suites were visibly clean and free of odours. A cleaner attended the mortuary every morning between 6am and 8am and performed cleaning tasks throughout the mortuary, viewing suites, office and waiting area. The mortuary officer was responsible for cleaning inside the fridges. Cleaning of the concealment trolley following transportation from the wards was the responsibility of the porters and mortuary officer. Any spillages were also the responsibility of the mortuary staff. There was an infection control annual audit that checked storage, hygiene and audits of all cleaning of fridges and knowledge of infection control processes.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe.

The hospital used the McKinley T34 syringe driver. All syringe drivers were maintained and monitored by the electrical devices department. Each ward had a syringe driver and additional drivers were available from the equipment library with access available 24/7. Equipment library staff carried out a basic safety check on every piece of equipment prior to it being put back in to circulation. All syringe drivers had an annual service and each had a sticker with the date the next service was due by.

Every piece of equipment was microchipped, allowing for GPS tracking within the footprint of the hospital. We were told that when syringe drivers went missing, they were most likely to be off site. For syringe drivers in use on wards, there was an electronic tool used to monitor checks. The syringe driver checking tool requests that a check takes place once after initial set up and then for four hourly checks to take place, similar to signing a prescription every four hours but to record that the syringe driver had been checked.

Wards such as Lamb ward, acute assessment unit and elderly care unit south, reported that syringe drivers were available if needed. It was reported that following the purchase of additional syringe drivers last year, access had not been an issue. Prior to this, access could be sometimes problematic. On Lamb ward, a syringe driver was available through the Swan resource trolley. The SWAN (sign, words, actions, needs) model of care for patients at the end of life.

End of life care

The Swan model of end of life and bereavement care is used to support and guide the care of patients and their loved ones at the end of life and after they have died. It enables all staff to provide equitable care and compassion for patients and their families who die and provides openness in the culture that providing quality end of life care is everyone's business. Additional drivers were reported as available via the medical equipment library if needed. Good access to pressure relieving equipment was also reported.

Currently all syringe drivers were second edition so unaffected by the current MHRA alert from October 2019. There was a robust system to monitor and respond to MHRA alerts. There was an electronic system in place that logged every device or piece of equipment. Following any MHRA alert relevant equipment would be highlighted by a data management system thus identifying the issue and tracking progress on this. We observed this in action by looking at previous alerts that had been in place for the second edition of McKinley drivers.

Within the mortuary suite, there were two viewing rooms. Access for relatives and loved ones was via a separate entrance accessed from the hospital corridor. There was a seated area outside of the viewing suites where relatives could sit prior to viewings or to meet with the mortuary and bereavement officers. There was a water dispenser located in the seated area and a kitchen and toilet were located nearby. There were religious texts available.

The mortuary contained 37 fridge spaces for adults. This included four bariatric spaces. The fridges also gave the capacity to break two spaces down to create one larger space thus increasing capacity for larger bariatric patients. There were three further fridge spaces used for babies and human tissue. There were also four freezer spaces available.

If capacity was reached, there was a contract in place with a local undertaker who had large fridge and freezer capacity. Larger walk in fridge spaces were also available for larger bariatric patients. This had not been required in the last five years.

The mortuary fridges were 33 years old. The most recent breakdown had occurred five months ago. Each block of eight fridges were independent of each other, which meant that any breakdown reduced capacity by eight spaces only. If fridges went out of temperature range or broke down out of normal working hours, there was an alarm that was linked to switchboard, who could contact engineers. The mortuary fridges and freezers were serviced twice a year. Servicing was carried out by an external company and reported as being thorough and helpful in detecting and remedying issues.

The trust confirmed that they were the original mortuary fridges and freezers from when the hospital opened in 1987 and consequently were past their expected end of life. However, repair works had been undertaken to keep them operational. The refrigerant gas was changed due to European F-gas regulations from R404A to R449A at the end of 2018 to ensure they remained legislatively compliant.

There were no current plans to replace these assets and they are not listed on the trust risk register as a concern. However, the need for their potential replacement had been raised with the head of property and projects so this could be added to the proposed capital plan for 2021/22 (it was not possible to add this to the 2020/21 plan due to lack of capacity for the year). Final determination of what would be included in the 2021/22 capital plan would be made in quarter 4 of 2021.

There was a concealment trolley for transporting patients from the wards to the mortuary, boxed for concealment. For bariatric patients there was a large blue cover placed over patients' beds which meant that no shape was visible. The hospital bed was then wheeled to the mortuary.

A hydraulic trolley was available for reaching the higher fridge compartments. A ceiling mounted hoist with a 70 stone capacity was also available. All personal protective equipment such as gloves and aprons were available and stored in cupboards that included a supply of body bags.

Transfer out of the mortuary was via a separate entrance that had controlled barrier access. The back door was also under cover.

End of life care

Assessing and responding to patient risk

Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

The specialist palliative care team (SPCT) held a daily handover and weekly multidisciplinary meeting. We attended the SPCT daily handover meeting, which had multi professional representation including three clinical nurse specialists (CNS), a senior nurse, lead nurse, a palliative consultant, an end of life care facilitator and a social worker. The handover consisted of an update from the previous day, reported on any new deaths, discharges and newly referred patients. We were provided with background and detail on the type and complexity of patients seen by the team. There were 21 active inpatients allocated to each of the three CNSs. There was one patient at the trust run nursing home and one new patient for allocation. 50% of patients were from the elderly care units.

Holistic needs of patients were discussed including pain and symptom control, spiritual and religious needs, nutritional needs, social background, psychological needs and needs of the family. There was evidence of shared decision making and negotiation of care with the patient and family. There was evidence of multi professional team input regarding the management of complex symptoms. There was evidence of cultural needs and evidence of bereavement awareness and support.

Each CNS provided a detailed summary of patient's history and EoLC needs. Palliative care and symptom control needs were identified and discussed. Family involvement and support was discussed. There was good awareness of consent and capacity in decision making and provision of anticipatory medicines. There was good awareness and knowledge of individual spiritual needs, social and family needs and the impact on care decisions and treatment plan. The team told us the handover was an opportunity for pooling knowledge and expertise to problem solve. There was peer support, group decision making and a planning of the day ahead.

We attended a ward round with the palliative consultant and two CNSs. We observed the management of four patients on four different wards including respiratory, acute medical assessment, older people's care and rehabilitation. We observed evidence of holistic assessment including physical symptoms, nutritional needs, psychological needs, family support, religious needs and discharge plans.

Discharge planning was also discussed at the handover meeting and preferred place of care was discussed and recorded on Coordinate My Care (CMC). Plans of care from the community setting were built within the CMC system. CMC is an individual care plan containing information about the patient, their diagnosis and medication, key contact details of their regular carers and clinicians, and their personal preferences across a range of possible care circumstances. It is uploaded on to the CMC system, to which professionals such as ambulance control staff, NHS 111 operators, GPs, out of hours GP services, hospitals, nursing and care homes, hospices and community nursing teams have access. With 24/7 electronic access to the plan, the professionals can then use it to guide their response to the patient's needs.

Discussions in the daily SPCT handover also included coordinate my care (CMC) and the need to update and communicate with the GP for advance care planning and preferred place of death. We observed a discussion around why a patient had reattended ED and whether it was in line with the treatment escalation plan (TEP). We observed discussions around TEP and ceiling of care. There was good challenge and discussion within the team, who all appeared at ease and confident to express views and opinions. The treatment escalation plan (TEP) was an electronic record and available to all staff to view. The TEP was comprehensive and was linked to the do not attempt cardiopulmonary resuscitation (DNACPR) record. It identified patients' escalation status and included key parameters such as IV fluids, IV antibiotics, blood transfusions, invasive ventilation, non invasive ventilation, renal replacement and outreach assessment. It also identified if there was a need for an independent mental capacity advocate (IMCA) and the needs of the family. There was a record of the rationale for decisions and what had been discussed with the patient or family. The TEP form identified the person completing the form and allowed for updating. We reviewed six TEPs. These were all

completed to a high standard with decisions clearly documented. We found the TEP to be a comprehensive tool that supported patient wishes and prevented unnecessary or unwanted interventions. The acute care unit (ACU) was a 35 bedded unit, with a majority of admissions via ED. We were told that treatment escalation plans were usually completed in ED and communicated at handover. If patients were recognised to be imminently dying they remained on ACU.

