Prospect Hospice Limited

Prospect Hospice

Inspection report

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Date of inspection visit: 10 November 2020
Date of publication: 16/12/2020

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	Inspected but not rated
Are services well-led?	**Inspected but not rated**

Summary of findings

Overall summary

This was a focused inspection to assess whether the service had made sufficient progress to address concerns we raised in a warning notice, following our last comprehensive inspection in June 2019. We had concerns about weak governance systems and poor oversight of quality, including patient experience, safety and risk.

Due to the limited focus of this follow-up inspection we did not rate the service. However, we judged that the service had made good progress in addressing our concerns, and the requirements of the warning notice had been met, although, there were still some areas where further improvement was needed.

We found:

Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff morale and the culture of the organisation had significantly improved since our last inspection. Staff felt respected, supported and valued.

Leaders operated effective governance processes. The service had strengthened governance processes and improved board oversight of quality and safety, including patient experience.

Leaders used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Leaders had good oversight and understanding of corporate risks and we were assured these were being managed well. The service had responded quickly to the challenges associated with the Covid-19 pandemic, showing agility, adaptability and a focus on safety.

The service was committed to continually learning and improving services. The management of audit had improved and there were many examples of quality improvement initiatives focussed on improving patients' experiences. The service had begun to undertake care of the dying audits.

However:

Minutes of meetings of the board of trustees did not reflect the work taking place in the sub-committees. Although we were told discussions took place, no formal reports from sub-committee chairs were recorded.

The board assurance framework did not describe key risks but set out the systems to manage risks. Key performance indicators were still in development.

The rationale for suspending the 'business as usual' corporate risk register, and the systems in place to ensure the risks continued to be managed during the pandemic, were not explicit in board meeting minutes or the board assurance framework.

Although a patient story was discussed at each board meeting, we found few other references to patients' experience recorded at board meetings.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	**Inspected but not rated**	Our rating of this service stayed the same. We rated it as requires improvement because: This was a focused inspection and did not affect the existing rating for the service.

Summary of findings

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Summary of this inspection

Background to Prospect Hospice

Prospect Hospice is operated by Prospect Hospice Limited. It offers community and inpatient hospice care for people affected by life-limiting illness, and serves the communities of Swindon, Marlborough and North East Wiltshire.

There is an inpatient unit, a 16-bed facility which provides respite care, symptom control and care for patients at the very end of life. During the Covid-19 pandemic, the inpatient unit closed from March to May 2020 and, after social distancing and infection control systems were put in place, re-opened six beds, accommodating patients in single rooms with access to outside space. During the pandemic, the service had begun to work differently, with much more crossover between teams and more focus on care in the community. Admission criteria for the inpatient unit was and continues to be focused on the provision of complex symptom control.

Prospect@Home delivers end of life care in patients' homes. There is a team of clinical specialist nurses, therapy services, bereavement services, a lymphoedema service and a single point of access team. There is a team of clinical nurse specialists working within a local acute trust, identifying end of life patients and their families who require specialist care in the hospital or who can be supported at Prospect hospice or at home by their multidisciplinary team. The clinical nurse specialist team also provides specialist end of life care to local nursing and care homes.

The current registered manager has been in post since April 2019.

We previously carried out focused inspections of the inpatient unit, in February 2018 and August 2018 and took enforcement action on both occasions. We undertook a comprehensive inspection of all services in August 2019 and rated the service requires improvement overall. We issued a warning notice because we had concerns about weak governance systems and poor oversight of quality, including patient experience, safety and risk.

How we carried out this inspection

We planned to revisit this service in April 2020 but postponed this due to the pandemic. We asked the service to provide us with information to enable us to assess their progress. Following a review of this information, we carried out a focused on-site inspection visit on 10 November 2020. Because the inspection took place during the second Covid-19 lockdown in England, we gave the service 24 hours' notice, in order to ensure safety could be maintained during our visit.

