Butterwick Limited

Butterwick Hospice Stockton

Inspection report

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Date of inspection visit: 04 - 06 May 2021
Date of publication: 15/07/2021

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	Inadequate
Are services safe?	Inadequate
Are services effective?	Inspected but not rated
Are services responsive to people's needs?	Inspected but not rated
Are services well-led?	Inadequate

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as inadequate because improvements made since our last inspection did not yet justify a higher rating:

- Staff did not always receive the correct level of training on how to recognise abuse but they knew how to report it. Staff did not always complete and update risk assessments for each patient and remove or minimise risks. Staff did not always identify and quickly act upon patients at risk of deterioration.
- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear, or up to date, but were stored securely and easily available to all staff providing care.
- The service did not always use systems and processes to safely prescribe, administer, record and store medicines.
- We were not assured incident reporting had been embedded because we found examples of incidents not being investigated such as medicine discrepancies and poor admission.
- Staff did not monitor the effectiveness of care and treatment. They did not use the findings to make improvements and achieve good outcomes for patients.
- Evidence of consent to treatment was not recorded in accordance with the provider's policy.
- The provider was undergoing a significant process of change, made up of many different programmes of work. There was an absence of any oversight or management of this. The leadership team had gaps in its skills. The governance structure was new and not embedded. Leaders did not run services well using reliable information systems but did support staff to develop their skills.

However:

- The service had enough staff of the right competence and skills to provide the respite service and day care service (physiotherapy and therapy) it was providing;
- The environment was clean and un-cluttered;
- Staff appeared enthusiastic about working at the service and said they had visible leaders.

Following our inspection, we raised significant concerns with the provider by issuing a warning notice relating to breaches of Regulation 12 and 17. In addition, we issued the provider with requirement notices and told the provider that it must take prompt action to comply with the regulations.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Inadequate 	

Summary of findings

Contents

Summary of this inspection

Background to Butterwick Hospice Stockton

Butterwick Hospice Stockton was operated by Butterwick Limited. The hospice had eight inpatient beds and a day hospice and provided care for adults from Stockton, and surrounding areas. We inspected hospice services for adults. Butterwick Limited was registered as a charitable trust and received funding from the NHS. Butterwick House Stockton is registered to provide diagnostic and screening procedures and treatment of disease, disorder or injury. At the time of our inspection there was an application in progress for a registered manager.

The provider's last comprehensive inspection took place on 05 November 2019 and 05 December 2019 at which it was rated inadequate overall, with all domains rated 'inadequate' apart from caring which was rated as 'good'. The service was placed into special measures which meant it had to be re-inspected within six months. However, this was delayed because of the COVID-19 pandemic.

Our inspection was in response to concerns regarding the quality of service and to follow-up on improvements made by the hospice to address concerns raised as part of our previous inspection in December 2019. We decided to carry out a focussed inspection of the safe, effective, responsive and well-led domains.

At the time of the inspection the hospice was only admitting a maximum of two adults each week, Tuesday to Thursday. This service re-commenced in January 2021, following a period of voluntary suspension. The service was also offering a limited day care service, which involved a nursing assessment, followed by physiotherapy and therapy, as indicated. Leaders told us the service was planning to re-commence end of life and palliative care by August 2021.

How we carried out this inspection

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. Our team consisted of an inspection manager, inspectors, a pharmacist specialist, and a specialist adviser with relevant experience in hospice care.

We spoke with 13 staff, including: trustees; the chief executive officer; the director of care; the clinical lead for adults; doctors; a clinical sister; and registered nursing staff and healthcare assistants. We reviewed 15 staff files (including trustee and leadership staff files) and eight patient records.

No patients were present during the inspection.

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 to improve:

We told the service that it must act to bring services into line with three legal requirements. This action related to treatment of disease, disorder, or injury services.

Summary of this inspection

- The service must ensure that staff fully and properly assess the risks to the health and safety of service users of receiving the care or treatment and do all that is reasonably practicable to mitigate any such risks (**Regulation 12 (2) (a) (b)**)

- The service must ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely (**Regulation 12 (2) (c)**)

- The service must ensure staff have sufficient quantities of equipment supplied to ensure the safety of service users and to meet their needs (**Regulation 12 (2) (f)**)

- The service must ensure the proper and safe management of medicines (**Regulation 12 (2) (g)**)

- The service must assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services) (**Regulation 17 (2) (a)**)

- The service must assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity (**Regulation 17 (2) (b)**)

- The service must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided (**Regulation 17 (2) (c)**)

Action the service SHOULD take to improve:

We told the trust that it should take action 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.

