Prospect Hospice

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Overall summary

Prospect Hospice is operated by Prospect Hospice Limited. The service provides community and inpatient hospice care. The inpatient unit is a 16-bed facility which provides respite care, symptom control and care for patients at the very end of life. During this inspection we only inspected the inpatient unit.

We inspected this service, unannounced, on 2 and 3 August. This was a focused inspection to follow up areas of serious concern which we identified following an inspection in February 2018. We issued a warning notice in March 2018 and required the provider to make significant improvement by 14 June 2018. During our inspection on 2 and 3 August we identified additional concerns, which were incidental to the warning notice. We therefore returned to further investigate these concerns on 14 and 15 August 2018. We did not inspect all key questions or all elements of key questions, but focussed on elements of 'safe', 'effective' and 'responsive' and 'well led' domains. For this reason, we did not rate this service.

The warning notice served on the provider in March 2018 identified areas for significant improvement:

Summary of findings

- Staff did not receive appropriate support, training, supervision, appraisal of professional developments as was necessary to allow them to carry out their roles safely and effectively. There was no training policy which set out staff training requirements and training records were out of date and incomplete. Registered nurses were undertaking clinical tasks for which they did not have up to date clinical competencies.
- There was no formalised process for recording when agency staff were used, or evidence of induction training and we could not be assured that agency staff were suitably skilled.
- There was no formalised system for recording, monitoring or reviewing when patient admissions were delayed or refused due to staffing levels on the inpatient unit.
- The provider failed to seek or act promptly on staff feedback to evaluate and improve services. Seven anonymous complaints had been received from staff about the culture on the inpatient unit and these had not been investigated promptly. The provider had not responded to widely expressed staff concerns about staffing levels and patient safety on the inpatient unit.

During this inspection we found:

- The requirements of the warning notice had not been met. The provider had submitted an improvement plan to us, as asked by CQC, in response to our previous concerns. We judged that they had not made progress at sufficient pace. The improvement plan was not supported by sound evidence and we found some assurances provided by the organisation were factually inaccurate.
- The training policy had been reviewed but it was not complete or fit for purpose for all staff employed by the organisation.
- There remained insufficient oversight of the employment of agency staff and a lack of assurance about their level of competence.
- There was incomplete evidence to support the assurance given to us, that most staff were up to date with clinical competencies and had completed a performance appraisal.
- There were many occasions where nurse staffing on the inpatient unit did not meet planned levels and therefore left the ward potentially unsafe.
- Staffing levels had a negative impact on their ability to provide a service and therefore the number of beds had been reduced. This had in turn had an impact on the local populations choice. This had resulted in six patients being unable to die in their chosen place of death.

Findings incidental to the warning notice were as follows:

- We were concerned about a lack of clinical leadership due to the long-term absence of the director of patient services and the vacant head of patient services position. The inpatient unit was led by the clinical lead, a band 7 nurse, who was working excessive hours and was under significant pressure. The risks associated with her resilience and wellbeing had not been acknowledged or acted upon promptly by the provider.
- Staff understanding of safeguarding processes was poor, so we could not be assured that vulnerable people sufficiently were protected from abuse. Volunteers did not have sufficient training in safeguarding.
- Systems and processes to prevent and protect people from healthcare-associated infection were not effective. We saw unsafe practice where staff did not take necessary precautions to prevent the spread of infection when nursing patients in isolation.
- There was a lack of oversight about patient records. We saw that risk assessments, for example, about nutrition and hydration and pressure area care, were not always completed and updated.
- The service did not manage patient safety incidents well. There was no formal incident investigation process to ensure that learning from incidents was identified and cascaded to staff to improve patient safety.
- Compliance with mandatory training for volunteers was poor. Only one out of 42 volunteers had received safeguarding training and volunteer compliance with manual handling, fire safety and health and safety were mixed.
- Some equipment on the inpatient unit, including equipment required in an emergency, was not properly maintained.
- Although the chief executive and trustees had arranged a series of visits to engage with staff on the inpatient unit, many staff continued to feel unsupported by the senior management team, who they said were not visible leaders.

Summary of findings

- The trustees and the chief executive had not given sufficient scrutiny and challenge to the improvement plan.
- Patient safety, quality and sustainability did not receive sufficient coverage in the organisation's board meetings, where the focus was on reputational risk and risks to income generation.
- Governance systems and processes were not effective, and we were not assured that there was adequate oversight or management of risks to patient safety and patient experience.
- The chief executive took the decision, following our inspection on 2 and 3 August to temporarily reduce the number of beds within the inpatient unit from 12 to six. This closure was not appropriately planned, communicated or implemented and the impact of this closure on patients and the wider healthcare system had not been assessed.