During our inspection we spoke with the director of services (also the registered manager), the medical director, two staff on the inpatient unit, the chair of the board of trustees and another trustee. We requested and reviewed further documents from the service, including minutes of board meetings and sub-committees of the board. We also reviewed patients' records.

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.

Summary of this inspection

Areas for improvement

Action a service 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.

The service SHOULD:

Review minutes of board of trustees' meetings to ensure:

- they explicitly reflect the cascade of information from sub-committees of the board.

- they capture patient experience more consistently and prominently.

Reinstate regular board review of the corporate risk register, including risks relating to Covid-19.

Progress work to report performance against agreed key performance indicators and embed these in board reporting.

Continue to develop end of life audit.

Our findings

Overview of ratings

Our ratings for this location are:

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

Inspected but not rated

Hospice services for adults

Well-led

Inspected but not rated

Are Hospice services for adults well-led?

Inspected but not rated

This was a focused inspection and did not affect the existing rating.

We found:

Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff morale and the culture of the organisation had significantly improved since our last inspection, when we described this as "mixed". The service employed specialist independent consultants to support a review of organisation culture. Their report summarised the journey completed by the hospice from the time that CQC raised concerns about culture. It described the milestones, including the establishment of the staff forum, which subsequently developed corporate values on behalf of the staff, and a culture and values day 'Your Prospect'. The report looked at the response to the Covid-19 pandemic and the resilience, flexibility and adaptability of staff. They concluded this response was made possible by a significant culture shift, visible leadership, a cohesive executive team, staff feeling valued, safe and cared for.

Feedback from the staff forum, reported to the people and resources committee in September 2020, highlighted how sessions called 'Prospect Perspective' "provided a platform for individuals to share experiences during the pandemic, which were well received by staff. Feedback from the forum indicated staff morale was generally high, and staff were feeling well supported. Trustee 'buddy' visits had been well received. Concerns about workload had been raised by staff on the inpatient unit, and these had been responded to promptly. A recent staff survey, shared with us, had shown positive results in relation to wellbeing and engagement.

During our inspection we spoke with two staff from the inpatient unit. Both were very positive about the culture in the organisation and the morale of the workforce. They felt teamwork and camaraderie had been enhanced by the pandemic and there was better collaborative working, facilitated by the organisation. They told us they were well supported by their managers and peers. They told us regular communication from the leadership team had been much appreciated throughout the pandemic. There were weekly updates and fortnightly meetings using video conferencing, so managers continued to be visible and connected.

Team meetings followed standard agendas, including a prompt to address how staff were feeling and capturing any messages to be fed back to the executive team. We saw many examples of this being used to provide thanks to the executive team for their support but also to raise concerns and anxieties. On the inpatient unit, once a week at their daily staff handover, staff were invited to share a 'weekly win', which was a positive story or achievement. We heard that communication to and between medical staff had improved during the pandemic with the introduction of a weekly evening meeting via video conferencing. A messaging application had been used to allow the team to stay in touch with each other and provide mutual support.

We learned staff had been demoralised by the outcome of our last inspection. The medical director wrote to tell us about the inclusive leadership of the chief executive and the other members of the executive team in response to this and the more recent challenges associated with the pandemic. The chief executive held a series of meetings with staff to discuss our findings and was reported to have reassured and reinvigorated staff ambition to improve. They told us the executive team praised and thanked the staff for their flexibility, adaptability and resilience during the pandemic. We saw notes from an all staff meeting held in September 2020 via video conferencing, which demonstrated appreciative relationships, with lots of examples of positive feedback and pride.

We heard about the many wellbeing initiatives put in place during the pandemic. These included a working from home guide for employees and managers, psychological and counselling support, a 'take 5' room for staff that needed 'time out' and providing staff with food.

At the time of our inspection, there were consultations taking place regarding restructuring and possible staff redundancies. Morale had understandably been affected in some work groups. Trustees and executive managers told us the chief executive had dealt with this in an open and sensitive manner.