Part of the new SPCT nurse lead's remit was to review patients coming through the emergency department (ED) and the acute assessment unit (ACU) thus extending the reach of the team and improving early identification of the dying patient. This included looking at the number of admissions people might have had. A standard operating procedure for how the SPCT could work better with ED had been developed and the team also carried out training with ED and ACU. On Elderly Care Unit South, there had been significant training that had included the recognition of the dying patient and communication with patients and families. Ward staff on Lamb ward, the pilot ward for the Swan model initiative, felt that there was now earlier recognition of the dying patient and staff felt confident to have discussions with the SPCT if needed. The SPCT on Elderly Care Unit North were described as open and accessible by the nursing team, who felt confident to approach and express concerns and thoughts around the recognition of a dying patient and care planning. They were able to provide an example of how a junior member of the team had initiated discussions with the SPCT about end of life care for a patient. Good involvement in multidisciplinary meetings was reported on Elderly Care Unit North where junior doctors were described as erring on the side of giving a higher CESDI score (Confidential Enquiry into Stillbirths and Deaths in Infancy, this is a scoring system that is used for all deaths) which would often be downgraded following discussion and review.

Staff on ACU were aware of the Swan model and attended the Swan steering committee. We were told they were looking forward to implementing it on ACU. Staff on the ward initiated the EoLC plan and had discussions with the consultant, team, patients and family. Deaths on ACU were discussed at the weekly operational meeting. The EoLC facilitator was reported as very accessible and supportive as were the SPCT. EoLC decisions may be discussed at the safety huddle that the EoLC facilitator had attended, MDT was also an opportunity to discuss and share. Regarding CMC, it was discussed at the board meeting/huddle.

Elderly Care Unit North reported that bereavement and mortality review meetings were taking place and that ward managers met every two weeks to discuss feedback from bereavement meetings. The main theme from feedback was around communication, which teams felt was improving. The early recognition of the dying patient was also described as improving. Elderly Care Unit South told us they always had nursing representation at mortality review meetings and used them as a learning opportunity for staff. Meetings were reported as very multidisciplinary and any themes and learning were identified.

An online app was used to measure aspects of care regarding palliative and end of life patients. It was also used to review the care received by patients at the end of life from the documentation on the electronic patient record. We were provided with an example of its use on Graham ward from December 2019, which demonstrated the metrics used. It asked a number of questions such as have anticipatory medicines been prescribed, has the DNAR form been completed by a designated healthcare professional, was an end of life care plan started and has the team documented recognition that the patient may be dying. This had been introduced at the hospital in July 2019. Results were fed back to ward teams who then plan the relevant actions.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The SPCT consisted of the following: one band 8A nurse lead, three band 7 clinical nurse specialists in palliative care (CNS), one social worker, a band 7 end of life care facilitator (funded by Macmillan for two years up to September 2020) and one whole time equivalent (WTE) clinical psychologist shared between cancer and the SPCT. The nurse lead was

new in post six months ago following consideration given to how palliative care was managed and developed. Both the band 8A and EoLC facilitator posts had been newly created. Apart from this, it was reported that the SPCT were an established team with little turnover. The team was overseen by a band 8B senior nurse, who also managed the cancer CNSs.

Medical staffing

The service did not have enough palliative medical staff to provide the right care and treatment in line with Royal College of Physicians guidance.

All on site palliative medical cover was provided by one consultant who worked four sessions, or programmed activities, over three days a week. There was no cover for study days, holidays or sickness. We were told it had been recommended that the post be increased to a full time post which would allow for improved initiative development and ensure that face to face palliative medical care would be available five days a week.

A job plan had been drafted for a shared post between the trust and the local hospice with the funding being an equal split. It was reported that the hospice had pledged their 50% of funding. However, this had not been pledged by the trust. The trust lead for end of life care told us there was a proposal for a shared post with the local hospice and that the hospice had identified funding towards the post. A final plan had not yet been agreed and trust resources had not yet been identified. However, it could be difficult to recruit to and there was a desire to make the role interesting and varied to attract the right candidates.

The Royal College of Physicians guidance states that current minimum requirements for hospital specialist palliative care teams is one whole time equivalent consultant per 250 beds as recommended in commissioning guidance for specialist palliative care.

Records

Staff kept detailed records of patients' care and treatment.

In each ward we visited electronic patient notes were easily accessed and available. Records we saw were accessible and up to date. Electronic patient records had reportedly made all relevant information available to teams, which supported decision making at handover, MDTs and other reviews. This was observed at the SPCT handover where patient records were readily available to support review and decision making.

The mortuary register was a paper book that was completed by mortuary staff and porters outside of normal working hours. It recorded essential details of each deceased person coming in to the mortuary and essential details of when leaving. There was an online system for recording of all deaths.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

It was evidenced that all members of the SPCT had a specialist understanding of medicines used for symptom control, including the mechanism of action of medicines and how they may interact with each other. The specialism of the role the SPCT in relation to these medicines was evident.

Dying patients who were discharged in to the community were sent home with both anticipatory medicines and a prescription chart. This ensured that symptoms could be treated without delay. NICE NG31 and NICE QS144 recommend anticipatory prescribing for all of the most common symptoms that included for pain, nausea and vomiting, agitation and anxiety, breathlessness and respiratory tract secretions. The anticipatory drug chart for community use by the trust identified four of the five symptoms by name. However, it had omitted breathlessness from the chart. The drug chart did provide space for 'other' symptoms to be added but this was down to user initiative and could lead to breathlessness not being included on the medication chart.

Regarding anticipatory medicines, on ACU we were told there was good availability and access and good support from the SCPT. On Elderly Care Unit South, there was good availability and access when we checked and good support from the SCPT. We also found that anticipatory medicines were available on Lamb ward; in stock and in date, with access out of hours if additional supplies were required. Good support was reported from the pharmacy team and good support from medical staff in prescribing and reviewing medicines. There was clear advice on morphine supply shortages for 5 and 10mg, with mitigation in place to use 30mg ampoules but guidance was available and clear in order to minimise the risk of excessive dose.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

The online reporting system was used to report all adverse incidents. All members of the SPCT were aware of how to use the system and of the type of incidents that should be reported. Every incident was assigned a handler, who would initiate an investigation of the incident and arrange feedback.

It was reported that the trust's online reporting system was unable to specifically identify incidents that related to palliative and end of life care before July 2019.There had been 38 incidents reported since this time that related to palliative and end of life care.

Outcomes of investigations that related to end of life or palliative care were reported to the nurse lead for palliative care for sharing with relevant professionals. We were told that learning was embedded in to practice. For instance, there were two instances where analgesic patches used on patients had been lost; not found in situ on the patient. A form had been developed for use to check the patch and record its location on the patient's body, which was completed every shift. The trust had incorporated working with the duty of candour by including a section on DoC within the online reporting system. Compliance was reviewed in clinical meetings.

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 trust reported no never events for end of life care in the last two years.

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in end of life care in the last two years.

Mortuary incidents were reported through the online incident reporting system. We were told this had been rarely used with the most recent incident being one year ago and was related to anatomical waste being clearly marked. Learning had involved all yellow bins being clearly marked and dated including with patient numbers and better recording of all products.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

The individualised care plan (ICP) was used for dying patients in the last weeks or last days of life. There were linked medical and nursing components that were both electronic. The medical component pulled information from the treatment escalation plan (TEP), thus preventing duplication. The ICP was explicit about nutrition and hydration, it referred to place of care and place of death. There were prompts for symptom recognition and anticipatory prescribing. We found the medical component to be robust and met the recommended criteria of a TEP.

