

Sandwell and West Birmingham Hospitals NHS Trust

Bradbury Day Hospice

Inspection report

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Website: www.swbh.nhs.uk

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Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Requires Improvement ●
Is the service well-led?	Good ●

Summary of findings

Overall summary

This inspection took place on 25 April 2016 and was unannounced.

Bradbury Day Hospice offers day care to people who have an advanced progressive, life limiting illness. The aim of the service is to support people with their physical needs such as symptom and pain management, and provide social and psychological support. The service is provided by Sandwell and West Birmingham Hospitals NHS Trust.

Bradbury Day Hospice is run by a palliative care nurse specialist, (nurse manager) who oversees the daily management of the service on behalf of the provider. The hospice operates Monday to Friday 8.30am to 3.30pm, and is closed on Thursdays. The day hospice can accommodate up to twelve people daily who attend one day a week for a twelve session programme. People are then signposted to other services within the community.

People looked forward to attending the day hospice but described the range of activities as limited. The attendance rate was frequently low and people said this limited their opportunities to fully enjoy the social aspects. The availability of complementary therapeutic therapies such as relaxation or massage was also limited. The provider recognised this as an aspect of the service that needed to improve and this was part of their improvement plan to re-design the day hospice provision so that people had access to the types of support that would aid their well-being.

People had not always received a consistent service because of short notice closures of the day hospice. The nurse manager had taken effective action to ensure staffing levels were consistently reviewed to ensure people's safety.

People were supported by staff who had been trained to recognise signs of abuse and how to report this. People told us they felt safe in the company of staff. Risks to people's safety had been assessed and included the action staff should take to reduce identified risks.

People brought their own medicines with them to the day hospice service and there were arrangements in place to make sure they could be stored and administered safely.

New staff received a thorough induction and regular training to make sure they had the knowledge and skills to deliver quality care. Staff told us they felt supported and had regular opportunities to discuss their care practices.

People were happy that their consent was always sought before care or treatment was provided and that they had been involved in decisions about their care and treatment. People were supported to share their choices around their end of life care and preferred place of dying. Family members told us the hospice at home service provided them and their relatives with the opportunity to realise their wish to receive their end

of life care at home.

People spoke in very positive terms about the quality of meals they had when at the day hospice. They were supported with their nutritional and health needs and had access to specialist nurses to support them with their symptom and pain management.

Staff had developed caring relationships with people using the service. People told us staff listened to them, and were caring and friendly. Staff treated people respectfully and promoted their dignity.

People knew how to raise concerns and were confident they would be listened to. There were opportunities for people who used the service, their relatives and other professionals to provide feedback.

The provider had benchmarked the day hospice service against local hospice community services and had a plan to develop their provision. The day hospice was in a transitional phase of redevelopment. The provider and senior managers had a clear vision for the future and demonstrated a commitment to providing people and those closest to them with a safe, quality and caring service within which they had access to the specialist care and support they needed. There was a range of auditing and monitoring systems which were shared with senior managers so they were able to look at the quality of care, clinical effectiveness and people's experiences. They also monitored how end of life care was delivered to people to ensure they performed in line with the national End of Life Care Strategy.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good 

The service was safe.

Staff had been trained to recognise and respond to any actual or potential abuse.

Potential risks to people and staff had been assessed and where required preventative measures were put in place.

People were supported by staff who had the specialist skills to meet their needs. The provider had taken action to ensure staffing levels were safe.

People maintained responsibility for their own medicines and secure storage was available.

Is the service effective?

Good 

The service was effective.

People were supported by staff who understood their needs and had the specialist knowledge and skills required to meet people's needs.

People's nutritional and hydration needs were assessed and monitored to ensure they received appropriate support to eat and drink well.

People were supported to make their own decisions and had choices about their care and treatment and their consent was sought by staff.

Specialist healthcare support was available at the day hospice so that people had access to symptom and pain management support.

Is the service caring?

Good 

The service was caring.

People were supported in a caring way with dignity, respect and kindness.

People were supported to have choice and to be involved in all aspects of their care and treatment.

Staff supported the emotional wellbeing of people and their relatives with end of life care being provided with sensitivity.

Is the service responsive?

The service was not always responsive.

People enjoyed the social aspect of the day hospice but there was a lack of opportunity to engage in activities with therapeutic benefits. There was not always enough staff available to respond to people's needs and this had led to closures of the day hospice at short notice.