The service had developed a set of corporate values, represented by the acronym ASPIRE (authentic, specialist, person-centred, inclusive, resilient, excellent). The values had been developed by the staff forum and we saw they featured in team meetings and buddy visits. They were also applied during staff supervision and appraisals.

The executive team, prompted by our visit, shared their thoughts on what they were most proud of. Comments described a cohesive and proud workforce.

Leaders operated effective governance processes.

The service had strengthened governance systems to ensure effective oversight of quality, including patient experience, safety and risk.

There was a committee and meetings structure which was designed to ensure the effective cascade of information from 'ward to board' and vice versa. The structure was set out in the Board Assurance Framework (BAF), which was supported by a suite of governance policies and included the hospice's strategy 2017 to 2022. The BAF was designed to link with the corporate risk register, where risks to the achievement of strategic priorities were recorded.

The BAF set out the range of sub-committees of the board, chaired by board trustees and scheduled to meet quarterly. These were: patient services committee, people and resources committee and finance and income generation committee. At the mid-point between scheduled board meetings, all sub-committee chairs met with the chair and the chief executive to discuss any emerging issues and risks and to plan the agenda for the next board meeting. In addition, the chairs of sub-committees met monthly with the relevant executive lead. The chair of the patient services committee told us they had a good working relationship with the director of services and contacts were often more frequent than those which were scheduled.

We reviewed minutes from the patient services committee. This committee met in January 2020 but the subsequent meeting, scheduled for May 2020, was postponed due to the pandemic. The committee next met again in September and then in November 2020, via video conferencing. Items discussed included quality improvement presentations (care planning, and bereavement care), complaints and lessons learnt, medicines management action plan update, incidents and accidents and a review of the risk register.

It was not clear from the minutes of these committee meetings or from the minutes of the board we reviewed, how information, risk and assurances were cascaded to the board. In the board minutes we reviewed, there were no formal reports from sub-committee chairs. The chair of the board of trustees explained that board members received the minutes from the sub-committee meetings in their board meeting papers; there was no formal agenda item but sub-committee chairs could escalate items as they saw fit or other trustees could ask questions of the chair. The chair of the patient services committee told us they provided a verbal update at board meetings. The director of services acknowledged that this cascade of information should be recorded in the future. Going forward, there were plans for each sub-committee to report using a performance dashboard, which would be summarised as a one-page overview at board level. A mock dashboard was tabled at the board meeting in September and a final version was to be presented to the next board meeting in November 2020.

The people and resources committee met in November 2019, February, and September 2020. Items discussed included the risk register (there were no 'red' risks), staff forum feedback, voluntary services update, staffing/cost reduction proposals update, pay, equality and diversity, education and training, communications and retail. At the meeting held in September 2020 it was recorded that the director of people was to explore options for reporting metrics to the board and was to work with the committee chair to progress this.

We discussed the decision to suspend sub-committee meetings during the 'lockdown' period of the pandemic with the chair of the board of trustees. They explained the priority was to allow the executive team to focus on the response to the pandemic. Liaison between executive leads and their 'partner' trustee (chair of relevant sub-committee) continued, with monthly calls, so trustees continued to be informed and engaged. Quarterly meetings of the board were increased to monthly and were conducted via video conferencing. Trustees maintained connectivity, and oversight through attendance at fortnightly video conferencing calls, staff forum meetings and some trustees had joined 'task and finish' groups to produce performance dashboards, which would feed into the board assurance framework. In addition, the chair met weekly with the chief executive and monthly with sub-committee chairs.

Board trustees were engaged and connected. In addition to the regular contact with executive managers, they had developed a 'buddy' system, whereby they formed supportive relationships with identified functions in the organisation. Each buddy arrangement had been put in place for two years to allow the partners to get to know and trust one another, increase knowledge and understanding of the area of responsibility, and understand their priorities and challenges. In the last 12 months, visits had taken place to the inpatient unit, the communications department, the community engagement team, the bereavement team, the community nurse specialist team (including accompanying a nurse on a home visit) and a meeting with a consultant (medical director). Feedback captured during the visits was recorded and shared with the executive team. Visits took place less frequently during lockdown; however, some continued to take place via video conferencing. It was acknowledged by trustees that this programme of visits should be reinstated, albeit remotely, in the current circumstances.