- The service should ensure that it can evidence that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely (**Regulation 12 (2) (c)**)

- The service should ensure that all equipment used on a patient that has not been supplied by the provider is safe to use and recorded as such in the patient record (**Regulation 12 (2) (e)**)

- The service should ensure staff use medicine care plans to support them in the proper and safe management of medicines (**Regulation 12 (2) (g)**)

- The service should ensure that all notices on display for staff and visitors have a version control and review date printed on them to ensure the information in the notice is current and in force (**Regulation 17 (2) (b)**).

- The service should ensure that it can demonstrate that the priorities set out in its published strategy 2019-24 are specific, measurable, achievable, realistic, and timed (**Regulation 17 (2) (b)**)

- The service should ensure that adult inpatients have signed a consent to treatment form or otherwise effectively recorded their consent to treatment where signing was not possible, in accordance with the provider's policy (**Regulation 17 (2) (c)**)

Summary of this inspection

- The service should consider using a tool to help it plan, monitor, and assess the staffing needs of the adult inpatient service

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hospice services for adults	Inadequate	Inspected but not rated	Not inspected	Inspected but not rated	Inadequate	Inadequate
Overall	Inadequate	Inspected but not rated	Not inspected	Inspected but not rated	Inadequate	Inadequate

Inadequate

Hospice services for adults

Safe	Inadequate
Effective	Inspected but not rated
Responsive	Inspected but not rated
Well-led	Inadequate

Are Hospice services for adults safe?

Inadequate

Our rating of safe stayed the same. We rated it as inadequate because:

Mandatory training

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

We reviewed six staff files on inspection. Staff were unable to produce to us training certificates for the six staff files we reviewed. Instead, we were given a spreadsheet which showed, except for record keeping (which staff were waiting a date for), staff had either completed their mandatory training or were booked to do so. Whilst this included 'induction' there was no mandatory course for medicine management.

We were not able to see from the six staff files we reviewed that each staff member had received an induction on starting employment. There was a documented process to identify which staff needed which training, and this distinguished between theory and observational competence. There was no target set by the trustees or leaders for staff compliance with mandatory training.

To ensure staff completed their mandatory training, the provider told us the hospice was transitioning to a process where its human resources department would track and monitor staff compliance with mandatory training. This was not completed at the time of inspection. We were not assured that the service had a robust process in place to maintain accurate oversight of mandatory training for staff.

At the last inspection there was no policy for education and training whereas at this inspection we saw that there was.

Safeguarding

Staff did not always receive the correct level of training on how to recognise and report abuse. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

The hospice had an adult safeguarding policy for staff to refer to which was in date and since the previous inspection, had been ratified by trustees. However, the policy was not in accord with published inter-collegiate guidance on adult safeguarding, (first edition: August 2018) and nor was it being followed.

For example, the policy stated that the director of care, who was named in the policy as the lead for adult safeguarding, should be trained to level three adult safeguarding. The director of care was trained to level three safeguarding. However, the inter-collegiate guidance on adult safeguarding stated that the named specialist in an organisation, such as the lead for adult safeguarding, should be trained to level four.

Also, the policy mandated that all staff and volunteers had access to and attended safeguarding training relevant to their role. Yet we found trustees were not recently trained in adult safeguarding. Under the policy, trustees were: "responsible for the implementation, review and sustainment of a robust policy to ensure adults at risk are properly safeguarded." Neither were volunteers as a 'group' trained in adult safeguarding. Volunteers being used at the time of our inspection, such as the receptionist, we were told, had been trained.

When we last inspected, we found the position was the same, in that neither trustees nor volunteers had received safeguarding training.

However, staff were up to date with both children and adult safeguarding training.

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.

On entering the premises through the public entrance visitors were required to wear masks, record their temperature and complete a COVID-19 questionnaire before being allowed to move further into the premises. We saw staff adhering to this process, which was designed to control the risk of spreading COVID-19. Staff and visitors could wash their hands using hand gel provided and there were clinical wipes on hand to wipe down surfaces or equipment used, such as the temperature machine or pens used.

