St. Luke's Hospice (Harrow & Brent) Ltd

St Luke's Hospice Kenton Grange Hospice Harrow & Brent

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

We carried out a focussed follow up inspection of the Safe, Effective and Well led domains to check compliance with concerns identified in the warning notices issued in October 2021. At this

inspection we found:

- The provider had complied with the warning notices issued in October 2021. The provider had made improvements to comply with the provisions of Regulation 12: Safe Care and Treatment, and Regulation 17: Good Governance.
- The service now 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 and ensured that all equipment used to provide care or treatment was safe for such use.
- The service now provided mandatory training in key skills to all staff and made sure everyone completed it.
- The design, maintenance and use of facilities, premises and equipment now kept people safe.
- The service used systems and processes to safely prescribe and record medications. They now safely administered and stored medicines.
- Staff kept detailed records of patients' care and treatment. Records were now individualised, clear, and up to date.
- Staff now assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- The service had enough staff to care for patients and keep them safe.
- Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Leaders were visible and approachable in the service for patients, relatives and staff. Staff felt respected, supported and valued.
- Leaders now operated effective governance processes
- Leaders and staff actively and openly engaged with patients, staff, the public

However:

- The senior leadership was not stable, and the recent changes were yet to be sustained or become embedded in practice
- Risk management systems and processes were not coherent and still in early development.
- There were no systems and processes in place to develop staff skills in quality improvement or monitor and embed quality improvement in the hospice.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Good	We carried out a focussed follow up inspection of the Safe, Effective and Well led domains to check compliance with concerns identified in the warning notices issued in October 2021. At this inspection we found: • The provider had complied with the warning notices issued in October 2021. The provider had made improvements to comply with the provisions of Regulation 12: Safe Care and Treatment, and Regulation 17: Good Governance. • The service now 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 and ensured that all equipment used to provide care or treatment was safe for such use. • The service now provided mandatory training in key skills to all staff and made sure everyone completed it. • The design, maintenance and use of facilities, premises and equipment now kept people safe. • The service used systems and processes to safely prescribe and record medications. They now safely administered and stored medicines. • Staff kept detailed records of patients' care and treatment. Records were now individualised, clear, and up to date. • Staff now assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. • The service had enough staff to care for patients and keep them safe. • Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. • Leaders were visible and approachable in the service for patients, relatives and staff. Staff felt respected, supported and valued. • Leaders now operated effective governance processes

Summary of findings

- Leaders and staff actively and openly engaged with patients, staff, the public

However:

- The senior leadership was not stable, and the recent changes were yet to be sustained or become embedded in practice
- Risk management systems and processes were not coherent and still in early development.
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Summary of findings

Contents

Summary of this inspection

Background to St Luke's Hospice Kenton Grange Hospice Harrow & Brent

St Luke's Hospice Kenton Grange Hospice Harrow & Brent is a registered charity providing specialist palliative and clinical support for people over the age of 18 years with life limiting illnesses irrespective of diagnosis. The service provides a 12-bed in-patient unit, a day service, outpatients' service and care in people's own homes provided by community teams. The hospice also provides support for families, friends and carers of people using its services. At the time of our inspection, there were approximately 555 people using or known to the service. Although the in-patient unit had capacity for 12 patients, only six beds were in use at the time of the inspection.

The service is registered for diagnostic and screening procedures, and treatment of disease, disorder or injury and has a registered manager in place to oversee this.

The location was rated inadequate and placed in special measures following a comprehensive inspection of the service in October 2021. We used our enforcement powers to serve two Warning Notices to the provider under section 29 of the Health and Social Care Act 2008. These was served for failing to comply with Regulations 12: Safe Care and Treatment, and Regulation 17: Good Governance.

We carried out a focussed, follow up inspection of the Safe, Effective and Well led domains to check compliance with concerns identified in the warning notices issued in October 2021. In order to re-rate the Safe, Effective and Well-led domains, we inspected and reported on all the key lines of enquires, in the respective core services.

How we carried out this inspection

We carried out an unannounced inspection of the service on the 20th April 2022.