However:

- The provider had processes to provide oversight of when and how agency staff were used.
- The provider had processes to gain oversight of when staffing levels affected admissions to the inpatient unit.
- The management of medicines on the inpatient unit had improved.
- The service was taking steps to improve staff engagement.

Nigel Acheson

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospices for adults		Prospect Hospice inpatient unit provides respite care, symptom control and end of life care for up to 16 adults. We found that the provider had not made improvements to the service at sufficient pace, in response to the warning notice we served on them in March 2018. There had been insufficient scrutiny and challenge from leaders and this was compounded by the absence of some key managers. There was a lack of managerial and board level oversight of patient safety and quality. This was demonstrated by our incidental findings, which represented potential safety risks. These included delayed patient risk assessments, poor infection control practice and ineffective systems for reporting and learning from incidents.

Summary of findings

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Background to Prospect Hospice

Prospect Hospice is operated by Prospect Hospice Limited. The service opened in 1980. It offers community and hospice care and services the communities of Swindon, Marlborough and North Wiltshire.

The organisation is a charity, of which 70% is funded by the local community through fundraising. Of its income, 30% is provided by statutory organisations such as the local NHS acute trust and the local Clinical Commissioning Group.

The hospice had a registered manager, who had been in post since 2016. At the time of our inspection, the chief executive was covering the roles and responsibilities of the registered manager due to their long-term absence.

Our inspection team

The team that inspected the service comprised three CQC inspectors, and two specialist advisors with expertise in adult hospice care. The inspection was overseen by Mary Cridge, Head of Hospital Inspection.

Information about Prospect Hospice

The inpatient unit service is a 16-bedded facility. One of the inpatient rooms was being used as a patient gym, which reduced the number of inpatient beds to 15. There were seven individual patient rooms and two four-bedded male and female bays. Since December 2017, when a review of bed occupancy and staffing took place, staffing levels had been set to provide cover for 12 out of the total 16 beds. This reflected the recent bed occupancy profile. We were told that staffing could be increased if more than 12 patients were assessed as requiring admission.

During the inspection, we visited the inpatient unit. We spoke with approximately 30 staff including; registered nurses, health care assistants, reception staff, medical staff, the clinical lead, the chief executive and trustees.

We reviewed 15 patients' records. We spoke with seven patients and six relatives, who were positive about their experiences of the hospital. One said that "the staff have all been brilliant" and another said, "the nurses have all been very helpful". Another relative said "I've visited every day for three weeks and I am very happy with the staff, and the care provided. Everyone is so helpful" and a patient said, "I am very happy with the care, it is peaceful here and the staff are so caring".

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected twice, and the most recent inspection took place in February 2018.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We did not rate safe. We did not inspect all areas related to this key question. We found:

- There remained insufficient oversight of the employment of agency staff and a lack of assurance about their level of competence.
- Staff understanding of safeguarding processes was poor, so we could not be assured that vulnerable people were protected from abuse.
- Compliance with mandatory training for volunteers was poor.
- Systems and processes to prevent and protect people from healthcare-associated infection were not effective and did not keep people safe. We saw unsafe practice where staff did not take necessary precautions to prevent the spread of infection when nursing patients in isolation.
- Some equipment on the inpatient unit had not been properly maintained so we could not be sure it was fit for purpose. We found consumable items for use in emergency situations, which were significantly out of date.
- The service did not manage patient safety incidents well. There was no formal incident investigation process to ensure that learning from incidents was identified and cascaded to staff to improve patient safety.
- There were many occasions where staffing on the inpatient unit left the ward potentially unsafe.

However:

- There was better use of agency staff to fill rota gaps.
- Nursing staff were up to date with mandatory training.

Are services effective?

- Some nurse training in role-specific clinical competencies had been provided. This was ongoing at the time of our inspection and the scope of the training was limited. There remained significant gaps in staff competence.
- Some improvement had been made in respect of staff appraisals.

Are services caring?

We did not inspect this domain on this inspection.

Summary of this inspection

Are services responsive?

- Because of shortfalls in staffing, there were times when patients, who had been assessed as requiring admission, were unable to access the service when they needed it. We saw records which showed six patients were unable to die in their chosen place of death.

Are services well-led?