End of life care

The nursing care plan within the ICP, along with the medical ICP, formed the full ICP. The ICP was built on the five principles of care as recommended by the Leadership Alliance for 'Care of Dying People', 2014; identification of dying, sensitive communication, shared decision making, needs of family and individualised care plan. With regards to the care plan all symptoms were explicit including pain, nutrition and hydration.

This was in accordance with NICE guidance on End of Life Care for Adults NG142 that covered organising and delivering end of life care services, providing care and support in the final weeks and months of life and the planning and preparation for this.

Any newly issued guidance was monitored by the quality and risk department. Clinical compliance assessment sheets were completed and returned to the quality and risk department to demonstrate how compliance was being met with NICE guidance. We were shown the compliance record for NG142 as an example of this.

We reviewed six individualised care plans for dying patients. All six were completed to a high standard and had daily medical reviews recorded. All six care plans had comprehensive documentation of daily nursing assessments recorded for every shift.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

The individualised care plan (ICP) for dying patients in the last weeks or days of life was built on the five principles of care as recommended by the Leadership Alliance for 'Care of Dying People', 2014 which included nutrition and hydration. Assessment of nutrition and hydration took place as part of the end of life care reviews. The SPCT and the EoLC facilitator carried out training on wards on the importance of nutrition and hydration as part of the end of life care plan. Nutrition and hydration could be part of treatment escalation plans and was also monitored through general ward based nursing care.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way, using suitable assessment tools and gave additional pain relief to ease pain.

The nursing care plan within the ICP, along with the medical ICP, formed the full ICP. The ICP was built on the five principles of care and included pain management. We observed the daily handover meeting of the SPCT which included detailed discussion on pain control effectiveness and side effects.

There was an acute pain team at the hospital who worked collaboratively with the SPCT. There was not a combined SPCT/pain team MDT but a good professional relationship between the two was reported by the SPCT that included effective referral and communication between the two. If pain was considered a chronic long term issue, we were told the pain team were more likely to be involved.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The National Audit of Care at the End of Life (NACEL) was commissioned in October 2017 by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government. The audit monitors progress against the Five Priorities for Care set out in One Chance To Get It Right, NICE Guideline NG31 and Quality Standards QS13 and QS144.

The National Audit of Care at the End of Life (NACEL) 2018 surveyed providers under the following themes: recognising the possibility of imminent death, communicating with the dying patient, communicating with families and others,

involvement in decision-making, needs of families and others, individual plan of care, families and others experiences of care, governance, workforce/specialist palliative care. The trust scored the same or higher than the national average in four of the nine standards of care surveyed. With one of the standards; families and others experiences of care, the score was omitted from trust reports.

The trust told us they did not get a score for the theme of 'families and other's experience of care'. As part of the audit, questionnaires were sent to 16 of the relatives of the patients who died in the audit period. However, no questionnaires were returned so a score had not been awarded in this section.

An action plan had been produced from the National Audit Care at End of Life (published 11/07/2019). It showed a number of planned improvements, with timescales for completion and named persons to take responsibility.

We were told that integrated palliative outcome scale (IPOS) would collect data upon referral (day one) and on day three, and after that when phase of illness changed or when the patient was discharged. This project was initiated in July 2019 and became embedded and ready to use on 1 January 2020. The aim of the project was to implement and embed outcome measures in palliative care within the electronic patient record in a way that data could be collated and monitored on a quarterly basis. Due to the project's infancy, there was currently no data to analyse.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The SPCT provided education to different teams and professionals around the hospital. It was reported that in the previous year, two hour sessions had been run six times for band 5, 6 and 7 nurses. There were stand alone education sessions on symptom control, often arranged following a request from a ward or department. Informal teaching also took place on wards. Training for the trust's community staff was provided in conjunction with local hospice staff.

A record of training for staff groups around the hospital for 2019 showed that the SPCT provided 62 items of training in a number of different settings. This included end of life care, updates, the role of the end of life care facilitator, the end of life strategy, DNACPR, fast track discharge, care in the last days of life, communication and end of life care for dementia. Sessions lasted for between 30 minutes and two hours and were attended by small numbers of staff, between 4 and 28. There were a range of audiences for the training such as overseas nurses, healthcare assistants, band 5 nurses, student nurses, surgical doctors, junior doctors, band 7 nurses and chaplains.

Records showed that 53 members of staff had received training in the use of the T34 syringe drivers in 2019. Some were 1 hour advanced training from the clinical nurse trainer and others were 30 min senior nurse refresher training.

EoLC was included in mandatory training and face to face training was also available. ACU told us there were two training sessions last year on communication skills and EoLC. Staff felt there was better earlier recognition of the dying patient.

Staff on Elderly Care Unit South recognised the importance of providing good end of life care. All the staff we spoke with told us they had received training and felt it had made a difference to how they provided care. The EoLC facilitator and SPCT were described as accessible and supportive, providing advice and guidance. They also delivered one to one and other ward-based training which had made the nursing team more confident about delivering end of life care. It was also reported that the EoLC facilitator had provided some additional training for the ward in response to an incident (no harm to patient but learning from near miss).

Staff on Elderly Care Unit North reported that they had received a lot of valuable input from the EoLC facilitator over the past year who was supporting ward use of the end of life care plan and providing training for staff. They took time to identify staff needs and concerns around EoLC so training could be targeted. Staff also reported having training in syringe driver use. Staff were aware of the Swan model, progress and plans.

Regarding training, as Lamb ward was the pilot ward for the Swan model initiative, there had been additional training input including face to face classroom and ward-based training. There was good follow up on the ward to support implementation of classroom learning, good use of reflective learning and using experience as examples and discussion, regular syringe driver updates and the facilitator had been available for 1:1 training for new starters. There was also regular EoLC training available all year round. Staff on Lamb ward were positive about the Swan training and reported that it had given additional knowledge and skills, beneficial in improving care. Staff told us they would feel confident in raising and having conversations with the team and families. We were told there was earlier recognition of the dying patient in recent months. There were two link nurses on the ward to support implementation of the Swan model and training.

Communication skills training and simulation skills training was also available to GPs, consultants and junior doctors. Induction training was now provided to all staff whereas it had previously only been provided to clinical staff. We observed the end of life and palliative care session on the trust's induction programme. This was a 15 minute session to a wide range of clinical and non-clinical staff. The session gave an overview of the EoLC strategy and service, its availability (Mon – Fri 8am to 6pm), out of hours arrangements for on call consultant accessed via switchboard, method of referral, and an emphasis of the need for all staff to support EoLC. It offered a succinct overview and aims for EoLC and how each individual member of staff can contribute. The final slide was a quote from Dame Cicely Saunders emphasising the importance of palliative care in modern medicine.

A training schedule had been completed in November and December 2019 for porters. It consisted of a tour of the mortuary, an explanation of how the mortuary functioned and how to ensure that dignity after death was maintained, including during viewings out of hours. We were told there were two groups of porters, one which had long service who had confidence to perform tasks with dignity and respect and a newer group who had been supported and recently trained. Training had taken place for 28 of 39 porters.

Care after death training was being delivered by the end of life care facilitator. We were told this was delivered within formal training sessions for end of life care and during face to face training in the wards. We were provided with training records which demonstrated that so far,(up to November 2019) care after death training, including last offices for nursing staff, had been provided to 34 theatre staff, 40 nurses and 12 porters.

The SPCT had access to education to support their role and to allow for professional development opportunities that included a monthly journal club, conferences, seminars, study days and university based education.

A post graduate certificate was currently being developed in palliative and end of life care at a local university. We were informed that all of the SPCT nurses would be supported to complete this course.

There was regular clinical supervision within the SPCT that took place as a clinical discussion group. Appraisal and professional development identified the training needs of the SPCT, who also had a journal club once a month where a paper would be presented by different team members. Appraisal rates were stated as in place for all groups of staff working in bereavement, palliative and end of life care including CNSs, lead nurse, EoLC facilitator, social worker, chaplaincy and mortuary officer.

The SPCT social worker was on a leadership course and one of the CNSs had recently completed a course on human rights. All team members attended a conference on the future of palliative care at a nearby university.