As a result of the learning from a COVID 19 outbreak incident, we saw that staff had access to written risk assessments about COVID-19, one for staff and one for patients. As well as dealing with taking off and putting on personal protective equipment (PPE) and hand hygiene, this guidance included a care after death procedure for a deceased person.

When we inspected there were no adult patients receiving care. However, all staff seen were bare below the elbow and had access to PPE, such as aprons and gloves, and wore masks. Staff had access to ample supplies of PPE. In each adult patient room, there were posters about handwashing technique.

The hospice had an infection control lead who was the director of care.

Infection prevention control audits were reported on quarterly and whilst there was an emphasis on compliance with COVID-19 health risks, this included: hand hygiene and uniforms and a leadership walkaround general observations audit. We saw completed audits for January and February. The hand hygiene and uniform audits showed nothing below 90% compliance. The walkaround audit adopted a 'yes/no' tick system to various questions asked, so it was not possible to see a compliance score.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use them. Staff managed clinical waste well.

We were not assured that staff always had all the equipment they needed to provide safe care and treatment. For example, many of the patients the adult inpatient unit received were, staff told us, wheelchair bound. However, the only weighing machine that could weigh a patient whilst seated in a wheelchair was in the children's unit. We saw stand on scales in the adult unit but given the patient cohort these would not always be appropriate to weigh patients. We found in several randomly selected patient files that staff on the adult unit had not weighed the patient where this would and should have been indicated. In one record a staff member stated weighing had not taken place because the adult unit did not have weighing facilities. Staff we spoke with had not flagged this as a risk to go on a risk register.

Further, we were not assured that the system the hospice had for checking equipment brought in by patients or their carers was robust. The absence of a policy for checking such equipment was noted at the last inspection. For example, we found reference in a patient's notes to items of equipment that did not have in the patient file any written risk assessment or check.

All portable equipment seen had an up to date portable appliance testing sticker. Equipment used by staff, such as hoists, and syringe drivers were in date for their maintenance checks. All sharps bins seen were assembled properly, off the floor, not over full, and signed and dated.

We saw staff used a maintenance spreadsheet, for premises and equipment, to monitor what needed doing and by when.

All fire exit signage was clear, and we followed the fire evacuation route and found all fire exits were free of obstruction, inside and out. All fire extinguishers seen were in date for their review. The fire system was tested one day a week.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and so remove or minimise risks. Staff did not always identify and quickly act upon patients at risk of deterioration.

The systems and processes for risk assessment were not person centred and were not routinely being completed accurately by frontline staff caring for patients. The system and process for assessing and responding to patient risk was not safely embedded.

At the last inspection staff told us there was no policy to guide staff around the frequency of clinical assessments and re-assessments. We were told last time such a policy was being developed. At this inspection we found there was still no specific policy for assessing and responding to patient risk.

Instead, what we found at this inspection, was that staff had an admissions policy to follow. This mandated a suite of risk assessments that nursing staff and doctors had to complete. This included a referral form from a healthcare professional (which we did not find on any patient record we reviewed) and a pre-admission checklist. The suite of risk assessments included: bed rails; falls; malnutrition; and skin care. Depending on the result of the risk assessment, a care plan would be written up, which mandated the frequency of checks.

As the suite of risk assessments were mandated, we did not consider they were person centred. For example, we found examples of fluid and balance charts in place when these were not clinically indicated.

We found examples where the charts in place were not completed properly by staff. This meant there was a potential that the risk to the patient was not being properly assessed.

In the one case, where a fluid and balance chart *was* clinically indicated, (the patient was reliant on a tube (called a PEG) for all their nutrition and hydration needs), we found the chart in place had: no targets specified; conflicts between the PEG care plan and other records present; and the record was not completed accurately.

On some patient files, we found a NEWS (national early warning score) sheet completed, but we could not find a policy to guide staff on its use, and the charts were not completed accurately.

Prior to accepting an adult into the service, staff were meant to complete a pre-admission checklist. However, on one file we found this had not been done. This led to a patient being admitted without staff being adequately appraised of the risks posed to and by that patient.

On other files we looked at, staff had not weighed the patient, even though there were risk assessments present in the patient record that were weight sensitive, such as weight maintenance or mattress settings.

If a patient deteriorated on the unit and required specialist support staff told us they would phone 999 and provide basic life support until the ambulance arrived.

Staffing

Senior leaders planned nurse staffing levels in advance against planned admissions. Senior leaders reviewed the clinical needs of all patients and planned staffing levels in accordance with this to ensure staff had the required clinical competencies to deliver care and treatment.

At the time of our inspection, the service was providing respite care and leaders told us nurse staffing numbers, supplemented by healthcare assistants, were adequate for such a service. The service was seeing two adult patients a week for respite.

Staff told us they aimed to have two registered nurses and two healthcare assistants for four patients receiving respite during the day, and two registered nurses and one healthcare assistant during the night. In addition, there were, during the day, two clinical sisters, who reported to the clinical lead for adults, who then reported to the director of care.

Recruitment of further staff was still ongoing and during one day of our inspection there was an open day to recruit further staff. This was to increase staffing levels for when the service re-commenced end of life and palliative care, which currently had been voluntarily suspended. At present staff told us there was a vacancy for registered nurses for this service of 2.4 whole time equivalents.

Staff told us they did not use a tool of any kind to help them assess their staffing needs but they were looking to develop a tool used by other hospices that looked at patient dependency.

The day service was the other service being offered for adults at the time of our inspection. This consisted of a nursing assessment, a physiotherapy appointment and an appointment with a therapist. The physiotherapists were brought in as needed, whilst the nurses, healthcare assistants and therapists were employed by the provider. Staffing of this service flexed according to demand.

The provider had a service level agreement in place with a local NHS trust for two consultants in end of life and palliative care. This enabled the consultants, who operated on a rota, to provide daily ward rounds. The job plan for the consultants also gave them time to contribute to governance at the hospice.

When a consultant was not present there was always one doctor present during the day who admitted the patient and conducted a medicine reconciliation and drew up a management plan for the patient.

Out of hours there was a doctor rota so doctors could attend the unit if required.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not always clear or up to date but stored securely and easily available to all staff providing care.

We looked at eight sets of patient records. These were not always comprehensive. We found the risk assessments and care plans were not always completed accurately.

For example, we found the following issues, across different sets of notes: fluid and balance charts were not completed accurately. In one record, there was no apparent order to the notes. In another record, a NEWS chart was used, but it was inaccurate. On another record, a NEWS chart was not signed, or totalled, there were no respiratory measurements noted, and there was no pain score recorded. In another record, a NEWS chart on a prior admission was un-signed and un-totalled. In one record, a mattress pressure was reduced in line with the patient's weight, but we could not find a weight of the patient recorded in the notes. In one record there was no indication of a mattress setting despite the patient needing complex pressure ulcer care.

To try and improve and maintain the standards required for record keeping, staff carried out monthly records audits. We saw audits for February and April 2021 which showed gaps and poor record keeping. The staff did not score 100% on any section in the audit and the percentage scores in some sections of the audit dropped when comparing the two months together. This suggested that the action plan from the February audit was not safe. The action plan for the April audit was still awaiting approval.

Patient records were still in paper format, as we found on the last inspection. Whilst staff did have access to an electronic patient system (called 'icare') it was not used in the adults' service. Staff told us the plan was to use icare. Moving from paper records to a mixture of paper and electronic records was a significant change. However, staff could not show us a risk assessment that had been completed prior to making such a significant change in record keeping practice.

When we spoke to staff about the records staff reported that they did not have electronic access to records held by third parties, such as GPs or hospital trusts. When we asked the leaders about this, we were told the provider was looking to join an electronic patient network used by other health professionals, but this was still in development.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

The systems and processes to safely prescribe, administer and store medicines, staff told us, was being reviewed. We found errors in record keeping for medicines. Medication reconciliation and counting of medication for the adult to take home at the end of their stay contained errors that were not investigated. Auditing of medication was not robust.

Staff at the hospice explained that the medication management policy was being reviewed.

We were also told that currently, whilst on the unit, no patients were able to self-administer medicines other than inhalers. The Royal Pharmaceutical guidance stated that all patients maintain responsibility for the administration of some or all their medicines, during a stay in a healthcare setting, unless a risk assessment indicated otherwise. The approach being utilised on self-administration was potentially restrictive of patient choice and did not appear to consider the guidance mentioned above.