- The service had developed an improvement plan in response to the warning notice we issued in March 2018. We judged that they had not made progress at sufficient pace. The improvement plan was not supported by sound evidence and we found some assurances provided by the organisation were factually inaccurate.
- Although the chief executive and trustees had arranged a series of visits to engage with staff on the inpatient unit, many staff continued to feel unsupported by the senior management team, who, they said, were not visible leaders.
- The trustees and the chief executive had not given sufficient scrutiny and challenge to the improvement plan.
- Patient safety, quality and sustainability did not receive sufficient coverage in the organisation's board meetings, where the focus was on reputational risk and risks to income generation.
- Governance systems and processes were not effective, and we were not assured that there was adequate oversight or management of risks to patient safety and patient experience.
- The chief executive took the decision, following our inspection on 2 and 3 August to temporarily reduce the number of beds within the inpatient unit from 12 to six. This closure was not appropriately planned, communicated or implemented and the impact of this closure on patients and the wider healthcare system had not been assessed.
- Staff grievances were still taking too long to manage.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hospices for adults	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Hospices for adults

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are long term conditions safe?

We did not rate safe.

Mandatory training

- All nursing staff had received mandatory training in safe systems and processes. This included training in manual handling, basic life support, and safeguarding.
- However, compliance with mandatory training for volunteers was poor. Out of the 42 volunteers working for the service, only one had received training in safeguarding and only 27 had received training in manual handling, fire safety or health and safety. This meant we could not be assured that volunteers had appropriate knowledge of key safety systems and processes to keep people safe.
- There remained insufficient oversight of the employment of agency staff and a lack of assurance about their level of competence. Following our inspection in February 2018, we raised concerns that there were no systems to ensure that agency staff employed on the inpatient unit were suitably skilled and were provided with orientation and induction. In the improvement plan submitted to us by the provider, we were told that contracts had been agreed with agencies supplying staff to the unit. Contracts stipulated the competencies required of staff. We found that contracts had not yet been agreed with any of the agencies supplying staff to the unit. We found that a new system had been introduced to ensure agency nurses were appropriately vetted and provided with orientation before commencing their shift. However, through looking at records we found the process was not being followed consistently.
- The safety orientation checklist contained an orientation checklist (to check mandatory training), a confidentiality agreement, a data protection agreement, an access to patient information declaration, and an agency staff electronic record checklist. We checked 27 orientation checklists completed between 4 June and 29 July 2018. Of these we found that 16 (59%) had not been completed fully. The orientation checklist had not been completed on two occasions and the electronic record checklist had not been completed on 16 occasions. There was one occasion where the orientation checklist had been signed by the shift coordinator and the agency staff nurse, despite identifying that they had not completed training to ensure they were competent to administer medicines.

Safeguarding

- There were systems and processes to protect people from abuse; however, staff understanding of their responsibilities to report concerns was poor.
- The hospice had a safeguarding policy, which was produced in May 2017. The policy provided clear guidance for staff about reporting safeguarding concerns. However, we noted the policy had no review date, which meant that up to date information may not have been considered.
- We spoke with staff about their responsibilities to report safeguarding concerns and found their understanding was mixed. For example, a member of staff was unable to identify what different types of abuse were and was unable to identify a concern with some scenarios we presented to them. Another staff member said they were unsure what to do if they witnessed potential abuse. Other staff we spoke with told us they would use a "common sense" approach to safeguarding and were confident about their responsibilities. Considering this inconsistency, we could not be assured that safeguarding concerns would be acted upon.

- None of the staff we spoke with on the inpatient unit could identify who the safeguarding lead was or who they should report any concerns to regarding safeguarding. However, they did say they would go to the ward manager for advice and support.

Cleanliness, infection control and hygiene

- Systems and processes to protect people from infection were not effective and did not keep people safe. There was an infection prevention and control policy; however, this was out of date (produced in 2007 and due for review in 2014) and did not reflect current best practice. There was no information regarding the management of patients with C-difficile (a toxin-producing bacterium which can infect the bowel, causing illness with diarrhoea and fever) within this policy. Several members of staff we spoke with were unable to locate the policy or tell us where it could be found. Therefore, we could not be assured staff were well informed about infection prevention and control practices.
- During our inspection on 14 and 15 August we observed nurses and volunteers did not observe necessary infection prevention and control precautions when supporting three patients who required isolation due to infection. These patients were isolated in side rooms; however, we saw one of the side rooms had the door propped open and nurses and volunteers entered side rooms without washing their hands.