There were currently no nurse prescribers in the SPCT. The 8A nurse lead was set to commence the advanced nurse practitioner course in May 2020.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

End of life care

We were told that the relationship in the hospital between the SPCT and oncologists was positive and that often patients were seen by both. The SPCT told us they had no reservations about contacting an oncologist to discuss the rationales and appropriateness of continuing or giving invasive treatments such as chemotherapy or radiotherapy, and that oncologists were open to discussions and this often promoted learning. The SPCT participated as members of cancer MDTs such as lung, colorectal and cancer of unknown primary. The SPCT office was also located next door to the oncology CNS's office and communication was described as always ongoing.

There was evidence of collaborative working between the SPCT and emergency department. For instance, the SPCT were contacted directly by ED and went to ED to assess patients and direct care.

We attended a ward round with the palliative consultant and two CNSs. We observed the management of four patients on four different wards including respiratory, acute medical assessment, older people's care and rehabilitation. There was good interaction between the SPCT and ward based staff. We spoke with a number of staff on each ward including a consultant, junior doctors, a senior sister and a staff nurse. We were consistently told that the SPCT provided a good service that was responsive to new referrals and were also approachable about new referrals when on the ward.

We were told the SPCT tended to leave the critical care unit alone as they inherently had their own expertise for caring for the dying patient. They did however, contact the team when patients needed to transfer out of critical care. We were told they provided effective and appropriate support. We were given an example of a patient admitted to the critical care unit who was supported by the SPCT who were responsive in providing support and hospice input.

Critical care had their own bereavement clinic that was run by a consultant and nurse. They liaised with the end of life care facilitator on an informal basis because they did bank shifts on the unit, but there was no formal input.

We observed the daily handover meeting of the SPCT where it was evidence of ongoing communication with 'host teams' at other trusts and community teams such as district nurses and other palliative care staff. There was evidence of multi professional referrals by the SPCT such as to social services and community palliative care.

Seven-day services

Key services were not available seven days a week to support timely patient care. The SPCT currently worked from Monday to Friday.

Palliative care services at the trust were working to develop a qualification in palliative care in partnership with a local university. This was intended initially to upskill cancer CNSs to improve their knowledge of palliative care in order for them to support Saturday working. We were told the service wanted to get more staff up to speed with symptom control and that a consistency of knowledge was needed. The module was named Assessment and Management of Symptoms in Advanced Illness and was aimed at healthcare professionals who want to develop specialist knowledge and skills in providing assessment and management of symptoms caused by malignant and non-malignant conditions encountered in palliative care of adults.

However, at present, this work could only be covered by the lead nurses three SPCT CNSs (the 8B or EoLC facilitator were not included in this) which would dilute the week day service. On completion of training which was still at the development stage, there would be a one in ten rota for Saturday working, but at the present time, it was not possible to confirm when the new rota would commence due to the need for the identified staff to complete the course to ensure they had the knowledge to undertake the role. The Royal College of Physicians guidance states the hospital specialist palliative care service should be provided on site 7 days a week. At weekends, the wards are supported by palliative care physicians through on-call. There were insufficient WTE to provide 7-day medical services on each site.

Consultant cover was available for telephone advice 24/7. The palliative consultant from the trust, the local hospice and nearby NHS trust combined to provide this service. Details of palliative care consultant cover out of hours was written in to patient notes and staff were told about this resource and how to access it.

End of life care

The trust lead for end of life care told us that patients receiving end of life care were included in the Friday handover to ensure they received daily review in line with NICE guidance, and to ensure patients received the anticipatory medications they needed. This was implemented in response to learning identified from the mortality review process.

Health promotion

Staff gave patients practical support to help them live well.

The philosophy of the SPCT was to support people to as stay well as they can and about involving relatives in care, provided it was safe first, under their guidance. For instance, relatives were often involved with providing mouth care and would also assist with washing. This was also part of the philosophy around the Swan model of care which also acknowledged how difficult a time this could be for relatives.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

We attended a multidisciplinary meeting of the SPCT, where the team demonstrated appropriate awareness and application of the mental capacity. We were also given examples of when the Deprivation of Liberty Safeguards and Mental Capacity Act might be required and examples of how DoLS and mental capacity were flagged on the electronic patient record. We were told that all team members had attended mandatory training for safeguarding level 1 and 2 which also covered mental capacity and deprivation of liberty.

Do not attempt cardio pulmonary resuscitation (DNACPR) was recorded on electronic forms and by different clinicians in different directorates. Patients who had a DNACPR decision had this identified on the home page of their EPR record. It was also flagged on the ward whiteboard so it was visual on the ward without having to refer to the electronic record.

We reviewed 11 forms which had all been completed to a high standard that included the designation of the person completing the form, dates when signed, rationales for decisions, consultant sign off and consultations with relatives.

Three of the forms indicated that patients lacked capacity. However, only one of the three patients had a mental capacity assessment completed. The mental capacity assessment reviewed was excellent. It had been completed electronically and was easily identifiable on the alphabetical tree of EPR.

We were told that an audit of DNACPR had not been undertaken. However, the trust extrapolated data from other audits completed on 2 April 2019 covering 10 wards over a 24 hour period auditing 242 patients. It showed a low compliance rate. 37% of DNACPRs had been discussed with patients. 42% of DNACPRs were discussed with a family member of the patient. 48% of DNACPR forms were countersigned by consultants. 16% of DNACPR forms were countersigned by nurses.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We attended a ward round with the palliative consultant and two CNSs. We observed the management of four patients on four different wards including respiratory, acute medical assessment, older people's care and rehabilitation. We observed all palliative care staff speaking to patients with compassion and understanding. We observed appropriate language and terminology being used to clarify and understand what had been said. All patients were treated with respect and dignity.

End of life care

We spoke with two other patients known to the SPCT. One patient told us they could not fault the care they had received. We were also told that "Staff are lovely and can't do enough for you". A second patient told us that care was excellent and they were very grateful to the staff for all they had done. We were also told they had been kept fully informed of what was happening.

Staff on Lamb ward, the pilot ward for the Swan model initiative, reported that having received EoLC training, it had given them confidence in having sensitive conversations about dying with patients and families.

Since December 2018, the bereavement survey has been given to relatives and loved ones with a covering letter signed by the chief nurse with a stamped envelope. The relatives of any patient who died at the trust received the letter when the death certificate was issued. Surveys were returned to the EoLC facilitator.

The bereavement survey results for June to September 2019 were provided. There were 14 themes the survey asked questions about: Condition and treatment explained in a way that was easy to understand, treated with dignity and respect, overall level of support given (including pain relief, relief of other symptoms, emotional support, spiritual support and practical support), quality of care, length of illness before death, how long ago was the death, whether male or female, age group, ethnicity, religion, relationship, overall support from the hospital, treatment from the bereavement team and treatment from the mortuary team. Questions that related to quality of care had favourable outcomes with most people satisfied with the care their loved ones had received.

We were told that the survey response rate varied on the quarter, with an average of 20% uptake from people post-bereavement. Feedback covered eight different clinical areas and the end of life care facilitator went to the wards to give staff feedback. Everything was collated quarterly and the information was presented at the EOL board and circulated to teams.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

We were told that the SPCT were able to recognise the bereavement need in relatives and loved ones. For instance, in people where events might be more life changing. It was reported that both the SPCT and ward staff signposted relatives to third sector organisations who provide bereavement services. This included a national bereavement charity and the local hospice, who provided bereavement counselling for the over 50's as part of a contract. However, we also learned that this was an oversubscribed service for which there was a waiting list. The bereavement booklet was given to relatives and loved ones by the bereavement team that included resources to support bereaved relatives. They also told us they would signpost people to resources such as counselling services. The Macmillan Cancer Support had a base in the hospital and a directory of resources.

An annual bereavement memorial service was held for children who had died, which also served as an opportunity for bereaved parents to meet each other for mutual support. A memorial service was held annually for staff that had died in the memorial garden. There was also an annual memorial service at the trust run nursing home located in the borough.