On our review of three patient medicine charts, we found discrepancies on two out of the three medicine charts. We looked at the medicine audit form that listed the medicines brought into the service and the medicines returned to the patient at the end of their stay. For one patient the record did not match the number of tablets administered from the Medicine Administration Record (MAR). For another patient, the dose of one medicine had been documented differently on the MAR and one medicine did not match the number of tablets administered. These discrepancies meant that we could not be sure that these patients had medicines as prescribed. Staff told us none of these discrepancies were reported as a medicine management incident so that an investigation could take place.

We saw no assessment that medicines brought in by patients were assessed as suitable for use.

When reviewing the counting of patient own medication to hand back to the patient when they left the provider, we found two discrepancies, which again were not reported as an incident.

The provider's current medicine policy stipulated that patient records should contain enough person-centred information to support staff to administer when required medicines as intended by the prescriber. But we did not find any as required medicine care plans in the records we looked at.

None of the eight patient records we saw had a medicine care plan. By this we mean a plan telling staff how medication should be managed for the patient. Whilst this was not stipulated by the provider's policy, (except for when required medicines) it was part of the proper and safe management of medicines.

According to the training matrix supplied to us by the provider, medicine management was not a mandatory training module for staff. At the last inspection we were told staff were due to complete a competency booklet for medicine management. The medicine management policy mandated that nursing staff should complete a medicine management module.

At the last inspection the provider had an external pharmacist who staff told us at the time carried out spot checks on medication administration records. At this inspection there was no evidence of external pharmacy oversight of medication at the provider.

The director of care was the controlled drugs accountable officer.

Incidents

The service did not always manage patient safety incidents well. Staff did not always recognise and report incidents and near misses. Managers did not always investigate incidents and share 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.

We saw the provider had a up to date incident policy and staff we spoke with knew how to report incidents.

Inadequate

Hospice services for adults

We found several examples of matters that should have triggered, according to policy, an incident investigation (whether medicine related or otherwise) but staff confirmed that this had not occurred. For example, a patient had been admitted without a pre-admission checklist. Staff confirmed an incident investigation had not been done. Further, when we reported the medicine discrepancies noted above (under Medicines) staff confirmed no incident investigation had been done.

Incidents were discussed at an incident meeting and a log was kept of all incidents so that any patterns or themes could be captured.

Incidents reported were investigated by staff according to a matrix set out in the policy. More serious incidents were investigated by more senior staff, using a root cause analysis method.

Staff told us learning from incidents was shared at safety huddles and in written form. Staff we spoke with confirmed this.

The provider had a system to receive and act on any national patient safety alerts.

Staff were aware of the duty of candour (a legislative duty to be open and honest with patients when something goes wrong).

Are Hospice services for adults effective?

Inspected but not rated

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment or use the findings to make improvements and achieve good outcomes for patients.

The service did not participate in relevant national clinical audits. It was not known whether outcomes for patients were positive, consistent and met expectations, such as national standards. Managers and staff therefore could not use the results to improve patients' outcomes.

The provider confirmed, apart from patient feedback and records or walkaround audits, it did not have any other data it collected to help inform leaders about patient outcomes.

When we asked medical staff whether there was a programme for clinical audit, we were told there was no programme.

Competent staff

The service did not always make sure staff were competent for their roles, but managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The service had put in place a system and process to track and monitor staff compliance with mandatory training to ensure staff were competent for their roles.

Inadequate

Hospice services for adults

We were unable to verify the information we had been given because we could not see evidence of staff training or appraisal.

Staff we spoke with confirmed that they had received training in competencies relevant to their role and we saw the provider had a matrix in place to determine what training each staff role should complete. Some staff reported that because the number of patients being seen was low, combined with it being respite care only, meant that the observational part of their competency assessment was not yet completed.

Consent and Mental Capacity Act

Staff did not always support 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.

At the last inspection we found that documentation to evidence consent was lacking in the records.

At this inspection we saw there was an up to date policy covering consent and mental capacity. However, this policy did not appear to be followed. This was because none of the patient records we reviewed contained a consent form, signed by the adult patient, where indicated.

For patients that did not have capacity we saw that relevant forms had been completed in the best interests of the patient.

Are Hospice services for adults responsive?

Inspected but not rated

Learning from complaints and concerns

It was not always 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. The service included patients in the investigation of their complaint.

We did not find in any of the patient rooms, notices about how to complain. We noted that this was an action from the February walkaround audit. When we inspected in May this action had not been actioned. This meant it may not have been always easy for people to raise concerns about care received.

Are Hospice services for adults well-led?

Inadequate

Our rating of well-led stayed the same. We rated it as inadequate because:

Leadership of the service

Leaders did not have the skills and abilities to run the service. They did not understand and manage the priorities and issues the service faced well. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The provider was led by a board of trustees who delegated day to day operation to a chief executive. Reporting to the chief executive were a director of care; human resources; an operational manager; but no clinical governance lead. Reporting to the director of care was a clinical lead for adults. Reporting to the clinical lead for adults were two clinical sisters, below which were the frontline clinical nursing and healthcare workforce.

The trustees were not formally allocated any specific portfolio to oversee and manage. Some trustees, staff told us, depending on their background, did take an interest in certain areas.

The service had recently appointed several senior leaders, but we found that there were gaps in the skill mix of the senior leadership team in relation to the identification and management of governance issues. Senior leaders we spoke with discussed the importance of establishing a clinical governance lead within the organisation. We saw that the provider did not currently have an appointed clinical governance lead. The responsibilities that would be fulfilled by this role had been distributed across various other senior leaders. It was unclear as to how the provider was ensured that these additional responsibilities were being fulfilled.

The new leadership team demonstrated a desire to make things better, but all the leadership team we spoke with shared with us the scale of the task that faced them.

At present the leadership team were not able to offer support to the wider healthcare economy. The team told us they were focussed internally on building the workforce, improving governance, stabilising finances, and improving patient care.

We were not assured the leadership team had good visibility on the quality of care being provided. We saw a lack of data available to the trustees and wider leadership team. We found an absence of any key performance indicators or clinical audit programme.

Vision and strategy for the service

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with some relevant stakeholders. The vision and strategy were focused on sustainability of services but not aligned to local plans within the wider health economy. Leaders and staff did not always understand and know how to apply them and monitor progress.

The organisation had a strategic plan currently in place to run from 2019 until 2024. We saw no evidence the written strategy had been reviewed considering the provider being placed in special measures following the inspection in December 2019. In the absence of a recent review, we were not assured that the goals outlined within the strategic plan were realistic or attainable by the provider.

The providers strategic plan did not reflect how national progress towards a model of integrated health and social care had developed locally. It did not include any details that referenced how this applied to the local community. There was an absence of detail how the wider community or key stakeholders, such as clinical commissioning groups, had been engaged in the development of the strategy.

The strategy did not contain details regarding service development or improvement plans to support the delivery of the strategic plan. The plan stated that "this strategy and the supporting plans will be driven by the board and the senior management team through action plans and regular monitoring". Senior leaders within the organisation told us that the focus was on establishing stability as opposed to focusing on the strategy. Senior leaders were unable to produce any documentation to reflect how the provider was maintaining progress in relation to their strategy.

We were not assured that the provider had oversight of their strategic plan and what steps needed to be taken to move forward.

Culture within the service

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 we spoke with felt respected, supported, and valued by their leaders. Staff reported a no bullying culture and felt they could raise anything they wanted to raise. The service had a whistleblowing policy which was available to all staff and information on how to raise concerns was available within this document.

When speaking with staff it was clear that their priority was focussing on the needs of the patients they cared for. Staff were passionate about making the services the provider supplied work well.

Whilst a small team, there was no recent staff survey that the provider had completed.

We found that the provider's strategic plan made no reference to the physical and emotional wellbeing of staff, and there was no data being currently collected.

We were not assured the trustees, or the leadership team had data on or about the culture of the service.

Governance

Leaders did not operate effective governance processes throughout the service and with partner organisations. Staff at all levels were not always clear about their roles and accountabilities and did not always have regular opportunities to meet, discuss and learn from the performance of the service.

The provider was undergoing a significant process of change, made up of many different programmes of work. There was an absence of any oversight or management of this.

We found there was a lack of clarity regarding the meeting schedule that underpinned the provider's governance structure. The clinical effectiveness group had yet to commence and we found no reference to this group in any of the provider's policies. Many of the provider's meetings were in the process of restarting. We found an absence of action logs for several of the provider's key meetings, such as, the quality, safety and risk committee (QSRC) meeting. We were not assured that the provider had mechanisms in place to establish ownership and maintain oversight of any actions agreed as part of these meetings.

We spoke with the senior leadership team to confirm the processes in place to maintain oversight of the ratification of

policies. We found that several policies were still in development or under review. Senior leaders gave conflicting responses. Some stating that there was no log that detailed which stage policies were at. Other senior leaders told us that this log was in the process of being developed. We were not assured that the provider had oversight of the status of policies for ratification. It was unclear as to who had ownership of the policy register.

We were not assured that the trustees and leaders were gathering data to enable them to have a clear grasp on quality management. We saw trustees received reports about matters such as patient feedback, records audits, and handwashing audits.

The provider expressed intentions to recommence end of life and palliative care by August 2021. We saw no evidence that the provider had completed any formalised planning to facilitate this. Senior leaders acknowledged the ambitious nature of this task but were not able to provide any written plans to demonstrate how they would reach this target.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identify actions to reduce their impact. They had plans to cope with unexpected events.

The organisation had a risk register in place at the time of inspection. The risk register was due to be reviewed as part of the QSRC meeting which reported to the board of trustees. We requested copies of the meeting minutes for the QSRC and we were only provided with a copy of the January 2021 meeting. However, we noted this meeting was due to take place on a bi-monthly schedule. We found that whilst the QSRC meeting had taken place, no revised timescales had been included for risks where the completion date had been surpassed.

We noted that the master risk register did not reflect the risks we found. For example, the lack of a clinical governance lead was not on the risk register. Further, the actions from the annual external infection control audit were not reflected on the risk register.

Each service was meant to have its own risk register, but we saw no risk register for adults. For example, the lack of weighing equipment in the adult inpatient unit was not on any service risk register. Neither was the proposed change from paper records to a mix of paper and electronic records on any risk register. This meant leaders lacked insight about tracking and mitigating these risks.

The approach to assessing risk was inconsistent and did not reflect the risk management policy supplied to us.

For example, a decision was made to remove wooden handrails from the adult inpatient unit because they posed an IPC risk. Staff confirmed that there was no written risk assessment completed and signed off before deciding to do this. No suitable replacement had been planned.

There were inconsistent infection control practices in relation to COVID-19 across the different locations managed by the same provider and senior leadership team.

For example, when taken on a tour of the adult inpatient unit at Stockton, we were only wearing masks. When we attended Bishop Auckland, staff told us, because of the bubble in operation, for our tour, we had to wear gloves, aprons and masks and if interviewing a patient. Yet, staff told us, Stockton was also operating a bubble.

We spoke with the leadership team regarding the approach to monitoring key performance indicators (KPI) for patient outcomes. Senior leaders confirmed that plans to establish key performance indicators for patient outcomes were not yet finalised and the service was not currently undertaking this. However, we found that the provider had previously submitted evidence in response to a previous inspection that stated: "KPIs identified and agreed. Formal reporting will commence once services restart." This action had been marked as completed. It was unclear as to what the current status regarding the usage of KPI was.

No programme of clinical audit was in place.

Information management

The service did not collect reliable data and analyse it. Staff could not find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not integrated.

Staff told us that other hospices in the area were on an electronic system that allowed them to view health records held by other stakeholders. It was the provider's intention to join this system. We were unable to see any formalised plans that outlined the actions the provider had taken to achieve this.

The provider had an electronic patient system but plans for its use in adults were in their infancy. This meant whenever leaders needed data it would have to be extracted manually.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They did not always collaborate with partner organisations to help improve services for patients.

We saw that the service conducted patient surveys by way of engagement. Overall, the patient surveys shared with us were positive and complimentary of the service received. We did not see any recent staff surveys.

As at the last inspection, there was no other regular use of any other methods of seeking patient, staff or wider community feedback.

Senior leaders told us that they were still in the process of developing links and forging working relationships with other hospice providers in the area. However, senior leaders told us they did take part in regional and national hospice related meetings.

Learning, continuous improvement and innovation

Although staff were committed to continually learning and improving services, they did not have understanding of quality improvement methods and the skills to use them. Leaders did not encourage innovation or participation in research.

Staff told us that they were invested in improving the service. However, there was limited innovation or service development, no obvious knowledge or use of improvement methodologies, and minimal evidence of learning and reflective practice. Plans to share good practice were still in development.

Inadequate

Hospice services for adults

We noted that the leadership team told us that it was their ambition to join a local electronic network so that they could have electronic access to patient records not held by the provider. However, staff told us other hospices in the local area had already achieved this aim.