During this inspection we observed care and treatment at the inpatient unit. We spoke with ten members of staff including senior management, medical and nursing staff. We reviewed six patient records, medicines and guidelines, and spoke with two patients.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

The service provided by this service was hospice care for adults.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Summary of this inspection

Action the service SHOULD take to improve:

- The service should ensure they have a stable senior leadership team in place.
- The service should ensure the risk management systems and processes continue to be developed.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hospice services for adults	Good	Good	Not inspected	Not inspected	Requires Improvement	Good
Overall	Good	Good	Not inspected	Not inspected	Requires Improvement	Good

Good

Hospice services for adults

Safe	Good
Effective	Good
Well-led	Requires Improvement

Are Hospice services for adults safe?

Good

Our rating of safe improved. We rated it as good.

Mandatory training

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

Mandatory training rates had improved since our last inspection. Over 89% of all staff had received and kept up-to-date with their mandatory training, which was above the hospice target of 85%. The mandatory training was comprehensive and met the needs of patients and staff. Records showed staff had completed courses in infection prevention and control, resuscitation, moving and handling and safeguarding children and safeguarding adults. Electronic learning was also completed by volunteers working in the hospice. Managers monitored mandatory training and alerted staff when they needed to update their training.

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 and volunteers received training specific for their role on how to recognise and report abuse. Training records showed all staff were trained to level 2 in safeguarding adults and children. The service had a safeguarding lead who was trained to Level 3 alongside senior managers. Staff kept up to date with their safeguarding training. There was a system to alert managers and staff when they needed to update or refresh their training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. They could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff said they felt confident to raise issues with the senior management team. They knew when they should make referrals to the local authority.

Cleanliness, infection control and hygiene

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.

Infection prevention and control had improved since our last inspection.Inpatient areas were visibly clean and tidy. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Since our inspection the service had introduced robust checks to ensure all areas and equipment were regularly cleaned. This included a daily walk around by senior staff, as well as regular audits of daily and weekly cleaning, sluice room cleaning, environmental cleaning, and clinical work surfaces cleaning. The audits showed 100% compliance with all cleaning schedules.

Staff followed infection control principles including the use of personal protective equipment (PPE). Hand hygiene had improved since our last inspection. Audits were now being undertaken weekly, and showed 100% of staff were compliant with hand hygiene practices, which included activities undertaken in order to prevent the spread of infection, including washing hands before patient contact and being bare below the elbows.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. The service now used 'I am clean' stickers on all equipment which showed when the equipment had last been cleaned and indicated that the equipment was cleaned and ready for use.

Environment and equipment

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

This had improved since our last inspection. Staff now carried out regular checks of specialist equipment, including daily checking of emergency equipment. Since our last inspection, the hospice had reviewed what equipment would be needed in an emergency, and now have a defibrillator, an airway management bag, and a portable suction unit available. We saw these were easily accessible to all staff, and that the equipment had been checked daily by the senior member of staff co-ordinating the unit.

The service had enough suitable equipment to help them to safely care for patients. Since our last inspection the hospice had invested in equipment such as new commodes and a bath trolley. Equipment was now stored safely and securely, storerooms had been repurposed and decluttered, and any unnecessary equipment had been disposed of.

Staff disposed of clinical waste safely. There were appropriate waste bins in each area which were clearly labelled with what could be disposed of in them. The bins in each room were regularly emptied. Sharps bins were clearly labelled with dates of assembly, as well as disposal. The hospice regularly audited the use of sharps bins and the correct disposal of waste, and we saw more than 95% compliance with both.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Staff undertook regular visual observations and told us that if patients were unwell, they would increase the frequency of these observations and call a doctor to review the patient if they still had concerns. There were guidelines for staff on when to escalate their concerns to ensure that specialist review took place when needed.

Staff completed risk assessments for each patient on admission in line with nationally recognised tools. Inpatient unit records included skin integrity and malnutrition assessments, as well as falls prevention.

Shift changes and handovers between staff, included all necessary key information to keep patients safe. Staff in both the inpatient unit and the community, met every morning and discussed each patient in detail, including their psychological needs. All staff had access to electronic patient records which were able to be accessed from both the inpatient unit and the community services.

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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. The number of nurses and healthcare assistants matched the planned numbers. Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants in accordance with national guidance. Managers could adjust staffing levels daily according to the needs of patients. The service had low vacancy rates, and low staff turnover rates.

The service had low rates of agency nurses. When necessary, the service used regular in-house bank staff who were familiar with the service. Bank staff received a full induction, regular mandatory training, and received regular updates from the service.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training 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 locum staff a full induction.

The service had enough medical staff to keep patients safe. The medical staff matched the planned number. The hospice directly employed one of their consultants and had honorary contracts in place for the other medical staff including consultants, specialty doctors, a junior doctor and trainee doctors.