With regard to chaplaincy support, wards told us they received good support from chaplaincy for spiritual and emotional support and had seen improvement in out of hours provision in the last 18 months. There had been a reported gap in roman catholic cover which was now resolved. We were also told there was good support from a Rabbi who was also now training their successor.

The chaplaincy office, multifaith prayer room, ablution room and resource space was known as The Sanctuary. The chaplaincy had tried to set up support groups for relatives of bereaved patients, but low uptake had prevented these from succeeding. The chaplaincy team carried out ward visits including non religious visits for pastoral care for all. A whiteboard table with stated days of the week identified which wards had been visited each week and how many people had been seen. It also enabled the same chaplain to be allocated to wards to build relationships with patients.

Chaplains supported staff for drop in sessions and also signposted staff to the trust's contracted employee assistance programme (counselling) provider. We were shown a memorial book where a calligrapher wrote the messages provided by the families and loved ones in to the book under specific dates for remembrance.

Staff gave positive feedback about the end of life care facilitator and the SPCT who were described as easily accessible and supportive. We were told there could be a lot of challenging discussions with patients and families around EoLC and dying and the team were supportive and always included ward staff so they could learn and gain experience.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Assessments carried out by the SPCT always included shared decision making and negotiation of care with the patient and family. We observed a discussion in the SPCT handover regarding a patient with highly complex needs and social needs where a family group meeting was agreed on to identify methods of support, discuss social needs and plan for future care needs. We attended a ward round with the palliative consultant and two CNSs. We observed the management of four patients on four different wards including respiratory, acute medical assessment, older people's care and rehabilitation. All patients were given the opportunity to consent to us being present. All four patients were new to the consultant, who asked them how they wished to be addressed. We observed appropriate language and terminology being used to clarify and understand what had been said. Plans of care were discussed with patients which contributed to shared decision making.

The SPCT listened to relatives' experiences. This was escalated to bring in relevant people to meet individual need. We were told this was about enabling people to be heard and would involve emotional responses to their loved ones' diagnoses which demanded sensitive responses and assistance to navigate the system and processes. Staff on Lamb ward, the pilot ward for the Swan model initiative, reported that having received EoLC training, it had given them confidence in having conversations about dying with patients and families. There was good awareness of diverse cultural needs and procedures around last offices.

Bereavement meetings were offered to all bereaved relatives approximately six weeks after death. The family were written to and asked if they would like to attend a meeting to discuss any questions or concerns they have. The meetings were facilitated by the head of nursing for acute adult services and attended by the matron/ward sister and named consultant which produced good balanced feedback both positive and negative. Verbal feedback was followed up by email and shared with the ward team.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

There was an advocacy service that had representation from all hackney communities who could act as interpreters in addition to the interpreting service, which helped understanding the needs of local communities. The chaplaincy were aware of the precise cultural make up of the community at the last census and were able to meet the needs of the local population accordingly; Christian 47%, non religious 28%, Islam 15%, Jewish 5% and 3% other including Hindu and Sikh. We were told by the chaplaincy that identifying the individual patient preferences for spiritual care, as well as family preferences, were important to provide patient centred support. The chaplaincy were also able to meet the needs of the local Hasidic Jewish population through contacts with community Rabbis. The lead consultant had carried out some work with the Hasidic Jewish community about end of life care. The service maintained contact with Hackney Sacre (Standing Advisory Council for Religious Education), which was a local authority resource who represented all faiths and cultures and kept abreast of the diverse cultural needs of communities.

End of life care

The chaplaincy team carried out ward visits including non religious visits for pastoral care for all. A referral sheet was completed for each patient in contact with the service, including on call contacts to enable follow up by regular chaplains. We were told that further analysis in terms of numbers over longer periods was not available but that the whiteboard table with stated days of the week meant that coverage could be monitored. The whiteboard identified which wards had been visited each week and how many people had been seen. We were told this averaged as an estimated minimum of 30 visits per week but further analysis of chaplain involvement was not available.

The chaplaincy office, multifaith prayer room, ablution room and resource space was known as The Sanctuary. This was a lot of provision being provided from one small space. The prayer room was used as a multifaith area commonly used by Muslim staff. However, there were no religious symbols on permanent display to promote inclusivity. An altar was tucked away and set up for Sunday service.

There was one full time lead chaplain, another who worked three and a half days and a vacant post which was one and a half days per week. Including volunteer and bank chaplains there was a total of 15 chaplains available. The service ensured there was a chaplain available on site from Monday to Friday between 8am and 4pm and always available on call. Humanist chaplains were also available and student chaplains were also on supervised placement. We were unable to establish the number of chaplaincy hours allocated per week and not able to ascertain whether dedicated chaplaincy hours were meeting demand or were in line with the NHS Chaplaincy Guidelines 2015 of 3.75 hours per week of chaplaincy care for every 35 patients. There had been no chaplaincy audit identify whether resources were in accordance with UK Chaplaincy in healthcare guidelines.

Regarding funeral poverty and low income, the trust signposted and assisted people to apply for state funding and to charity sources to secure funding. Funerals were sometimes arranged by the hospital chaplaincy. We were also told the trust will expedite funerals and reclaim costs from the estate. The SPCT social worker could become involved and secure grants for funerals and also help relatives apply for funeral grants.

Where there was a lack of funds the SPCT were able to give supermarket vouchers due to a charitable funding scheme that had been set up. Connections with a local homelessness charity were also reported, where work had been done in collaboration with a lung CNS and a homeless community team. The SPCT told us they worked in conjunction with the local authority with non UK residents who had the right to remain who were dying.

Lamb ward (respiratory, haematology, and general medicine) was a pilot ward for the SWAN (sign, words, actions, needs) model of care for patients at the end of life. There was a Swan resource trolley available on Lamb ward that contained patient and relative information, door signs with the swan emblem, a syringe driver, comfort packs for families (essential toiletries and comfort items) and deceased property bags which currently had the butterfly logo but would be changing to the Swan logo.

Regarding facilities for family/carers, there was no ward based quiet room on Lamb ward and no space available near the ward for visitors to use to meet with relatives or for sensitive conversations. Staff used the ward office, staff room or day room if it was available. There were no facilities for relatives who wished to stay overnight such as mattresses or reclining chairs. We were told that staff could access a fold out bed from ITU. However, access and availability depended on its use by ITU and other wards. Standard armchairs were available. Some side rooms had limited space available for relatives to stay. Staff provided drinks and snacks to families of end of life patients who were there for long periods and there was also a shop and restaurant on site.

There were five side rooms on the acute care unit and staff told us they did their best to make one available which may involve a discussion with infection control. Staff on ACU were aware that the ward could sometimes be very busy and often not the most ideal place to provide end of life care. However, they would not want to move a patient to a ward if

there was a risk of death within a short time. The unit had a flexible visiting arrangements and tried to make families staying for long periods as comfortable as possible. We were told there was a lack of space for private or sensitive conversations to take place on ACU but the visitor room on ITU could be used. However, access and availability depended on its use by ITU and other wards. 58% of patients died in a side room in 2019.

Facilities for families were also limited on Elderly Care Unit North and South but relatives were provided with armchairs and refreshments. A carers passport for visiting had been adapted from LD and dementia carers passport on Elderly Care Unit North and South, which allowed for visiting outside usual hours without challenge or need for explanation. Staff made a note on the drinks board in the kitchen for the hostess to offer visitors of dying patients' drinks. Four side rooms were available on each ward and we were told they were able to provide a side room for dying patients where it was preferred. Parking was reported as a concern for relatives as it was a limited resource at the hospital.

There was open visiting for relatives of dying patients who could also stay overnight. There was currently no access to recliners or zed beds for relatives staying overnight. However, the trust had recently secured funding for two reclining chairs. Parking provision was a limited resource at the hospital and the SPCT told us were currently negotiating a parking permit scheme for the relatives of patients who were dying and spending longer periods of time at the hospital. This was as part of the Swan model of care initiative. The SPCT nurse lead had met with the domestics about the Swan initiative to stress the importance of including relatives in tea rounds who were staying for long periods.