Patient experiences, including complaints, were discussed as a standing agenda item at clinical governance meetings. Clinical governance meetings reported to the patient services committee, chaired by a trustee and this was a standing agenda item on the board agenda. In addition, a patient story was shared at each board meeting. We were provided with a feedback trend report, presented to the patient services committee on 4 November 2020. This showed the number of complaints received by hospice area/function each quarter. There was no detail included to indicate the nature of complaints received or any arising themes, although we noted, only seven complaints had been received in the last 12 months and no complaints had been received in the most recent reporting period to the end of September 2020. The minutes of the meeting held on 4 November recorded a discussion about a complex complaint received earlier in the year, the lessons learnt, and the actions taken in response. These included feedback to staff. There was also a discussion about a complaint about the clinical nurse specialist team and the remedial actions taken.

Similarly, the number of compliments received was reported by quarter (there were 101 in the quarter ending 30 September 2020) but again, there were no themes reported. We found little evidence in the minutes of the board that patient experience was discussed. We discussed this with the director of services and the chair of the patient services committee. They both agreed this could be more prominently recorded. This said, both trustees we spoke with were well informed about patient feedback and spoke with us about a complex complaint which had recently been investigated. The chair told us, in normal circumstances they personally visited the inpatient unit and spoke with patients about their experiences. Going forward, patient satisfaction, compliments and complaints were identified as key performance indicators in the performance dashboard, to be reviewed by the board.

The service had taken action to improve the quality of care planning on the inpatient unit, to ensure documentation reflected a holistic approach to identifying and meeting patients' needs. Following our last inspection in 2019, where we raised concerns about the quality of some care plans, staff had received bespoke training in care planning. The content of the training and training records were shared with us and confirmed all registered nurses on the inpatient unit had completed relevant training in 2019. Further training was planned during November 2020 and we saw staff, including bank staff and health care assistants, were booked to attend this. A quality improvement plan was being led by the newly appointed matron for quality improvement. Regular audits were ongoing to provide assurance that improvements were made and sustained. A report to the patient services committee on 4 November 2020 reported progress on this.

We spoke with two staff employed on the inpatient unit. They described the electronic patient record system as straightforward to use and an improvement on the previous system. They had not received bespoke training in holistic care planning as neither were employed on the inpatient unit when this training was rolled out in 2019. However, they told us this was regularly discussed at team meetings and they were aware of further training planned. They were also aware of regular audits of care plans and told us staff received individual feedback if there were any concerns. They told us they had recently introduced 'What matters to me' in each care plan. This prompted them to record information about patients' background, preferences and beliefs. They felt they had always delivered person-centred and holistic care but perhaps were not so good at recording it in the past.

We reviewed six care plans for all patients receiving care on the inpatient unit at the time of our inspection. In all six plans the 'What matters to me' document had been completed well. This demonstrated an in-depth discussion had taken place with the patient to determine their needs and preferences. One patient had also been supported to complete the document themselves.

Care plans were recorded on an electronic system following the completion of the 'Holistic Assessment' booklet. We reviewed four records on this system and found care plans were individualised and person-centred, for example, indicating preferences for temperature control and pain relief, with specific strategies for each individual. Staff told us this was an improvement on the documentation used previously, which had consisted of a set template for each patient.

Leaders used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Leaders had good oversight and understanding of corporate risks and we were assured these were being managed well. The service had responded quickly to the challenges associated with the Covid-19 pandemic, showing agility, adaptability and a focus on safety.

Hospice services for adults

At our previous inspection we were concerned that there was not a corporate risk register or oversight of organisational risk. Prior to this inspection we had requested the most current corporate risk register to review. We were provided with a Covid-19 risk register, which set out the current strategic and operational risks relating to the pandemic and its impact on services, with mitigating actions in place. There was also a comprehensive board assurance framework for infection, prevention and control. Given the ever-changing circumstances associated with the pandemic, both documents were live, regularly reviewed, and clearly set out the risks and how these were being managed. It was unclear however, if there were ongoing 'business as usual' corporate risks, which were not being reviewed or actioned. We discussed this with the director of services and two trustees. They explained that, in recognition of the significant increase in the executive team's workload, their primary focus was to be directed to managing risks associated with the pandemic. 'Business as usual' risks continued to be managed by directorates and we saw work had continued to manage risks, such as medicines management and staffing. We reviewed the patient services risk register and saw some risks had been reduced and some removed. Longer term risks remained but we were assured they were being monitored and managed. Both trustees we spoke with were well informed as to the status of these risks and the continuing work to manage them.

The service was committed to continually learning and improving services.

The management of audit had improved. There were monthly quality improvement and clinical audit meetings, led by the director of services and a monthly tracker was used to record and monitor progress. A newly appointed matron was to take over the lead for this going forward.

Scheduled audits took place consistently, with only a few suspended due the temporary closure of the inpatient unit.

An annual audit of end of life care had been completed to review whether patients received their end of life care at their preferred place, for example, at home, hospice or elsewhere. The audit reviewed the care of 915 patients. The audit showed 61% of patients achieved their preferred place of death, with 9% who did not. However, 30% of preferences were unknown. The report had been scrutinised by the executive team and further work was being developed to determine why those preferences were unknown. The audit was to be completed weekly in the future. It was hoped this audit would lead to improvements in ensuring patients received care in their preferred place.

The service was proud of the quality improvements that had been achieved in response to CQC action, patients' feedback and audit. The service approached quality improvement initiatives using a four-stage problem-solving model (PDSA - Plan, Do, Study, Act). Recent quality improvements included:

The service was trialling the use of carers, who were trained and supported to administer subcutaneous injections. This allowed patients, who would normally be cared for as inpatients, to be cared for at home. Subcutaneous injections allow medicines, such as morphine, to be absorbed by the body slowly, providing pain relief over a longer period.

A complaint received about responsiveness of the clinical nurse specialist (CNS) team prompted a review of how the service currently worked and led to the introduction of a duty CNS role, who was flexible within their working day and able to respond to urgent requests for support.

The medical director led a piece of work on holistic pain management. This included the production of patient information on different aspects of holistic pain management. The service had a pain management working group and planned to launch a weekly multidisciplinary pain management meeting which would review and discuss pain

management options for every patient, whether an inpatient or cared for at home, who had reached an identified 'ceiling' of pain relief medication. The medical director had also developed a 'virtual reality' application, using mindfulness techniques, and had enlisted the support of a well-known broadcaster to provide the narrative. They had agreed to support further applications to support patients with anxiety, fatigue and breathlessness.

The chief executive participated in the local system-wide (BaNES, Swindon and Wiltshire) oversight group, working collaboratively with other system partners. A collaboration meeting was held with the trustees of a neighbouring hospice and links had been developed with executive leaders between the two organisations.

The service acted quickly during the pandemic to reconfigure services and redeploy staff, accelerating the planned 'direction of travel' outlined in the hospice's strategy. With the temporary closure of the inpatient unit, admission and discharge criteria were reviewed and the inpatient unit provided more specialist care to patients requiring complex symptom control. The medical director reported to the board in May 2020 that they were "impressed with people energised and flexible in their new ways of working". A new model of care, known as 'Prospect without walls' was being developed, responding to both financial constraints and the desire to deliver care differently.

The service had invested in further specialist education for staff, including a number of degree and masters level courses. The service was also engaging with the Clinical Commissioning Group (CCG) end of life group which would be rolling out training in end of life care for all levels of staff across the CCG area.