The service always had a consultant on call during evenings and weekends. There were no doctors onsite after 5pm on weekdays but a medical on call rota meant nursing staff could access specialist advice seven days a week.

Records

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

This had improved since our last inspection. Nursing care evaluations now reflected the care needs of the patients, as well as the care that had been delivered. The last three nursing entries for six patients were checked during our inspection. Pain had been mentioned in all the evaluations, meaning we could now be assured that staff were consistently assessing and addressing patients' pain needs.

Care plans were now consistently completed and were individualised to meet the care needs of patients. Although generic care plans were used, they now allowed for the patient's care needs to be tailored to meet their specific needs. Since our inspection, the hospice had introduced a review section to the care plans. We saw that care plans were reviewed weekly, or earlier if the patient's care needs had changed. We saw all patients had individualised care plans specific to their needs.

Nursing staff now regularly documented syringe pump checks. A syringe pump is a piece of equipment that uses a syringe to administer a continuous supply of medication such as pain relief, medication used to control breathlessness, anti-sickness or sedation. Managers told us syringe pumps should be checked every four hours, to ensure the pumps were administering the medicines correctly. We reviewed three syringe pump documents and saw checks were now regularly being completed.

Patient medical notes were comprehensive, and all staff could access them easily. The hospice used a mix of paper and electronic records. Most patient notes were kept on an electronic system that could be accessed from both the inpatient and the community settings. This included the patient's resuscitation status. Care plans, risk assessments and medication charts were completed on paper.

Records were stored securely. We observed that all computers were locked when not in use. This meant patient records were kept secure and confidential. Patient written records were stored in the office in the inpatient unit which was accessible only by staff.

Staff had access to up-to-date, accurate and comprehensive information on patients' medical care and treatment. All staff had access to an electronic records system that they could all update.

The hospice had a centralised electronic medical notes system which could be accessed by both the inpatient and the community staff. This meant that staff could seamlessly continue with a patient's medical plan of care, if they were transferred from the community to the inpatient unit and vice versa. The hospice was looking to introduce an electronic system that linked in with local GP and community services so that patient's information could be quickly and easily accessed and shared with the appropriate people, if and when needed.

Medicines

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

Medicines management had improved since our last inspection. Staff followed systems and processes to prescribe and administer medicines safely. Staff now stored and managed all medicines and prescribing documents safely.

During this inspection we checked the expiry dates of all medications and found that none had gone past their expiry date. Since our last inspection, the hospice had introduced weekly checking of medications to ensure no expired medications were available for use. The hospice had changed the service level agreement they had with the pharmacy, and we saw that the pharmacist was now on site on a more regular basis to ensure stock was appropriately controlled and prescriptions were regularly reviewed.

We saw that fridge and room temperatures were now checked regularly and these checks were audited on a weekly basis to ensure compliance. Controlled drugs were stored appropriately and the amounts regularly checked in line with the provider's policy.

Good

Hospice services for adults

Staff followed systems and processes when safely prescribing medicines. Medicines records were complete and contained details on dose, when patients received them, review dates, and any reasons for omissions. Staff stored and managed prescribing documents such as FP10 prescriptions in line with the provider's policy.

Incidents

The service managed patient safety incidents well. Staff recognised and could describe how to report 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

The service did not report any serious incidents for the 6 months prior to our inspection, however, staff knew what incidents to report and could describe the process for reporting incidents. All staff we spoke with were clear about their duty to report incidents and knew how to do so using the reporting system.

Staff understood the duty of candour. They could give examples of when they were open and transparent and gave patients and families a full explanation if and when things went wrong. The service had no never events for the 6 months prior to our inspection.

There was a clinical incident policy, which made it simpler for staff to report incidents. All incidents were reviewed by the director of patient services, quality improvement lead and lead for area where the incident occurred.

Managers described the process used to investigate incidents thoroughly, including the involvement of patients and their families in these investigations. The service had a clear process for reporting and investigating incidents. When necessary, incident review meetings would be held to examine all actions following an incident.

Are Hospice services for adults effective?

Good

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver care according to best practice and national guidance. Staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Staff ensured that patient's medical plan of care included symptom control, social and spiritual support, and psychological needs. Evidence of discussions with patients and relatives, were recorded in the electronic notes and discussed in handover meetings. Anticipatory medicines for distress, agitation, seizures and pain were prescribed and given in line with National Institute of Health and Care Excellence (NICE) guidelines.