There was a seated area outside of the mortuary viewing suites for relatives to sit and meet with the bereavement team prior to viewing. The area did not have a door to ensure privacy for sensitive conversations to take place. However, the doors to the viewing rooms could be closed which gave the area total privacy.

We were told the most recent CQUIN in relation to end of life care was in 2015/16 and 2016/17 and there had not been an end of life CQUIN since then.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences.

The specialist palliative care team's (SPCT) assessments and daily handovers considered the holistic needs of patients including pain and symptom control, spiritual and religious needs, nutritional needs, social background, psychological needs and needs and the family. Cultural, bereavement needs and discharge planning was also incorporated in to individual assessment of need and preferred place of care was discussed and recorded.

The SPCT worked across the wards and alongside ward staff, doctors as an advisory team and carried out holistic assessments in partnership with nursing and medical teams. They also brought in other resources to meet individual need such as chaplaincy, social worker and psychologist. The EoLC facilitator was able to work alongside ward nurses to meet individual patient need depending on the nurse's experience. We were told the SPCT did not really go to ward rounds as it was not considered a good use of resources. The EoLC facilitator sometimes went to handovers and the SPCT nurse lead had been attending ACU board rounds as part of developing the service but this had now stopped.

The SPCT worked closely with community teams and the community palliative care team managed by the local hospice. The SPCT regularly visited a local nursing home managed by the trust. The end of life care facilitator was working to develop a band 6 champion in end of life care. There were good links reported with the local hospice and a palliative occupational therapist contributed to the work of the trust's rehabilitation team which included attendance at the SPCT's MDT.

We observed a discussion of mental health issues in a multidisciplinary meeting of the SPCT and were informed there was a liaison psychiatry team at the hospital. The SPCT reported a good working relationship with them.

The mortuary and bereavement officers understood the cultural needs after death. We were given examples of liaising and working with different groups. There were good links with coroners and local mortuaries to further meet people's

needs. It was explained to us how a patient would be cared for after death and prepared for presentation. If there was disfigurement, relatives would be advised of this and could be offered the opportunity to see a photo first. Regarding organ donation, as of 1 April consent was assumed unless otherwise stated. Guidance for different faiths was provided by chaplaincy. (From spring 2020, organ donation in England will move to an 'opt out' system. This means that all adults in England will be considered to have agreed to be an organ donor when they die unless they have recorded a decision not to donate.)

Access and flow

Patients could access the specialist palliative care service when they needed it.

Regarding access and support from the SPCT and EoLC facilitator, ward staff told us the team were easily accessible and available for advice and support. The referral process was described as easy via EPR and telephone. The SPCT required an electronic referral but would speak to referrers and go straight away if needed. There was an average time of 19 hours from referral to seeing a patient, which was often a lot shorter. Current data showed that 65 to 70% of patients who died in the hospital were seen by the SPCT.

Wards told us they received support with fast track discharges. There was an integrated discharge team with whom the SPCT worked around difficulties with delay to discharge. The SPCT social worker facilitated fast track discharge for patients. With patients living out of borough there were elements of the process that were outside of the control of the SPCT and these often took longer. The availability of care home places locally could cause delays, affecting the outcome regarding preferred place of death. The SPCT were involved with continuing healthcare fast track referrals which were described as resource intensive for the SPCT but was considered highly beneficial to patients. The SPCT were mindful of supporting but not taking over. The team felt they had the balance right but kept involvement under review. Following our inspection, we were subsequently told that discharge delays were an ongoing problem that was on the risk register.

We were told the team were working with improvement to rapid discharge including out of hours. This included working on getting the care at home with things such as washing, moving and incontinence. We were told they used to be able to get a bed in six hours but now this could be the same day or the day after. The SPCT social worker was carrying out a QI project on rapid discharge as part of a leadership programme and discussions included the CCG. We were given examples where people had been home within 24 hours but told that the service was trying to work quicker in more cases and wanted to establish a standard for this. The service was aiming for eight hours which was currently aspirational.

A project took place on the elderly care units on continuing healthcare fast track pathway. It was found that delays were occurring in patients' discharge with the outcome that they were dying in hospital. A number of factors were found to be involved. They included low levels of confidence among junior staff in completing the fast track paperwork and often a lack of clarity in whose overall responsibility it was to complete and submit the documentation. Data from the project showed that before intervention, the average number of working days to submit a fast track had been 4.2, the longest wait had been 16 working days and only 22% had been completed within a 48 hour target.

We were told that the project was completed in September 2019 and data showed that delays to discharge patients had been reduced. A quality improvement (QI) project on rapid discharge was now taking place. The aim of the project was to develop, implement and embed an interdisciplinary rapid discharge pathway/guidance, to facilitate a smooth and timely discharge.

There was a working relationship between the SPCT and local hospice evidenced in discussions regarding referrals to the hospice including transfer of patients. An occupational therapist was shared between the hospice, hospital and community which allowed for continuity and community follow up. For patients known to the SPCT who had been discharged in to the community, a palliative care update was sent to the community palliative care team and district nurses. We saw two of these communication updates which contained information to enable continuity of care

including diagnosis, symptoms, investigations, medications, social situation, care needs, psychological and spiritual needs and likely priority for a community follow up visit. The communication was sent via secure NHS email along with a copy of the discharge summary and medication chart for anticipatory medicines if appropriate. The team also worked with the local GP out of hours service and community GPs, who were always notified when patients were going home.

Preference for patients' preferred place of care and preferred place of death (PPC/D) was recorded on the pro forma for palliative care and we were told this was always recorded for all patients and the team always had discussions with people about PPC. Discharge planning was also discussed at the handover meeting and preferred place of care was discussed and recorded on Coordinate My Care (CMC). The team worked towards this with discharge and multidisciplinary team review. There was no specific audit of success in achieving preferred place of death and preferred place of care, but CMC produced a monthly report for each CCG containing data on deaths and the preferred place of death (PPD). These were cumulative and included all patients with a CMC plan since April 2013 so were not broken down by month or year. The most recent report which included data up to the end of January 2020 showed that 1044 patients with a CMC record had a death recorded. Out of these 948 had a place of death recorded and 691 of those patients had stated a preferred place of death. Out of the plans where a PPD was recorded 63.2% died in their preferred place.

A palliative care activity dashboard recorded the number of patients that had been seen by the team, the total number of visits carried out, the duration of visits and total hours spent on wards. The data for December 2019 showed that the SPCT saw 46 patients that amounted to 230 ward visits with an average duration of 43 minutes per visit. There was an average wait time of 17 hours and 44 minutes from referral to seeing the patient.

We were told that more data could be extracted from the electronic patient record and that work had been carried out to expand what was recorded on the dashboard. This was due to be rolled out within weeks of our visit which would also record: the number of patients who died with an end of life care plan, the discharge destination of patients who the SPCT were involved with, the date of admission vs date of referral to the SPCT, the date of palliative care referral vs date of death and the number of hospital admissions in the last 6 months prior to SPCT referral.

Ward staff reported good access to the mortuary for viewings out of hours, with relatives contacting the wards to arrange viewings. Ward staff accompanied the family to the mortuary. It was the porters' responsibility to transfer the patient from the mortuary fridge to the viewing area. If there were leaks or if the body was not visibly prepared, it was the nursing team's responsibility to do this. This would be a nurse from the origin ward. We were told that all new nurses from ED will have a basic induction about expectations regarding preserving evidence and preceptorship midwives had a basic induction and tour of the mortuary. In terms of preparation of bodies on the wards, we were told that this was not always completed satisfactorily and the EoLC facilitator had identified that some nurses lacked confidence about care after death. We were told that some training for this had taken place but was not in depth. Nurses received mortuary training in dignity after death which we were told, had so far been ad hoc. However, this had been noted and the end of life care facilitator had been tasked with moving this work forward.