People received personalised care which was responsive to their changing needs.

People were actively involved in devising their own advance care plans which described the care and support needed.

People knew how to raise concerns and complaints.

Requires Improvement ●

Is the service well-led?

The service was well-led.

There were opportunities for people who used the service and their relatives to comment on and influence the quality of the service provided.

There was an effective quality assurance system to monitor the service. The management team were committed to continually improve services and ensure they reflected the needs of the local community.

The provider and management teams had worked effectively to develop a clear strategy for the long term development of the service.

The provider worked with other healthcare professionals to implement the strategy for palliative and end of life care to promote care within the community.

Good ●

Bradbury Day Hospice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 25 April 2016 and was unannounced.

The inspection was carried out by one inspector, a member of the CQC pharmacy team and a specialist professional advisor. The specialist advisor had experience working as a palliative care nurse within the community.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made the judgements in this report.

We checked the information we held about the service and the provider including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

We spoke with two people at the day hospice. We spoke with the nurse manager, one clinical nurse specialist, a health care assistant and the cook. We viewed six people's records to see how their support was provided and recorded. We looked at a selection of medication records to check medicines were managed safely. We also looked at the quality assurance, clinical audits and staff training records. We reviewed information about the quality of the service people received from the provider's compliments and surveys. Following our inspection we spoke with three people by telephone who attended the day hospice and two relatives.

Is the service safe?

Our findings

People told us that they felt safe when being cared for by staff. One person using the service told us, "My goodness yes indeed I feel very safe here". Another person said, "I feel quite secure here; the staff give me a lot of reassurance; especially when they provide personal care which I can't do at home".

Staff were aware of their responsibilities in keeping people safe and understood how to recognise signs and symptoms of abuse or harm and how to escalate concerns to senior managers. Staff told us they had been provided with guidance and training so they understood their role in keeping people safe from harm or abuse. One staff member said, "If I had any concerns about people's safety I would talk to the person first and then the nurse manager". There had been no reported incidents regarding people's safety at the service.

Staff were aware of the procedures for reporting any incidents and they were encouraged to access incident-reporting systems. They told us any serious incidents would be discussed at weekly team meetings. The outcomes from these were shared with them so that any lessons learned could be shared appropriately.

We saw that risk assessments for the environment and equipment used were in place and that action had been taken to reduce risks. For example the previous ambulance used to collect and drop people to and from the hospice was unreliable and prone to break down. This had been escalated to management and staff told us a different vehicle was now used. Maintenance and servicing of equipment such as fire systems, boilers and the buildings was evident. Audits were undertaken to make sure all equipment such as hoists were checked and serviced as required. Staff understood their role in managing emergencies such as fire safety and fire training had been provided. Fire safety equipment had been serviced and was regularly checked.

People told us that staff were aware of any risks to their safety. One person said, "When I first came here they asked all the right questions about what help I need, when I come here now they know I need pressure relief and that I am a bit unsteady on my feet". We saw staff assisted this person with their mobility and provided them with appropriate pressure relief equipment. A staff member told us, "We have information about people's health and any risks to their safety, sometimes this is already completed if the person has community nurse contact before coming to us". Staff said that if a person failed to attend the day hospice or their condition deteriorated the clinical nurse specialist (CNS) would visit the person at home. This ensured risks to people's deteriorating health were assessed and acted upon.

The provider information return (PIR) told us that people attending the day hospice had an individual assessment by a qualified nurse on their first attendance. This included their physical, psychological and emotional needs. People also had a falls assessment and a nutritional and hydration assessment carried out. We saw the information in the PIR was an accurate assessment of how staff managed these risks. Care plans identified risks and the support people needed to meet their needs. Although staff were not primarily responsible for assessing potential risks to people in their own home, when people attended the day hospice staff followed any risk assessments to mitigate risk. For example where people required pressure relieving equipment to support their skin at home this was provided in the day hospice. People attending

the day hospice told us if they had any additional concerns or their needs had changed they could discuss this with hospice staff. Staff told us they promoted people's safety by checking with each person on their visit to the hospice if the person's condition had changed. People's care and safety was discussed daily so that staff were informed of people's needs before they arrived. Information sharing and risks were also shared at weekly meetings to improve the outcome of people's care.

People told us they had at times not been able to attend the day hospice due to low staffing levels. One person said, "I am supposed to attend one day a week, but the first two weeks were cancelled. They phoned me each week to tell me there was not enough staff or not enough people attending to stay open, but even so it was disappointing".

The hospice was staffed by a nurse and health care assistant; we were told this was the usual staffing level. The nurse manager had rectified previous staffing concerns which had resulted from escorting people to and from the day hospice. This had left one staff alone for a number of hours. A nurse from the hospice at home community nursing team provided cover to the day care hospice when day care staff were escorting people, this ensured safe staffing levels were in place. People had access to palliative care nurses at the hospice who assisted them with their medical care needs.

Staff told us there had been occasions when sickness or holiday cover could not be provided and the hospice had to close. We saw that the number of people attending the hospice on a daily basis was very low; two people were attending on the day of our inspection visit and each day attendance generally rose to five or six people. The provider told us in their PIR that they were redesigning day hospice services and that additional staffing was planned so that people would have access to therapy services as well as specialist palliative care nurses. We found that the provider had reviewed the staffing situation and taken action to cancel the service where they had considered staffing levels could not safely meet the needs of people.

The provider had safe arrangements in place to recruit and appoint staff who would be suitable to work with people. A staff member said, "I had a police check, produced references and I completed a medical disclaimer". Volunteers had their recruitment checks carried out by their provider to ensure their suitability to support people using the service.

We talked with people at the day hospice about their medicines. One person told us, "I bring in my regular medication and take it myself". Staff told us no medicines were stored at the service, however if people brought their own medicine supply with them then they would be stored securely in locked cupboards. There were four nurse prescribers within the community specialist team that supported the day hospice and in addition two palliative medicine consultants were available. Clinical pharmacy support was provided by pharmacy at Sandwell and West Birmingham Hospitals. The Nurse Prescribers undertook mandatory training in medicine management twice a year. We were also told that the Nurse Prescribing team met every two months to discuss issues including any updates on medicines. Medicine incidents were reported with arrangements in place to ensure they were investigated. We were told about one incident which had led to a change in practice to ensure it did not happen again. The learning from these incidents helped to improve medicines safety and therefore people safety. We found that advice and any discussions with people about their medicines were recorded including reasons for the prescribed medicine being given.

Is the service effective?

Our findings

People told us they were very happy with the care they received from staff. One person told us, "The staff are very good; they know what they are doing". Another person said, "I've been able to talk to staff nurses as well as care staff about my condition and I think they are knowledgeable".

Staff told us they had undertaken various training courses which equipped them with the skills needed to meet people's needs. Competencies were checked to ensure they had the skills and knowledge to carry out various tasks. One staff member told us this included values; how they promoted people's dignity and demonstrated compassion. The nurse manager confirmed that observations of staff skills were a part of this process to ensure staff had the competencies to meet people's needs.

Staff described their support as 'excellent'. One staff member said, "I feel very well supported; I have regular supervision and can access the nurse manager when I need to". Another staff member told us, "There has been some changes which has reduced the pressure on us; we have daily meetings so caseloads, delegation and team working is clearer and more effective in meeting people's needs". Staff had an annual appraisal which provided an opportunity to reflect on their practice and to plan objectives to further develop their skills.

People we spoke with had no concerns about the ability of staff to meet their needs. One person said, "I've been able to talk to them to get information and advice, they know how to help me and if there's something up health wise the nurse here will sort it out". People told us staff were attentive to their health needs. People were supported with their health needs by nurses who were trained and experienced in palliative and end of life care. We saw and heard if staff recognised changes in a person's health since their last attendance at the hospice this information was shared with community professionals. The nurse manager told us that the McMillan therapy team had joined them in a move to create a more seamless service. McMillan staff attended the weekly MDT and had access. They said that they were up to date with essential training and training in end of life care. Staff had attended conferences to share learning from external colleagues. We saw the palliative care team (including the day hospice staff) met monthly at their quality improvement session in which they discussed a variety of subjects to further enhance their own knowledge. Trust wide issues were also communicated and addressed ensuring important information was cascaded to staff. Staff told us that there were weekly palliative care multi-disciplinary team meetings, (MDT) a group of people who have responsibility for providing specialist areas of support within the service. This meeting enabled staff to discuss and plan medical interventions for people with complex needs so that the best approach was utilised to improve care for each person. This also provided opportunities for staff to develop their skills and understanding about the best outcomes for people receiving end of life care.

Staff told us they were able to access various websites and received electronic updates re medications and other updates. The nurse prescribers worked with Sandwell Acute Trust and had protected training days to refresh their skills in medicine prescribing, this ensured people had access to pain relief without delay. Staff had training in Advanced Communication. This provided staff with guidance and knowledge on how to listen and respond to people who may have to make difficult decisions about their treatment and care. One

person told us, "yes I had a conversation about my wishes; I know I am terminal; the staff member was very professional". People we spoke with told us the approach of staff during difficult times was professional and caring.

Staff told us they had a detailed induction which included the opportunity to shadow established staff. We heard from staff that their access to the electronic patient records. We were told that a project was underway to look at the role of the occupational therapist in the day hospice so that therapists could take an active part in providing relaxation and advice regarding equipment that might benefit people.

Staff told us there was an effective communication system in place to ensure people received care when their needs changed suddenly, for example where additional pain management was needed. Staff said usually this was assessed at the day hospice but if the person had returned home out of hours support from the community CNS could be provided via a visit to the person in their own home. Updates from other health care professionals involved in people's care were entered on to each person's records on the computer to ensure people's care was reflective of any changes in their health and well-being.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. For people living in their own home, this would be authorised via an application to the Court of Protection.

We checked whether the service was working within the principles of the MCA and discussions with staff showed that they were aware of the principles. We were advised that whilst staff may be involved in any best interest decisions, other agencies that were the primary lead in people's care would be responsible for making any applications. There were no Deprivation of Liberty Safeguards (DoLS) or authorisations by the Court of Protection in place for people who used the service. An alert system on the electronic records informed staff if a person was deprived of their liberty.

People were supported to make their own decisions and consent was sought when staff provided any care, treatment or support. When people attended the day hospice staff reviewed with them any decisions in relation to their resuscitation known as Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR). We saw documentation for DNACPR were in place where people had chosen this. We heard from staff that where people had been recently discharged from hospital care and attended the day hospice or received community support, their DNACPR status was discussed daily. This was to ensure that these were up to date. Staff told us they would liaise with the person's GP as they had responsibility for signing these. One person told us, "I don't have a DNACPR in place but they did talk to me about it". The nurse manager had a system in place to check this documentation on a regular basis. This ensured DNACPR's were properly maintained; signed by a doctor, completed in full and made in the person's knowledge and agreement.

Health care providers referred people to the day hospice providing an initial overview as to the person's needs. Staff told us that as part of the initial assessment all new people attending the day hospice had a nutritional and hydration assessment and care plan if required. The provider told us in their PIR that staff adhered to the Trust wide Nutrition and Hydration policy. Staff we spoke with told us they had not had any specific training around nutrition and hydration but that if they had any concerns they would refer people to a dietician. We saw people at the day hospice were offered a choice of a three course cooked meal with drinks and snacks during the day. People told us they enjoyed the meals provided. Drinks were readily available throughout the day. Assessments of people's nutrition and hydration needs included a visual

inspection to assess oral hygiene or possible infection. Staff were able to provide advice to people regarding mouth care and fluid intake to avoid dehydration. People we spoke with had no concerns about their dietary needs and told us they managed these independently in their own homes.

Referrals to the day hospice were made by health care professionals who staff liaised with to ensure that the service was able to work collaboratively to provide the best care. This promoted a joined up approach to care in order to provide on-going health care support. For some people this had included support from community nurses and district nurses in their own homes before attending the day hospice. Nurses told us this enabled them to support people with symptom and pain management to avoid unnecessary discomfort or suffering. We saw an example of this where a person attending the day hospice talked about 'break through' pain. The nurse manager told us that the clinical nurse specialists (CNS) would assess and discuss this with the person and liaise with health care professionals to ensure the person had the necessary support. This meant staff had the skills needed to manage people's symptoms. Nurses at the day hospice shared their knowledge with the wider community palliative care team for the benefit of people who attended the day hospice. We saw this worked effectively as nurses were competent in monitoring people's health conditions when attending the day hospice. For example a person told us the nurse had contacted their consultant with regard to follow up tests and changing symptoms.

Is the service caring?

Our findings

People spoke positively about the caring attitude of staff. One person told us, "I do get lonely and here I have somebody to talk to, the staff are really nice and friendly". Another person told us, "They are very friendly, even the driver is a friendly and helpful chap; he checks my seatbelt every time".

People told us that they knew the staff who cared for them as the healthcare assistant worked permanently in the day hospice. This provided some degree of consistency and familiarity for people which they said they appreciated. We saw people used first name terms with staff, one person said, "I do get stressed and the staff here are really good at supporting me; listening to me and giving advice, they are very kind". Another person said, "Staff are 110% caring and lovely".

We saw people who had used the day hospice and their relatives had provided positive feedback on their experiences. The care and compassion demonstrated by staff was a consistent theme in people's comments. One person quoted, "Thank you for the fun and caring times at the hospice, it lightened up [name of person's] day and gave me the support I needed". A family commented, "I really do not know where dad and I would be without your support, and now he has passed I wanted to say how thankful we both were at the time and still now".

We saw that people had been collected from their homes in the hospital transport with an escort from the day hospice staff. On their arrival we saw people were relaxed and happily chatting to staff. People were assisted to be comfortable and offered refreshments whilst they settled in. Other staff greeted people and made them welcome. One person said, "They are great; always friendly and helpful and we enjoy the journey in with them".

People told us because staff understood their needs and knew about their likes and dislikes they felt valued by staff. One person told us, "Last week staff said to me don't forget to bring your reading glasses; so I did this week". We saw that staff were attentive to people and took the time to talk to them about their condition and how they were managing at home, this was conducted in a friendly and unobtrusive manner and we saw people responded to the opportunity to discuss their anxieties. We saw staff assist people to be seated comfortably. Staff supported people to relax for example by reading newspapers, doing quizzes or watching T.V.

People told us they had discussed and planned their care. This had included their symptoms and pain management as well as the practicalities of living with their condition. One person said they were informed and aware of how the team were trying to treat their pain and said, "I have been fully involved about my condition and I have made decisions about my care, including my end of life and my preferences of where I wish to die". Another person said, "I am kept informed about my illness and what to expect". Staff showed compassion and concern for people. One staff member told us, "If someone doesn't attend the hospice as planned we would enquire about that person's well-being". We saw on the day that staff checked with a person by phone to ensure they were safe and well. We heard from staff that they had visited people at home if for any reason they could not attend. Staff told us they would share any concerns with the clinical

nurse specialist. A home visit could be undertaken where people who attended the day hospice needed support with their symptom and pain management outside of the hospice opening times.

Volunteers supported people within the day hospice with for example chair based exercise programmes. The nurse manager told us they recognised the availability of volunteers was limited usually to one day a week. They were hoping to extend the availability of and role of volunteers with a particular focus on inclusion. They were actively looking at ways to encourage people from different ethnic and religious beliefs to access the service. They had identified volunteers as a positive way to visit people and encourage them into the day hospice. People told us that if they needed spiritual or religious support they could access this via speaking to staff. People and their family members could access bereavement and spiritual support by staff signposting them to resources. Guidance was available for people about support services which provided people with life limiting illness with bereavement, spiritual, advocacy and counselling help. Staff told us that following a death they contacted relatives and offered to signpost them to bereavement counselling.

We saw that staff promoted people's privacy, independence and dignity whilst providing personal care. They asked people what aspects they wanted help with so that people maintained their independence. A person told us that staff always made sure they were covered up to respect their dignity. People told us that if they used the facilities to have support with a bath and hair wash; they were encouraged to bring in their own toiletries. A person said, "I really enjoy a bubble bath and the staff will get it all ready and then leave me to relax".

People and their family and relatives had been encouraged to visit the day hospice before they decided to attend. We heard from people this enabled them to see what was on offer and talk to staff and other people. One person told us, "It's a personal touch and takes away the anxiety, you know then what to expect".

People had access to information about the day hospice before they decided to attend. One person told us, "They came out to my house to talk about the day hospice, explained what they did and what was on offer, they also gave me leaflets with information, I was well informed before I came". People had access to information about the services provided by the day hospice which was made available to them when they commenced the service. This included specialist advice, support and information on medical conditions, referral to other services, and help with medication. People told us that staff provided them with information and explanations at the time they needed this. Staff were able to explain how they involved the person and their family in decisions about how they wished their end of life care to be provided.

Is the service responsive?

Our findings

People told us that staff asked them what they enjoyed doing and tried to provide this when they were at the day hospice. People said they enjoyed quizzes, reading the newspapers, crosswords and talking to people. Although people were not critical of the support they received they did express disappointment at the lack of a variety of activities. One person said, "It's alright, better than being alone at home, but the staff company is wonderful". Another person said, "There's not a lot to do, it can be quiet but the staff do their best and always ask us what we want to do". We saw people enjoyed a quiz and interacted with staff. Staff told us they were sometimes limited in what they could offer people because there was no formal programme of activities and a limited supply of volunteers to support these.

The aim of the service was to provide people with a twelve week programme during which people had nursing support for the management of their pain or symptoms. Whilst at the hospice people had access to palliative care nurse specialists and palliative medicine consultants. The hospice aimed to provide therapies to people including occupational therapy, physiotherapy and complimentary therapy but these services were intermittent and only available at limited times by visiting professionals. Likewise chair based exercises were provided on alternate weeks. Some diversion therapies in the form of group activities, quizzes and bingo were evident. Therapeutic support was limited. Complementary therapy for people with cancer and other types of life limiting illnesses can support symptoms or side effects or help people to feel better emotionally. Massage can alleviate many symptoms in people with long term conditions. The nurse manager told us that they recognised the need to enhance the day hospice service. The leadership team recognised that the service did not provide a full programme of services in line with the Gold Standards Framework, (A set of recognised standards to meet the holistic needs of people with a life limiting illness). They were doing all they could to respond to benefit the people who used the service. The provider was redesigning the day hospice services provided to people, in the interim sessional occupational therapy and physiotherapy was pre-planned so that people could benefit from this. Access to a hand therapy session provided by the complimentary therapist was arranged.

Staff told us the occupational therapists were reviewing the provision of relaxation/breathing sessions as there were two rooms available that could be used for this purpose. The nurse manager told us a Fatigue and Breathlessness (FAB) clinic had been provided by an external physiotherapist although this was only available for limited dates. We saw people who had attended these sessions had described positive impacts for them in managing their breathlessness. One person said, "I found the group very beneficial, especially understanding my condition a lot more. I made use of the breathing and relaxation methods very often". Another person said, "The breathing exercises and relaxation exercises I do use at home and found the videos that were shown helped me to understand my problem better". One person we spoke with told us, "I haven't had any complementary therapies; anything relaxing would be nice". The facilities and space where people could enjoy privacy, time by themselves or a designated room for prayer or reflection was limited and the provider was aware this needed to be taken into account as part of their re-design.

People told us staff were responsive to their needs. One person told us, "I was initially visited at home and they told me about the day hospice and how I would benefit from additional support they could provide".

Another person told us, "At the day hospice I can have help with my pain or symptoms, see the nurse as well as practical help to manage my personal care".

We saw people attending the day hospice were comfortable and had the support they needed to undertake personal care tasks they found difficult at home. This had positive impacts for people. For example one person told us how pleased they were that staff supported them to have a bath and wash their hair, they said, "I can't do this at home because I can't get up the stairs to the bathroom".

Most people attended the day hospice on a weekly basis for one day a week and told us they looked forward to this as for most it was their only opportunity of leaving their house. People told us that they were disappointed at the low numbers of people attending the day hospice because this limited their opportunities to socialise with people. One person told us, "I expected more people, a bit disappointing. This week two of us, last week three of us, not a lot of company, but still it's a change". Staff told us they recognised the risks of social isolation and loneliness and the importance of social contact and companionship for people. People reported that at times they had been unable to attend the day hospice due to low staffing levels. One person said, "They are great staff but I have missed some days because of no staff being available". Another person said, "I've had a couple of days cancelled and considering I only come once a week that's a shame". Staff told us that staffing levels limited the people they could offer a service to. An example was provided which showed staff could not always provide a service to people who had a high level of physical needs or dementia because they did not have the staffing levels to accommodate them. This meant the service was not always responsive to people who had been identified as needing the hospice support.

People told us their needs were assessed when they arrived at the day hospice. They told us they were happy that their wishes in relation to their care were discussed and recorded. People's future care wishes included where and how people wished to receive their end of life care and treatment, such as in their own homes, a hospice or hospital. They had discussions regarding their diagnosis, prognosis and treatment options. This provided staff with the information about what action should be taken in the event of people's health conditions deteriorating. One person told us that their wishes had been discussed with regard to where they wished their end of life care to be delivered. This allowed each person to have control over their individual treatment and care options.

People we spoke with had no concerns about the day hospice and had not raised any concerns or complaints. Information about how to make a complaint was included within the information provided to people when they commenced using the day hospice. We heard from staff that there were regular opportunities for people to sit and discuss any concerns they might have. We saw a range of compliments from people which showed that they were happy with the support they received despite the lack of facilities and therapies available. One person wrote, "Thank you so much for everything you did for my mom. I am so grateful towards you and words cannot express how I feel for your help."

Is the service well-led?

Our findings

People we spoke with were consistently positive about the day hospice, the staff and the care and support they received. The only exception was the limited choice of therapeutic activities and low attendance numbers which they felt limited their social opportunities. One person told us, "I do look forward to coming here, the staff are marvellous and very helpful, and it is a nice place to be".

There was a positive culture which was inclusive and supportive to both people and staff which enabled them to provide their feedback and suggestions via surveys about the hospice services. We saw the suggestions for improvements were noted and action taken. We saw the provider had responded to people's feedback. For example people did not want to leave the day hospice after their twelve week programme was completed. The provider was setting up signposting to other services so that people had the support they needed once they had ceased attending the day hospice. The provider had sought people's feedback and the nurse manager told us information from the questionnaires was in the process of being analysed.

There was a clear management structure within the wider organisation with a board of trustees, chief executive officer and managers and support services. Staff told us their immediate nurse manager was approachable and had a regular presence at the hospice. They said that she had made changes such as introducing daily handover meetings which had enabled a better sharing of information so that staff could support people in the hospice. Staff confirmed that they had additional support from the CNS's on a rotational basis to ensure there was sufficient staffing in the day hospice to support people attending.

The manager is a palliative care nurse specialist who managed both the day hospice and hospice at home teams. She had been in post for several months and showed an open, reflective and approachable management style. The nurse manager told us that they had undertaken stakeholder events to look at other day hospices and improve their performance and review themselves against local best practice. They told us that plans were in place to develop the day hospice end of life care provision and included a palliative care coordination hub due to operate from May 2016. This would enable clinical staff (end of life facilitators) to identify the needs of people at end of life and have their wishes for preferred place of death to be documented. We were told that teaching sessions for the team had been implemented and electronic records put in place to ensure information is shared appropriately between professionals delivering end of life care. We heard an urgent response team was being recruited to which would include nurses and therapists who would provide care and support to people in their own homes over a twenty four hour period. This recognised the link between the day hospice and other services to provide end of life care provision to people who may move between the services of the day hospice and community as their condition deteriorated.

We heard from staff that they enjoyed their work and felt that they were well supported. One staff member told us, "I love working with people and doing what we can to help them, we know there needs to be improvements to the service, but what we do currently is provide good care". Staff told us teamwork was good and that they shared concerns where people at the day hospice needed additional help. For example

one staff member told us how they had referred people to their CNS colleagues where they had concerns about people's deteriorating health. The staff member told us this enabled the palliative care team to provide immediate support to people with their symptoms or pain.

Staff we spoke with were aware of the provider's whistleblowing policy and their role in reporting any concerns they had. One staff member told us, "I would report any concerns about colleague's performance".

The lack of facilities and services available to the people who attended the day hospice had resulting in a decrease in referrals to the service. Staff told us the low attendance rates and lack of therapeutic services limited what they could offer to people but that they were working hard to improve these aspects. The provider had a clear focus and vision for the development of the day hospice. They told us about their ambitions to remodel the day hospice service to provide people with a range of therapeutic activities for example offering people the opportunity to access other healthcare professionals on the day, such as the physiotherapist or occupational therapist. We saw a number of listening events had taken place and included relevant stakeholders so that future developments could be explored. There were plans to provide complementary therapies and look at new facilities so that the location of the day hospice was suited to the needs of the people it served. We heard from staff that they were kept informed about proposed changes and improvements; however they were uncertain about the future of Bradbury Day hospice.

Quality checks were undertaken to review and measure the performance of the hospice services people received. The audit checks were seen by all the management team and staff and reported to the Trust board. The Clinical Governance Group monitored the service to ensure that the aims and objectives were achieved in a range of areas; complaints management, the availability of staff to meet the needs of the service, and the outcome of questionnaires seeking the views of those it supports.

The provider was committed to benchmarking the quality of the service people received. They had researched and compared the performance of their hospice with other hospices. The information gathered showed the effectiveness of their service and the desired impact on people's care needed improvement and we saw they had plans to try and achieve this. The nurse manager told us Bradbury Day hospice was under review and part of the wider development project for end of life services across the Trust.