Staff protected the rights of patients subject to the Mental Health Act and followed its Code of Practice. All staff had received training in the Mental Health Act and staff described the process to follow to us, if they had concerns about a patient's meant health.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. Patients told us they were happy with the food and drink they received, and we saw that those who were able to drink had water provided and this was within reach. Staff offered drinks to patients throughout the day and we saw that regular mouth care was attended for patents with poor oral intake.

Staff used a screening tool to monitor patients at risk of malnutrition. This was appropriately completed in the care records of patients we looked at. Staff completed patients' fluid and nutrition charts where needed.

Specialist support from staff such as dietitians, could be arranged for patients who needed it through the local hospital trust.

The hospice provided a full menu for breakfast, lunch and tea, including hot and cold food options, and staff told us that they could provide hot and cold snacks to patients outside regular mealtimes. Patients were able to request meals that met their religious and other beliefs, such as halal and vegetarian.

Pain relief

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

The assessment and monitoring of patient's pain had improved since our last inspection. Staff now used a nationally recognised pain assessment tool to regularly assess and monitor patients' pain. The pain tool included both verbal and non verbal pain assessments, which allowed staff to assess and monitor pain for patients who were unable to tell staff if they had pain.

During this inspection we saw that patients' pain was now assessed on admission to the inpatient unit for all patients, and that this was regularly reviewed. Since our last inspection the hospice had introduced and embedded the use of an individualised pain assessment, care plan and intervention record that was tailored to each patient's individual needs. This allowed staff to monitor the site of the patient's pain, type of pain, how long they had the pain, the severity of the pain, what makes the pain worse or better, what pain relief had been given, and if the pain relief had been effective. We saw that the use of the pain assessment, care plan and intervention record was regularly audited to ensure compliance, and any failure to complete the document was addressed with the staff involved.

Patients' pain was discussed as part of the agenda of the daily community team meeting and included any changes that had needed to be made to the patient's plan of care, or prescription, and it's effectiveness, to ensure that their pain needs had been met.

Patient outcomes

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

All patients cared for by the service had the opportunity to develop an Advance Care Plan. Advance care plans allow patients and their families to make decisions about the care they would like in the future, including their preferred place of death. During 2020-2021, 100% of patients died in their preferred place of death.

Managers and staff carried out a programme of repeated monthly audits to check improvement over time. Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits. The hospice shared the results of all audit undertaken since our last inspection, which showed an improvement since our last inspection. The hospice shared a clinical effectiveness and audit programme for 2022/2023.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. In addition to an induction, all members of staff were expected to complete a competency pack, that was tailored to their role.

Managers supported staff to develop through constructive appraisals of their work. All staff we spoke with told us they had a recent appraisal and that they found it useful. Managers told us that they did not conduct the appraisals of the medical staff on honorary contracts, and that these were completed by their main employer. Since our last inspection, managers now checked that these appraisals had been completed, meaning they were now aware of any concerns or areas of development for staff who were employed on honorary contracts. Managers checked medical staff's registration with the General Medical Council (GMC) yearly to ensure they had current registration and that no concerns had been raised with their practice.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

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

Staff held regular and effective weekly multidisciplinary meetings to discuss patients and improve their care. In addition to this, the hospice held daily handover meetings for both the inpatient unit and the community services, which were

attended by doctors, nursing staff, health care assistants, therapy and administration staff, working together to share information. Nursing staff and doctors reported good working relationships and felt well supported and part of a team. Staff told us that since our last inspection team working had further improved and all staff had the one goal of doing the best for the patients.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff worked well as a team within the hospice and with outside agencies. There were clear lines of accountability and all staff we spoke with knew what and who they were responsible for.

Seven-day services

Key services were available seven days a week to support timely patient care.

A 24-hour advice and support line specialising in hospice care was provided to all users of the service. Staff could call for support from other disciplines such as chaplaincy and mental health services, 24 hours a day and seven days a week. Staff told us they found access to support easy and always available.

Health promotion

Staff gave patients practical support and advice to lead healthier lives, and for patients at the end of their lives, to live well before they died.

The service had relevant information promoting healthy lifestyles and support. Day hospice services were being delivered remotely due to the COVID-19 pandemic. Physiotherapist's offered virtual assessment consultations to patients, and they ran virtual exercise classes. Complementary therapists offered support to inpatient unit patients and offered outpatient appointments at the hospice to community patients / carers. The social work team supported the patients on the inpatient unit, and in the community over the phone and via home visiting. Virtual Art therapy was offered alongside wider therapeutic services, including a virtual gardening service.