The bereavement officer was available from Monday to Friday 8am to 4pm. They were co located in the mortuary suite along with the mortuary officer. Relatives would come to collect the medical certificate from bereavement and were assisted to book a registrar appointment. Patients were picked up from reception and brought round to the bereavement suite. A separate entrance was used which meant that the mortuary area remained separate. We were told that relatives were advised on what to expect with the process of registering the death with the local authority and where they needed to go. Part of the bereavement officer's role was to ensure that all medical certificates were completed promptly and correctly. Medical certificates of cause of death (MCCD) could be taken to medical staff for quicker completion. The role of the bereavement officer was taken on by the clinical site manager out of hours. The trust only used paper certificates.

The bereavement office and mortuary offered a flexible service based on the individual needs of people and communities. Staff from both mortuary and bereavement were knowledgeable about the cultural and religious needs of

different local communities and families were kept involved throughout the process. The bereavement service was also in contact with the funeral director and GP. If the next of kin could not be identified a further process was followed in conjunction with the local authority. Staff were also familiar with the needs and expectations when deceased patients needed transporting overseas.

A booklet was given to relatives and loved ones on what to expect and contact numbers including how to book an appointment with the town hall to register the death with the borough registrar.

The borough registrar was available at the town hall Monday to Friday and out of hours, between 9.30 and 11.30 on Saturday and Sunday. However, a new service was starting at the hospital the week following our inspection, in February 2020, where the registrar would be located in the hospital and close to the mortuary suite from Monday to Friday; two full days and three half days, which would better facilitate the process and meet the needs of prompt funeral arrangements for Muslim and Jewish deaths.

Learning from complaints and concerns

The service treated concerns and complaints seriously and shared lessons learned with all staff.

The trust had recently purchased a component for their electronic incident reporting system that could draw out themes relating to end of life and palliative care from PALS and complaints data to improve learning. However, this was not yet embedded. We were told that the service had looked at some data around complaints, but the service needed to spend further time on this.

All comments, compliments and themes from the bereavement survey were fed back to wards and that regular reports were sent to matrons. We were given an example of learning from the survey that involved a patient with learning disabilities where a ward linked with trust's learning disability lead who also did teaching with the SPCT. We were given an example where the SPCT carried out one to one reflective sessions with ward staff about a specific complaint that related to caring for people at the end of their lives, which enabled staff to reflect better in caring for patients at the end of their lives.

Is the service well-led?

Leadership

There was a leadership structure and clear lines of accountability in place for different aspects of end of life care.

The medical director was the lead for end of life care at the trust. We were told their role was about overseeing governance around end of life care. They felt the trust leadership supported end of life care and had the executive's support. There was a non-executive member for end of life care who was new to the position and attended the end of life board meetings.

The SPCT was led by a band 8A nurse, who reported to the 8B senior nurse for cancer and palliative care. The leads reported to the deputy chief nurse who was described as supportive of end of life care. The mortuary and bereavement officers were line managed by the lead chaplain who were all part of the bereavement team.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

The End of Life Care Strategy 2018 – 2021 was launched in June 2018 with the support of the chief nurse and chief executive. The strategy was in the form of an eight paged, A5 sized booklet. It included an introduction from the medical

director and outlined a vision which was broken down in to the following priorities: personalised end of life care, supporting our staff, environment, communication and information and indicators of success. The booklet referenced good practice sources including One Chance to Get it Right 2014, A Different Ending 2016 and Ambitions for Palliative and End of Life Care 2015.

Indicators of strategy success were stated as nine bullet points, that included an increase in numbers of patients with an individualised care plan, increased engagement with advance and individualised care planning, improvement in the identification of a patient's preferred place of care, increase in the percentage of patients dying in their preferred setting, reduction in end of life related complaints, participation in local and national audit and research, completion of training in end of life care where it is role specific and positive feedback from bereaved relatives. We were provided with the strategy's action plan. It identified named leads for each action along with timescales for completion. The Swan scheme concept was introduced at the launch of the Strategy and all attendees were asked to comment on the initiative. The swan symbol featured on the cover of the strategy booklet. However, explanation of the Swan model of care for end of life or its implementation was not referred to within the strategy.

The medical director was the trust lead for end of life care. They told us there had been a focus in the trust on end of life care. Key pieces of work linked to this aim were: the introduction and completion of the treatment escalation plans and individualised end of life care plan to support decision making and to record and communicate those decisions. We were told the electronic patient record had been key to embedding this across the trust and ensuring consistency among nursing and medical staff. The tools within the EPR had enabled this work and were designed and tested with clinician involvement. There had been interface with the recognition of the deteriorating patient work stream, advance care planning and Coordinate My Care. Recent additions to the SPCT (lead nurse for palliative care (May 2019) and EoLC facilitator (September 2018)) had increased the skills of the SPCT, which was described as key.

Culture

The service promoted a culture to make end of life care everybody's business.

The trust lead for end of life care told us there had been a focus in the trust on end of life care with the aim to make it everybody's business. A priority had been to engage ward and clinical staff but not to de-skill staff. There was a pride in how the team had addressed this and achieved a change in practice. The aim was to empower staff to have the conversations and deliver care. We were told they were passionate about EoLC and had a five year history of supporting and driving improvement in palliative and end of life care at the hospital, and was previously the lead clinician for older people and acute care. They also maintained a clinical role on ACU where handover meetings always considered treatment escalation plans and EoLC needs along with anticipating family needs.

The cancer and palliative care lead nurse had been in post for just over two years. Part of their role was to focus on improving end of life care within the trust. This had included creating new posts of SPCT including a lead nurse specifically for palliative care and end of life care facilitator, further develop the role of CMC, the strategy, the Swan model of care, post graduate certificate and palliative care module. Through the Swan model of care, the hospital wanted to promote a culture that end of life care was everybody's business which involved talking about it more and for all staff to contribute to its implementation. This included meeting with domestics and porters about their needs. A focus group was set up about the Swan scheme's implementation which highlighted issues about communication. We were told they were also arranging to attend the older person's reference group; a community group managed by Age UK and the local authority. In addition to this the lead chaplain was planning to set up a meeting with mosques about the Swan scheme. We were told the priority was about integrating what matters to people and including that in to what was set up.

On the wards, we found that staff had different levels of understanding about end of life care being everybody's business. However, most people had heard of the Swan model and its imminent implementation.

End of life care

Governance

Leaders operated effective governance processes. Staff were clear about their roles and accountabilities and had regular opportunities to learn from the performance of the service.

The end of life board met quarterly and included the medical director, non executive director for end of life care, palliative nurse lead, public governor, chaplaincy, chair of unplanned care at CCG, director of care from local hospice, geriatrician, lead for CMC and chaired by the palliative consultant. The end of life board reported in to the improving clinical excellence committee who reported to the board. We were provided with minutes from the end of life board for July 2019, October 2019 and January 2020. There was regular attendance from the lead consultant for palliative care (who also chaired the meeting), the senior nurse for cancer and palliative care, the quality improvement and governance lead from the local hospice, a public governor, the end of life care facilitator, the quality improvement lead, the medical director (and consultant geriatrician), the non executive director for end of life care, the SPCT lead nurse, lead chaplain and representative from Marie Curie. Standing items included progress on CMC implementation and an update on the end of life strategy. Progress with other work including chaplaincy, audit from deaths and SPCT team updates were also discussed.

SPCT business meetings took place monthly. There were also cancer and palliative care meetings every two months.

The bereavement team consisted of chaplains, the bereavement officer, mortuary officer and gynaecology representation for termination of pregnancy. A team meeting was held weekly and served to update staff, discuss business, feedback on issues and included a rota for the provision of cake. The lead chaplain attended the end of life board, this post holder had been the previous line manager of the team.

Mortuary and bereavement staff told us they were not involved with the end of life care board. The bereavement officer used to attend but that it was more about care before death.

Management of risk, issues and performance

Leaders and teams used systems to manage performance.

The SPCT contributed to the trust's risk register through the directorate of Surgery, Women's and Sexual Health Services, where the register was reviewed in its governance meetings.