Environment and equipment

- The maintenance and use of equipment in the inpatient unit did not keep people safe.
- We checked the emergency equipment in the inpatient unit. This was kept in two different locations, which increased the time it would take to retrieve this in an emergency. Also, emergency medicines were kept in the treatment room, which had controlled access and not all staff had access to it.
- There were no processes to check the contents of the emergency bags. We found consumables in it which were out of date. These included pocket masks, latex gloves and airway tubes. Three of the airway tubes went out of date in 2015, one went out of date in 2014, another went out of date in 2013 and one went out of date in 2008. This meant that equipment used in an emergency may have been unsafe.
- There were no processes to check the contents of the blood spillage kit (equipment used for cleaning and disinfecting sites where blood has been spilled). We checked the blood spillage bag and found that there were some consumable items, such as alcohol wipes and dressings, which were out of date.
- Clinical waste was not always disposed of safely. Throughout the inpatient unit we found sharps bins which were open and some which were open and overfilled. This posed a risk of spillage, injury and/or contamination. On one occasion, in the sluice room, we found a sharps bin (a bin for the safe disposal of sharp objects, such as needles) with two pairs of scissors sticking out of the top, posing a risk of injury to staff.
- The design of the facilities did not always keep people safe. Although patients' rooms and bays had hard flooring, other clinical areas, such as the corridor and the nurses station area, were carpeted. There was a risk of bodily fluids being spilt in this area when moving them to the sluice room, which created a contamination risk. Also, in some clinical areas skirting boards were not flush with walls, meaning there were gaps, which would increase the risk of bacterial harbourage.

Assessing and responding to patient risk

- During our inspection on 2 and 3 August, we found that comprehensive risk assessments were not always carried out for patients. However, following feedback to the organisation during our inspection, the completion of risk assessments improved.
- Patient risk assessments were mostly carried out on admission to the inpatient unit. However, we found that ongoing re-assessments were not taking place consistently. This meant there was a risk that staff were unable to identify and respond appropriately to the changing risks to patients, including deterioration of health and wellbeing. For example, patients were at increased risk of developing pressure ulcers or becoming malnourished or dehydrated.
- We looked at the records for nine of the 11 patients receiving care on the inpatient unit on 3 August 2018. We found that, in all but one set of patient records, there were assessments which were delayed, some by significant amounts of time. This meant that patients may not be not receiving the right level of intervention to reduce the risk.

- Six of the patient records had delayed pressure risk assessments. Such as those which are used to assess the risk of a patients developing a pressure ulcer. One patient, who should have had daily assessment, had a seven-day gap between assessments.
- Five of the patients' records had delayed nutritional assessments, which, if used in a timely way, can identify and manage weight loss or weight gain. One patient, who should have been reviewed weekly had 16 days between assessments and another patient, who should have been reviewed weekly had 11 days between assessments.
- Three patients had delayed functional ability assessments, two of these were significantly delayed. If used properly these assessments can identify concerns with a patient's ability to be active and ensure adequate support is put in place. These assessments should be done weekly but we found a gap of 11 days for one patient and a 12-day gap for another patient.
- One patient did not have a care plan written for three days after they were admitted to the inpatient unit. There was a risk that staff may not know how best to care to for the patient, who was admitted with a pressure ulcer, and therefore had specific care needs to prevent deterioration of this condition.

- When we returned to the inpatient unit on 14 and 15 August, we checked six patients' records. We found all records were completed correctly and in a timely way within assessed timescales. This meant that patients risks were being managed well.
- However, our findings demonstrated that there was a lack of oversight of patient records. There were no documentation audits conducted by the service to gain assurance that they were being completed appropriately. We reviewed the organisation's 'Audit planner 2018-19', which identified that inpatient unit records audits were removed from the plan in 2017 and the last documentation audit had been conducted in 2014.

Nurse staffing

- It was not clear how the provider had established their staffing levels. The staffing levels did not meet the planned levels of staff required to provide safe care.
- During our inspection in February 2018 most staff expressed concerns that staffing levels on the inpatient unit were not always safe, due to a shortage of staff. Staff told us they were frequently unable to take their breaks and they were exhausted. During our inspection on 3 and 4 August staff some staff we spoke with were more positive about staffing on the unit. One member of staff described a "better climate for supporting staff" with better use of agency staff to fill rota gaps. Staff we observed were more able to manage the workload on the unit. Other staff told us that staffing levels were not always maintained in accordance with planned levels.
- The ward manager told us that safe staffing levels and skill mix on the inpatient unit had been assessed as eight staff in the morning and afternoon and four staff overnight (including both registered nurses and healthcare assistants).
- When asked what the staffing establishment was for the inpatient unit, no one the ward or in the senior leadership team could confirm this. We asked for documentation regarding the nursing establishment numbers and the number of vacancies, but the provider did not have this information. We were told by a senior staff member that there was no set establishment and no processes for ensuring the budget was correct for the nursing workforce on the inpatient unit. In addition, it was not clear if the planned staffing levels (eight staff in the morning, eight staff in the evening and four staff overnight) were set for 12 or 15 beds.
- We reviewed staffing information between 1 March 2018 and 31 July 2018 and, out of 146 days where staffing data was submitted, there were 59 days (40%) where staffing numbers did not meet expected levels.
- In the same period there were:

- 36 occasions where the unit was short-staffed by one member of staff over a 24-hour period,
- 12 occasions where the unit was short staffed by two members of staff over a 24-hour period,
- six occasions where the unit was short-staffed by three members of staff over a 24-hour period.
- Two occasions where the unit was short-staffed by four members of staff over a 24-hour period,
- One occasion (on 5 March) when the unit was short-staffed by five staff over a 24-hour period,
- and one occasion (on 30 July) when they were short-staffed by eight members of staff in a 24-hour period.

- On 3 August we asked for all incident reports of safety concerns on the inpatient unit since the last inspection in February 2018. We were provided with information of two incidents, which were related to staffing.

Medical staffing

- There were risks to the organisation being able to provide consistent medical cover. During our inspection, the only employed consultant left the organisation and short-term temporary cover was provided by a locum consultant, pending the recruitment of a permanent replacement. This had caused some concern among staff regarding the resilience of this arrangement and the support available to more junior medical staff. A long-term locum was subsequently employed on a fixed term contract until February 2019. The locum worked four days a week, rather than five worked by the permanent consultant. In the absence of a consultant, two rotational GP trainees could access telephone advice from a neighbouring hospice or the local acute hospital.

Records

- We did not inspect this heading as part of this inspection.

Medicines

- We spoke with two pharmacists from the local clinical commissioning group who supported the inpatient unit for two sessions a week. They were responsible for ensuring that medicines were ordered, and stock checked appropriately. They also had oversight of the quality of prescribing.
- Medicines, including controlled drugs, were stored securely.
- The emergency drugs bag was checked daily to ensure that its tamper-evident seal had not been broken. Monthly checks were done by an external pharmacist to ensure all medicines were in date.

Incidents

- The service did not manage safety incidents well. Staff told us that they regularly reported incidents. However, when asked for more information on this, some could not recall the last time they reported anything. One member of staff said incidents "go up and nothing changes coming down". There was no formal mechanism to feed learning from incidents back to staff. This posed the risk that staff may not report incidents because they were not confident that they would result in change.
- There was no formal incident investigation process to ensure that learning was identified and cascaded to staff to improve patient safety. When an incident was reported it was added to a log book, which was then reviewed by the clinical lead for the inpatient unit. If they identified that learning could be gained, they produced a report. However, this reporting process was informal and ad hoc and not supported by an incident reporting policy.
- We reviewed two papers on 'accident and incident trends' reported to the patient services committee in April 2018 and July 2018. Between 1 April and 30 June 2018 there had been 32 reported incidents. Of these, 17 were related to medicines management, and seven were related to slips, trips or falls. It was reported to the patient services committee that the risks associated with these incidents were "potentially of litigation and/or prosecution if health and safety isn't managed properly". There was no identification of the impact on patient safety and patient experience or any preventative actions taken to lessen the risk of further incidents.

Safety Thermometer (or equivalent)

- We did not inspect this heading as part of this inspection.

Are long term conditions effective?
(for example, treatment is effective)

We did not rate this key question.

Evidence-based care and treatment

- We did not inspect this heading as part of this inspection.

Nutrition and hydration

- We did not inspect this heading as part of this inspection.

Pain relief

- We did not inspect this heading as part of this inspection.

Patient outcomes

- We did not inspect this heading as part of this inspection.

Competent staff

- Not all staff had received competency training to sufficiently prepare them for their role. During our last inspection the provider was unable to provide evidence to demonstrate that all staff had received role-specific competency training to equip them to perform their role safely and effectively. During this inspection we found the provider had made limited progress in response to our previous concerns. This was to some extent compounded by the recent absence of the training facilitator. Although some competency training had been provided, the scope of the training was limited. Training was ongoing but there remained significant gaps in staff competence.
- We reviewed the organisation's 'Training and Development Policy and Procedure', approved by the senior leadership team on 12 June 2018. It contained a list of competencies and recommended timescales for refresher training for medical and nursing staff. However, it did not contain information on competencies for healthcare assistants, allied healthcare professionals, volunteers, or other patient-facing staff. Senior staff told us that the list produced was not based on evidence-based-practice or based on what other hospices or hospitals provided to staff working in end of life care. They told us it was based on the "best guess" of the nursing staff on the inpatient unit. There was no specific training in palliative care identified. We had been informed the education department provided this but were told this was not the case.
- We spoke with the education team of Prospect Hospice regarding this and found that they had no input into the development or approval of this policy before it was implemented.
- The policy identified that there were 15 competency modules for permanent nursing staff, including medicines administration, syringe driver training and catheterisation. However, the most up to date training matrix for the service at the time of our inspection identified that, on average, nursing staff had only completed eight modules. No staff had received training in tracheostomy care, enteral care, insertion of nasogastric tubes, 'safe swallow' assessments or cannulation, even though staff cared for patients with some of these requirements.
- The policy identified that there were four competency modules for bank nursing staff. These were medicines administration, syringe driver training, intravenous medicines training, and female catheterisation. The most up to date training matrix for the service at the time of our inspection identified that no staff had completed all four competencies required of them. One member of staff had no identified competencies completed, one had only intravenous medicines training in date. Of the nine bank staff only two had up to date training in female catheterisation.
- There were 19 healthcare assistants employed on the inpatient unit. Of these, 11 had expired healthcare assistant competency training. However, the risk register identified that additional training had been booked for the summer of 2018. We asked staff what constituted competency training for healthcare assistants and we were told "we don't know".

Multidisciplinary working

- We did not inspect this heading as part of this inspection.

Seven-day services

- We did not inspect this heading as part of this inspection.

Health promotion

- We did not inspect this heading as part of this inspection.

Consent and Mental Capacity Act

- We did not inspect this heading as part of this inspection.

Are long term conditions caring?

We did not ask this question as part of our inspection.

Compassionate care

- We did not inspect this heading as part of this inspection.

Emotional support

- We did not inspect this heading as part of this inspection.

Understanding and involvement of patients and those close to them

- We did not inspect this heading as part of this inspection.

Are long term conditions responsive to people's needs?
(for example, to feedback?)

We did not rate this key question.

Service delivery to meet the needs of local people

- The provider had planned to have 15 beds available, however staffing levels had a negative impact on their ability to provide a service to this level and therefore the number of beds had been reduced. This had in turn had an impact on the local populations choice. The provider was not behaving in a responsive way to manage the provision of the service to the local population. Between February 2018 and July 2018, 145 patients were put on the pending list. Of these, 114 patients were admitted. However, six patients waited over 11 days, one waited 10 days, one waited nine days and four patients waited seven days before admission. The remaining patients were either admitted on the same day or waited up to six days.
- Of these patients, 31 were removed from the waiting list. Two patients had been waiting over 11 days before being removed, one had been waiting nine days before being removed and one had been waiting six days before being removed. The remaining patients were removed on the same day as being added to the pending list or up to five days of being on the waiting list.
- Of the 31 patients removed from the pending list, six had been removed because they had died while on the waiting list for a bed at the hospice. The reason for these six patients not being admitted to the hospice was because of a lack of sufficient staff to keep them safe.

Meeting people's individual needs

- We did not inspect this heading as part of this inspection.

Access and flow

- We did not inspect this heading as part of this inspection.

Learning from complaints and concerns

- We did not inspect this heading as part of this inspection.

Are long term conditions well-led?

We did not rate this key question.

Leadership

- Leaders did not have the skills to lead effectively. Senior staff on the inpatient unit did not have adequate support to lead effectively.
- The inpatient unit was led by a band 7 nurse, the clinical lead. They told us they had attended a leadership course but that this did not fully prepare them for the role. They were supported by team leaders, who had not received any specific training for this role.
- The clinical lead previously reported to a head of patient services, but this position had been vacant for four months. This role, in turn, reported to the director of patient services; however, this post holder had been absent for two months. In the short term, the clinical lead had been offered mentor ('buddy') support from the director of resources but in the absence of senior clinical leadership, they told us they felt vulnerable. They told us they worked more than 50 hours per week and they were exhausted. We were concerned about their resilience and well-being.
- At the time of our inspection a senior nurse had recently been seconded from the clinical commissioning group to support the hospice, and the inpatient unit. They worked three days a week and we were told they would be employed for a period of approximately six months. At the time of our inspection, there was a lack of clarity about line management for the clinical lead upon this appointment.
- The clinical lead was well respected by staff on the inpatient unit, who told us she was visible and supportive.
- Staff told us that the chief executive and the trustees had visited the inpatient unit on several occasions following CQC's last visit but, except for the director of resources, the senior leadership team (SLT) were not

regular or frequent visitors to the unit. Many staff we spoke with referred to the fact that members of the SLT frequently worked from home; they felt the clinical lead was unsupported and bore too much responsibility.

- One member of staff told us there was a "total lack of support from the senior leadership team" and "they are letting us down".
- Following our inspection on 14 and 15 August the chief executive spent some time working from home. This meant that the clinical lead for the inpatient unit and the other clinical leads had no direction or support to facilitate changes during the temporary bed closure. One member of staff we spoke with said they were in a "state of disbelief" as to how the senior leadership team had put all responsibility for managing this change on the clinical leads.
- The chief executive told us that the decision to temporarily close beds was made to allow managers the capacity to get assurance on safety and quality. However, this had not been communicated effectively to staff, who were confused as to the reasons behind the closure of the beds. The clinical leads were only given the opportunity to discuss this with the chief executive 10 minutes before it was due to be announced to the unit's staff.
- Furthermore, the chief executive had not made the decision with the rest of the senior leadership team, trustees of the charity or external partners. Trustees were informed of the decision by email on the morning it was announced to staff. There was no forum for the trustees to share concerns or to discuss the impact this would have on the service. The chief executive discussed with CQC how she planned to use this time to "put things right" on the inpatient unit.

External stakeholders such as the local acute trust, and the clinical commissioning group were only informed of the decision once it had been announced to the inpatient unit staff. This meant they had no time to prepare their own services or manage risks that the bed closures would present. A decision was made by the chief executive not to inform care homes or GP's of the closure.

- The chief executive held a meeting with all staff on the inpatient unit on 15 August to inform them of the temporary bed closure. We asked them how the staff reacted to the news; she told us that she "almost saw excitement on their faces". However, when we spoke with the staff immediately after the meeting, we found they were "devastated" and upset regarding the decision. Some staff left the unit and went home because they were so distressed.
- In the absence of a head of patient services and a patient services director, the senior leadership team had developed a 'buddy' system so that senior staff could seek advice and support from a member of the SLT. Senior staff were appreciative of the moral support provided by the director of resources but the pairing of the consultant with the director of income generation, they said, "felt inappropriate".
- We were told by the senior leadership team that the trustees had a programme of visits to different parts of the organisation, including the inpatient unit. Between February and August 2018 there had been one visit by two of the trustees. They produced a provider visit report, identifying what they saw and who they spoke with. There were some concerns identified but there was no associated action plan or follow up of these concerns.
- When we asked trustees about the process for follow-up, they told us they thought there was a mechanism for this but were unsure and could not provide any examples of any actions taken following their visits. Staff on the inpatient unit confirmed to us that they received no feedback following the last trustee visit.
- Trustees were not fully involved and did not provide adequate challenge or hold the senior leadership team to account. They were content with the progress reports provided to them in relation the warning notice improvement plan. One trustee told us "we are totally assured across the totality of the plan" but could not provide any details as to how they were assured. They expressed disappointment when we fed back our early findings, which demonstrated significant gaps in assurance. We attended a board of trustees' meeting on 9 August. Agenda items for discussion included the risk register and the warning notice improvement plan. The trustees did not provide any challenge regarding the content or progress of either papers and did not ask for evidence regarding assurance around the measures in place. Discussions focussed on reputational risk and the management of media. One trustee told us, referring to the improvement plan "I had better read this".

- The chief executive told us they did not feel supported by the trustees in terms of her own performance and learning needs.

Vision and strategy

- We did not inspect this heading as part of this inspection.

Culture

- Managers did not promote a positive culture that supported and valued staff. Staff on the inpatient unit continued to feel unsupported by the senior management team and the trustees. Staff morale was mixed; some staff felt their working environment had improved but instability in the management team had caused staff to feel unsettled and anxious about the future.
- During the last inspection we found that action was not taken in a timely way to address behaviours and performance that was inconsistent with the values of the organisation. We found that staff complaints and grievances had not been investigated in a timely way. During this inspection we found that the grievances that where ongoing during the time of the last inspection had been fully investigated as far as they could be, considering the long-term absence of a key individual. However, there were two long-standing grievances ongoing at the time of our inspection. In one case it had taken a month to arrange an initial meeting with the grievant following submission of the complaint. Both grievances related to bullying behaviour and involved members of the senior leadership team.

Governance

- The service did not have effective governance systems to monitor safety, quality and sustainability.
- There was a lack of up to date policies, systems and checks to provide assurance of safety, as our findings, reported under safe, earlier in this report, demonstrate. There was a lack of managerial oversight of the risks to quality and safety and a lack of scrutiny and challenge at the top of the organisation.
- The chief executive was unable to demonstrate how they gained assurance on quality or risks. They acknowledged during our inspection that they had failed to adequately scrutinise the improvement plan or provide adequate challenge around the evidence to support it. We found numerous examples where the improvement plan provided false assurance around progress. For example, the improvement plan stated that there would be daily escalation of safety and staffing concerns to the registered manager to gain oversight of staffing issues. However, there was no evidence to support that this had been happening. The action plan stated that shift coordinator competencies and training for staff in incident management had been rolled out, but we found that this had not happened.
- The action plan stated that 100% of staff on the inpatient unit completed a performance appraisal, when in fact only 17% had been completed at the time of our inspection. The action plan also stated that there would be monthly reports to the registered manager on compliance with training but there was no evidence to support this was happening.
- Some actions, such as the use of a checklist for agency staff had been introduced in response to or concerns but there were no systems to ensure ongoing compliance with new systems.

Managing risks, issues and performance

- The service did not have effective systems for identifying and managing risks. The chief executive recognised that there was a culture of under-reporting of incidents but had taken no action to address this. They acknowledged patient falls were a common theme of incidents that were reported, but there were no actions to address this. We asked if there was a falls group within the service and the chief executive did not know. Therefore, we were not assured that there was sufficient oversight of risks in the organisation, such as falls, had sufficient oversight in the organisation.
- We reviewed both the corporate risk register and the risk register for patient services. They contained insufficient detail to provide assurance that risks were properly assessed and graded, according to current information. We were concerned that risks did not align with what staff told us was in their 'worry list'.
- At the time of our inspection there were three risks which had either an increase or a decrease in risk status, despite no new actions being identified. For example, one risk regarding loss of income due to negative media attention had been upgraded from a low risk (graded a six) to a high risk (graded 12) with the only comment being 'update 16/07/18 – No new update'. This omission had been identified by the trustees in the board meeting on 9 August, but no reason was provided for this

change. Another example was a risk about a loss on income due to a loss of referrals, which had been downgraded from a medium risk (graded as nine) to a low risk (graded as six), with no new information provided.

- On the corporate risk register there were items which had limited action but no explanation as to why risks had increased. For example, a risk around medical staffing on the inpatient unit had been upgraded from a low risk (graded as three) to a medium risk (graded as nine) because they had 'successfully recruited locum consultant'. Another example was regarding reputation and financial risks associated with the General Data Protection Act (GDPR). This had been upgraded from a low risk (graded as four) to a medium risk (graded as eight) because of 'recent negative media publicity', which did not appear to be a valid or relevant explanation.
- We asked both the chief executive and the trustees for their views on the risks associated with gaps in the senior management team (vacant head of patient services position and absence of director of patient services) and the resilience of the clinical lead for the inpatient unit, without their support. Both the chief executive and the trustees acknowledged this represented a significant risk to the organisation, but it was not identified on the risk register and there were no contingency plans or mitigating actions identified.

Managing information

- We did not inspect this heading as part of this inspection.

Engagement

- The service was taking steps to improve staff engagement. In response to our previous concerns about staff morale and dissatisfaction with management, the service commissioned a staff survey on the inpatient unit. The results were analysed and reported on by an external consultant, and the chief executive shared the report with staff. In her covering letter in April 2018, she acknowledged staff concerns and pledged to make improvements. She also invited staff to raise any further concerns.
- In July 2018 the organisation set up a feedback box for staff to use to raise concerns and ideas in the inpatient unit. This was publicised in a weekly newsletter called Snippets. However, we found that this had not been used effectively. Although some staff knew about the box, they thought it was for patient feedback rather than their own feedback about the service.
- The service had set up a staff forum meeting, which was held every three months. This gave staff an opportunity to express concerns and have an input into the senior leadership team. These were attended by a mix of staff from the inpatient unit, community services, voluntary serves and support services.

Learning, continuous improvement and innovation

- We did not inspect this heading as part of this inspection.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance There were not effective governance processes to provide assurance that patients on the inpatient unit received safe and high quality care and treatment.