Staff assessed each patient's health when admitted and provided support for individual needs to live a healthier lifestyle. Staff referred patients to stop smoking services and leaflets covering topics such as smoking cessation were on display in communal areas.

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.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. Patients entering the hospice did not routinely receive an assessment of their capacity, but where there were concerns, this was conducted, usually by a doctor, and clearly documented in their notes.

Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Good

Hospice services for adults

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. Staff contacted the local authority's Deprivation of Liberty Safeguards Team for advice and support where needed. Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Do not attempt cardiopulmonary resuscitation (DNACPR) decisions were discussed with the patient concerned and, where consent was given, their family. The service had adopted the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) at the service. This is a national patient held document, which was completed following an advance care planning conversation between a patient and a healthcare professional. Patients' records contained the ReSPECT document with evidence of discussion with the patient and their family as well as recent reviews, to ensure they remained current and valid. When mental capacity assessments revealed that patients were unable to give consent to care and treatment, staff made decisions in their best interest, considering their wishes, culture and traditions.

Are Hospice services for adults well-led?

Requires Improvement

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Leaders were visible and approachable in the service for patients, relatives and staff. They understood and managed the priorities and issues the service faced. Leaders supported staff to take on more senior roles, however they did not always ensure they had the training and skills to do so.

There was a board of trustees which appointed the chief executive for the hospice. The board was made up of 13 trustees and were all appointed by open advert. Each trustee was appointed for a three-year term, which could be rolled over to a second three-year term. The maximum term that could be serviced as a trustee was six years. Some trustees had management experience and were appointed to try and reflect the local community.

The hospice had an interim chief executive, who was appointed in February 2022, initially for three-months, but this had been extended to six months. The chair told us they were confident in the interim chief executive. Staff told us the interim chief executive has had a positive impact on the organisation and she had been helpful in supporting to get basic 'building blocks' in place. However, the hospice was unable to provide firm succession plans for when the interim chief executive's six month term had been completed.

Senior leaders told us the leadership had improved since our last inspection and the interim chief executive had been a benefit to the organisation. She had a clear understanding of what healthcare should be driven by and had implemented structures and process in place to drive it. We were told that the changes were being implemented at a fast pace but were being done compassionately. For example, the interim chief executive had introduced electronic tablets for nursing staff to document care and permitted healthcare assistants to document care, both of which placed less burden on nurses' time.

Good

Hospice services for adults

Since our last inspection, the director of finance and facilities and the director of human resources (HR) had both resigned. The board was in the process of appointing director of finance and facilities. The head of HR was acting up as the director of human resources, with the chief executive mentoring them . We were told the quality assurance lead was new in post and had not yet undertaken any specific training in quality assurance and was an area for improvement. Senior leaders acknowledged that some staff lacked the skills required to carry out their lead roles.

Therefore, whilst there were early signs of improvement in the organisation's senior leadership, as some were in interim posts, we still had some concerns about the stability and sustainability of the changes, as they were yet to become embedded in practice.

Staff we spoke with told us managers and leaders were approachable and visible. During the inspection, we observed positive interaction between staff and managers. Staff told us they felt comfortable and able to raise any concerns they had with the management team.

We noted that leaders were now aware of the concerns we highlighted during the last inspection and had begun to address them. They acknowledged that the leadership at the hospice was on an improvement journey, and that changes made to systems and processes required further time to become embedded in practice.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had clear vision and values, and these were displayed throughout the hospice, including on the ground floor by the reception area.

The values of Caring, Respect, Inclusivity, Excellence, and Empowerment were the screensaver for all computers used by the hospice. In addition, the hospice's mission was: to Reach more people, Constantly improve what they did, Extend their impact through collaboration, innovation and education, and Be an accountable and sustainable organisation.

The chair of Board of trustees told us the board sets the direction, strategy and approved the governance structure for hospice. They said the board was about 'what we do', whilst the operations team is about 'how we do it'.

The service had a strategic plan which was launched in 2019 and it was aligned with Hospice UK guidance, national strategy and the local sustainability and transformation partnership for end of life care. The board was working on a new strategy, but this was put on hold, following the outcome of our last inspection.

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. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff felt valued by organisation and said their voices were taken seriously. Staff told us they enjoyed working in the organisation and both colleagues and managers were supportive. Staff told us they now felt heard and listened to. One senior leader told us they were now proud of the service the hospice currently provided, but they were not six months ago. Staff described the culture as open and welcoming to all.

We were told there was an emphasis on equality and diversity. The hospice served a very diverse community and there was a diverse group of staff working across the organisation. Leaders acknowledged that an area for improvement was engagement with the LGBT group and more needing doing to encourage them to join the service. There was equality and diversity inclusive training and staff described the organisation as having a very caring culture. We were told that reasonable adjustments have been made to accommodate staff with disabilities.

We noted that staff in the Home Care Team were passionate about caring for patients. We were told the team felt valued by the organisation and had a diverse workforce. The PALL 24 Team (a team that provided 24hr palliative care and support) was sensitive to religious events such as the Muslim festival of Ramadan. The team had also partnered with religious and cultural agencies in the local community.

There was an emphasis on equality and diversity within the Home Care Team and staff felt they were treated well. Teams worked collaboratively, and we saw examples of positive cross-team working to provide joined up care for patients.

Governance

Leaders operated effective governance processes, throughout the service. 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 now an oversight group to address the issues highlighted from our last inspection, which was made up of trustees, medical director, chief executive and nursing leads.

The chair told us the management board met formally once a quarter, and the sub-committees met in the month before. The chair met with the chief executive weekly and spoke with chairs of committees often. All trustees gave a monthly update to the chair. Newly appointed trustees underwent a detailed induction programme. This included undertaking a shift on the inpatient unit, as well as the community, visiting other hospices, carrying out a fundraising event and working in the charity shop once a quarter.

The management board had two sub-committees, which were reduced from four, since our last inspection, that had a semi-independent look at the governance of the hospice. These sub-committees were the finance and performance committee and the clinical governance committee. Both sub-committees were chaired by trustees. The chief executive chaired the oversight group, to better understand the different elements of quality, risk and performance, as part of the management action plan, post the October 2020, CQC Inspection.

The management board adopted a governance calendar to ensure it systematically reviewed key management information and governance meetings were held quarterly. The oversight group consisted of the chief executive, director of patient services, medical director, director of fundraising, quality improvement lead, and trustees. The group was chaired by a trustee. We were told a trustee was reviewing the terms of reference for the clinical governance sub-committee.

The management board sought assurance, information and held discussions about policies and procedures, before signing them off. There was also time at board meetings for generic questions. Relatives had previously brought stories at every board meeting, but the recent pandemic had stopped this.

We were told by the quality assurance lead that the hospice had done a lot of improvement of work following our previous inspection and they were assured the requirements had been met. However, they acknowledged that this was a continuous improvement process and some recent changes needed more time to become embedded. For example, the interim chief executive had only been in post two months, therefore changes they had introduced needed more time to cement into everyday practice.

The interim chief executive implemented a system for complaints, concerns and compliments and these were now formally logged, however this was a new system and therefore needed more time to become embedded and to also evaluate its effectiveness. The hospice also recently implemented daily patient and family feedback focus. The uptake was initially high, but this had since waned.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively.

They identified and escalated relevant risks and issues and identified actions to reduce their impact, but there was some duplication of this. They had plans to cope with unexpected events.

Leaders now identified and escalated relevant risks and issues or identified actions to reduce their impact. There was a risk management policy which was in date. The policy sets out the strategy and process for the management of strategic and operational risks. There was also now a risk register which identified and escalated relevant both clinical and strategic risks, as well as an operational risk register. However, the risk register was not consistent with the risk management policy for risk analysis and utilisation of a risk matrix. We reviewed the risk register and whilst this contained both clinical and strategic risks, it was incomplete and was told that it was a work in progress.

The director of patient services was the lead for the risk register, but the CEO and executive leadership team monitored and reviewed the strategic risk register, which included both clinical and corporate risks. Individual managers entered their risks onto the risk register. This resulted in risks being duplicated on the register. To address this, we were told all risks would be filtered through the director of patient services in future, before they were entered onto the risk register.

The risk register was still in an early stage of development. Staff said the hospice concentrated on safety matters after our last inspection, therefore, the risk register was not the first thing to be addressed. However, following the inspection, the provider told us, the leadership team readily recognised the importance to get the risk register fully established and integrated as part of their systems and assurance processes.

We were told that there were two operational risk registers; one with actual risks and one with potential risks. Risks were scored before and after control measures, and RAG (Red, Amber, Green) rated to clearly identify the highest risks. Managers were able to tell us what the highest risks for the service were.

The top risks on the risk register were:

- Risk that all PALL 24 nurses and the medical team may give incomplete or incorrect advice to patients, as they had no access to GP and Harrow community electronic patient records

- Risk of compromise of medical care to patients, due to low medical staffing
- Risk that patient results and information may be missed due to inability to access hospital systems

Information Management

Information systems were secure, and staff had access to patient records. Data or notifications were consistently submitted to external organisations as required. However, the service did not always collect data to reflect and analyse live performance and make improvements.

Senior leaders told us the hospice needed to have better data to reflect live performance and the board had agreed to invest in a digital platform. However, there was now oversight of performance data, which was reported monthly. There was a new way of reporting incidents and staff were being educated to use it through workshops. If staff attendance at mandatory training dropped below 85%, this would be flagged, to allow early intervention so there was an improvement, but this was a manual process.

The service continued to manage information well and kept patient records safe. There were systems and information to manage current and future performance. Information systems were secure and appropriate for use. For example, the electronic patient record system enabled data to be extracted and analysed accurately, as all entries were automatically timed, and date stamped. All staff we spoke with said they were confident in using the system.

Staff continued to undertake audits to make sure information they used was accurate, valid and reliable. Leaders proactively collected information and analysed it to drive improvements in care. Information governance training formed part of the mandatory training programme for the service.

Engagement

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

Leaders and staff continued to actively and openly engage 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. The interim chief executive updated staff in the weekly newsletter. This was so staff were reminded they were important to the service.

The interim chief executive told us she was constantly engaging with all levels of staff and held regular meetings, briefings and open forums with staff, as she was still getting to know people. She did daily walk abouts to ensure she was visible to staff and they could report any incidents or accidents directly to her. The interim chief executive also sat and spoke with patients and liked to see them prior to their discharge, to get their feedback.

The hospice continued to work collaboratively with the local health and social care groups to deliver services needed in the areas they covered. The service actively engaged staff, so their views were reflected in the planning and delivery of services and in the shaping of the culture. We noted that relatives and visitors had lateral flow tests on site, before being allowed to visit relatives.

On the inpatient unit, there was a comfort board for both patients and staff to express themselves. There was a memory wall, where relatives left messages about loved ones who had passed on. There was no waiting list for admission to the unit, but referrals dropped over the holiday periods, as many staff were on leave. Volunteers manned the reception area.

Good

Hospice services for adults

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. They had some understanding of quality improvement methods, but the process and skills to use them, were still in development.

Senior leaders told us the hospice needed to improve its oversight of nursing and needed a director of quality and new equipment.

A senior leader told us the hospice was trying to embed systems of quality improvement at the hospice and the quality of the service had improved since our last visit. The quality improvement post was created following our last visit. However, we noted there was still work to do for quality improvement to be embedded in the organisation.

Junior doctors were involved in quality improvement projects, which included, improving the quality of prescribing PRN medicines and single nurse administration of controlled drugs. We had not seen evidence of these, but we saw documentation on a quality improvement project on Reducing Prescribing Error in the Inpatient Setting.

Whilst there was information and records that the organisation carried out quality improvement projects, there was no evidence of a formal structure, systems and processes to develop staff skills in the area, as well as monitor and embed quality improvement in the hospice. For example, we were told and saw some documentation of a community QI project on the management of patient symptoms at home, in a timely manner. However, this project did not follow a formal QI methodology and the project was still within the study phase.

A senior leader told us the hospice had no succession plans in place and 30% of its staff were going to retire in next five years. They said they therefore needed to consider re-modelling its workforce with different types of staff such as care associates, supported by a variety of multi-disciplinary apprenticeships.

The board of directors had given approval for a registrar post to be funded by the hospice which meant that there would be more senior doctors available for the hospice. The board recently approved a seven-day advice line to be introduced soon, including 9AM-5PM on Saturday and Sunday, either in community, PALL24 or the inpatient unit. We were also told that the hospice was now running a seven-day doctors service.

A senior leader told us quality was everyone's business and that the organisation's quality circles included nursing staffing, maintenance and facilities staff as well as volunteers. The hospice now had a strategic health and safety committee and a health and safety board. Heads of departments were now carrying out an advanced Health & Safety Training for Managers which will be accredited.