There was not a separate palliative/end of life care risk register so any risks identified would be added to the divisional risk register and there was nothing on the risk register for palliative and end of life care. If a risk was identified, a risk assessment record form was completed in line with trust policy. This included the identification of control measures, evidence to demonstrate that the control measures were effective and what outcome was needed. Risk assessments were discussed at the divisional governance committee meeting whether this needed escalating as a trust wide or corporate risk. Any risk was reviewed at the bi monthly divisional governance assurance meeting and the bi monthly divisional governance committee until it was resolved.

Mortality review meetings took place every two months and were led by a consultant geriatrician who was also the mortality review lead. There was a new policy in 2019 and the introduction of an electronic mortality tool to which all deaths were entered on to. Reviews identified themes and learning which were broken down to address what was done, what could have been done and what was not done. The EoLC facilitator went to all meetings and also brought in more nurses to the meetings so they were more involved. The trust lead for end of life care told us they felt that the mortality review meetings were effective, with good learning outcomes. A quarterly report went to the board and the introduction of the electronic tool had made a difference in assurance that all deaths were reviewed. Most recent data showed that 98% of deaths were reviewed through this process.

The Swan steering group met every month and included bereavement, chaplaincy, porters and a wide group of nurses and medical staff from the hospital. This commenced in September 2019 and was intended to pilot and introduce Swan initiatives.

End of life care

We were told the aim of the Swan project was to 'Implement the Swan model for End of Life Care in the adult inpatient wards at the hospital and by 1 April 2020'. The main drivers were identified as: improving the care environment, improving patient experience at end of life and end of life care being everyone's business. However, so far, as of 29 January 2020, only one ward had been piloted and it was not clear how progress was being measured.

The Annual Report on End of Life Care for 2018-2019 summarised the progress made in end of life care in the trust from 2018 -2019. It showed work carried out by the SPCT which aligned with implementation of 'Ambitions for Palliative and End of Life care: A national framework of local action 2015-2020'. It also showed progress with taking forward the end of life care strategy, identifying learning from complaints and incidents related to end of life care, networking, mortality meetings, use of CMC and the national end of life care audit.

For the reporting period June 2018 – May 2019 (the latest published 12 month period), the trust had a SHMI value of 0.77, meaning it had a lower than expected SHMI (the SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there).

During 2018/19, there were 436 patient deaths, and 357 (82%) deaths were reviewed. Six of the 436 patient deaths during the period were graded as a CESDI 2 (suboptimal care - different care might have made a difference). These cases were all reviewed appropriately via the incident management system, and three cases underwent an RCA or SI investigation. During Quarter 1 2019/20, 98% of adult inpatient deaths underwent a mortality review, 95% were assigned an initial score and 86% went on to have an MDT or independent second review.

The medical examiner system is being rolled-out across England and Wales by NHSI to provide greater scrutiny of deaths. The trust lead for end of life care told us the trust was looking to introduce this role and was engaged with London and national groups. The proposal was for the examiner to join the bereavement and mortuary team. The national lead visited the trust two months ago to look at how the trust might implement the role and how it might be resourced. We were told the post was out to advert. It was also reported there had so far been no interest shown in taking up this role which was a part time consultant post.

Regarding a non executive director lead for learning from deaths, the trust lead for end of life care told us there had been a recent change of NED in the last two months and that they chaired the clinical effectiveness committee.

Information Management

The information systems were integrated and secure.

It was widely reported that the introduction of the electronic patient record had made information more secure and more easily accessible. Electronic patient records had reportedly made all relevant information available to teams, which supported decision making at handover, MDTs and other reviews.

For the purposes of data collection such as with DNACPR and patient outcome measures, the electronic patient record had made information more accessible, which supported improvement measures through data analysis.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services.

The Swan initiative was given emphasis and importance at the trust in being central to its development of end of life care services. It was also reported on as a QI project for end of life care facilitator. We were told that integrating what matters to people was a priority and including this was central to its set up. This included meeting with domestics and porters. A focus group was also set up that highlighted issues about communication. We were told the SPCT were arranging to attend the older person's reference group; a community group managed by Age UK and the local authority. In addition to this the lead chaplain was planning to set up a meeting with mosques about the Swan scheme.

End of life care

We were told that patient stories were not currently part of board meetings. However, the trust lead for end of life care told us they were currently working towards the inclusion of patient stories at board meetings.

Dying Matters week took place in May 2019 where information on dying and end of life was shared.

We were told the SPCT had spoken to a focus group of relatives about coming to the end of life steering group as patient representatives. One relative from this focus group offered to be a member of the steering group. They were also a member of a local authority user group. The team were also working on a guide for relatives about syringe driver use and opioids. The team were also planning to use a local authority user group to secure further patient representatives.

Importance was placed on collecting feedback on services from the bereavement survey and sharing this information with ward teams.

Learning, continuous improvement and innovation

Staff had a good understanding of quality improvement methods and the skills to use them.

The Swan model of end of life and bereavement care was given emphasis and importance at the trust in being central to its development of end of life care services and was reported on as a QI project for end of life care facilitator.

Minutes of the SPCT business meeting from January 2020 showed there were a number of improvement initiatives taking place. This included updates on implementation of the integrated palliative outcome scale (IPOS), improving how MDTs were recorded to include nutrition and hydration, opioid conversion charts were being worked on within the pharmacy team, an SOP to facilitate rapid discharge was being developed and patient information leaflets were being developed.

The SPCT were part of a broader palliative care network that included the local hospice and a large neighbouring NHS trust. This group met quarterly and shared presentations and audits in order to share knowledge.

It was reported that members of the SPCT were part of other groups: An STP sub committee looking at education at end of life, the City and Hackney CCG End of Life Board and the End of Life Care Network facilitated by University College London Partnership (UCLP) attending quarterly meetings. The end of life care facilitator had developed links with national teams through their role in implementing the Swan scheme.

'Let's Talk About Death' was a trust newsletter that picked up on themes and learning in order to raise the profile of end of life care within the hospital. For instance, CMC and learning about reviews. The SPCT team lead did a case review of a death on ACU, getting in to side rooms and working with nurse, asking about playing music. The patient died listening to their favourite song. We were provided with recent examples of the newsletter that was published quarterly. Information included news from the SPCT, literature, brief case studies and mortality reviews.

An initiative was in place that included an ED project to increase awareness of early referral to the SPCT. It included the development of a standard operating procedure for palliative and end of life care in acute medicine and ED.

The SPCT's lead nurse was currently doing a PhD and had presented their work on LGBTQ+ and end of life care entitled 'culturally competent palliative and end of life care for gender and sexual minorities'. This was reported as having received positive feedback and was one of the finalists of the Nursing Times Awards 2019. A request had also been raised with the trust's electronic patient record coordinators to include sexual orientation/gender identity information monitoring to better understand the needs of different groups.

Areas for improvement

Action the provider SHOULD take to improve

End of life care

- The trust should provide care and treatment in line with Royal College of Physicians guidance of one whole time equivalent palliative consultant per 250 beds.
- The trust should ensure that patients sent home with anticipatory medicines and prescription charts have their needs regarding breathlessness covered.
- The trust should ensure that planning and risk assessment takes in to account the age of the mortuary's fridges and freezers.
- The trust should ensure that plans for palliative weekend cover are satisfactorily progressed.
- The trust should ensure that mental capacity assessments are completed where DNACPR forms indicate that patients lack capacity.
- The trust should ensure that it is able to quantify whether chaplaincy hours allocated per week are in line with the NHS Chaplaincy Guidelines 2015 of 3.75 hours per week for every 35 patients.
- The trust should ensure that success in achieving patients' preferred place of care and preferred place of death is being measured and monitored.
- The trust should ensure that the emphasis it places on the Swan model of end of life and bereavement care is reflected in its end of life strategy and that timelines for its implementation are realistically measured.

Our inspection team

The inspection team was made up of a CQC lead inspector, two CQC inspectors, three assistant inspectors and a range of specialist advisors with expertise in the areas we were inspecting. The inspection team was overseen by a CQC inspection manager and a CQC head of hospital inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance