

Arthur Rank Hospice Charity

Alan Hudson Day Treatment Centre

Inspection report

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

Ratings

Overall rating for this location	Outstanding	
Are services safe?	Good	
Are services effective?	Good	
Are services caring?	Outstanding	
Are services responsive to people's needs?	Outstanding	
Are services well-led?	Good	

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as outstanding because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers and went above and beyond what would have been expected to meet individual needs and wishes.
- Services were delivered in a way to ensure flexibility, choice and continuity of care and were tailored to meet patients' individual needs and wishes. The service planned and provided care in a way that fully met the needs of local people and the communities served. It also worked proactively with others in the wider system and local organisations to plan care and improve services.

We found areas of good practice:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- There was a holistic approach to assessing, planning and delivering care and treatment to people who use the services. The safe use of innovative and pioneering approaches to care and how it is delivered were actively encouraged. All staff were actively engaged in activities to monitor and improve quality and outcomes. Teams were committed to working collaboratively and found innovative ways to deliver more joined-up care to people who use services.
- Leaders ran services well, led innovations and supported staff to develop their skills. Staff understood the vision and values, and how to apply them in their work. Staff were motivated to provide the best care they could for their patients. There was a common focus on improving the quality and sustainability of care and people's experiences. Staff were proud to work at the service and felt respected, supported and valued. Leaders operated effective governance processes and staff at all levels were clear about their roles and accountabilities. The service engaged well with patients, staff and the local community.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Outstanding 	Our rating of this service stayed the same. We rated it as outstanding. See the summary above for details.



Summary of findings

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Summary of this inspection

Background to Alan Hudson Day Treatment Centre

Alan Hudson Day Treatment Centre is operated by Arthur Rank Hospice Charity. The service

provides a nurse led adult day treatment centre, based in Wisbech, supporting adults who are living with a life-limiting illness and their families. The service provides day therapy, treatment and clinical sessions (including haematology and oncology work), complementary therapies, a living well service and bereavement and support service. The centre primarily serves the communities in Wisbech.

In addition, the service provides a hospice at home service to the North region of Cambridgeshire, providing day and night visits to support patients at the end of life and their families to be cared for at home. A specialist palliative care nursing service was also provided by the centre and they supported three specialist palliative care inpatient beds on an adjacent ward at the community hospital site where the service was based. At the time of the inspection there were no palliative care patients being cared for on the inpatient ward.

The service manager was the registered manager.

The service is registered with the CQC to provide:

Treatment of disease, disorder and injury

How we carried out this inspection

We visited the treatment centre and spoke with staff delivering services. We held interviews with service leads. We spoke with 15 staff including the service manager, treatment centre registered nurses, a clinical nurse specialist, hospice at home staff, the hospice at home lead nurse, the director of clinical services, a specialist palliative care consultant, the human resources director, a student nurse, a complementary therapist and receptionist. We also spoke with five patients and two relatives who had experienced support from the service. We observed care and treatment provided at the treatment centre, attended a home visit to a patient, observed a planning meeting, reviewed data about the service and reviewed eight patient care records.

We undertook this inspection as part of a random selection of services rated Good and Outstanding to test the reliability of our new monitoring approach.

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

Outstanding practice

We found the following outstanding practice:







Summary of this inspection

- Staff demonstrated the highest level of compassion. There were examples of where staff had gone the extra mile to support patients and those close to them at the end of life. This included supporting patients to manage social issues at the end of life. Treatment centre and hospice at home staff took on care coordination for patients and advocated on their behalf when dealing with complex social care issues. Feedback from patients and those close to them was consistently positive.
- Services were delivered in a way to ensure flexibility, choice and continuity of care and were tailored to meet patients' individual needs and wishes. The service planned and provided care in a way that fully met the needs of local people and the communities served. The service worked to meet the complex needs of patients living in disadvantaged situations. They worked to increase access to services for people living with homelessness and local travelling communities.
- The service manager and senior hospice leaders promoted high standards and supported staff and volunteers to develop their skills. Staff were actively involved in developing services and were highly motivated to provide high standards of care and support for patients and those close to them. The services had been developed during the COVID-19 pandemic to increase support for patients to be cared for at home at the end of their life, where this was their preferred place of death. Staff engaged well with patients and the local community to understand and prioritise people's need. They took action proactively to make improvements to services.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hospice services for adults	Good	Good	Outstanding 	Outstanding 	Good	Outstanding 
Overall	Good	Good	Outstanding 	Outstanding 	Good	Outstanding 



Hospice services for adults

Safe	Good	
Effective	Good	
Caring	Outstanding	
Responsive	Outstanding	
Well-led	Good	

Are Hospice services for adults safe?

Good



Our rating of safe stayed the same. We rated it as good.

Mandatory training

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

Nursing staff received and kept up-to-date with their mandatory training. Overall training compliance for all staff was 97%, and 96% for clinical staff, against a target of 95%. Face to face basic life support training was the only subject that fell below the target, at 88%. This was due to COVID-19 absences and difficulty accessing face to face training. However, these issues had been addressed and we saw that compliance had increased from 85% over time and staff were booked in to attend sessions.

The mandatory training was comprehensive and met the needs of patients and staff. This included infection control, health and safety, fire safety, data security, moving and handling and conflict resolution.

Clinical staff completed training on recognising and responding to patients living with mental health needs, learning disabilities, autism and dementia as part of their equality and diversity training. In addition, staff had completed modules in supporting patients living with dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse. All nursing staff had completed level two safeguarding children and adults. Senior staff had completed level three safeguarding adults training. There was always a senior member of staff on duty to provide support.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.



Hospice services for adults

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. There were clear safeguarding leads within the service who provided support for staff in developing their skills in identifying safeguarding concerns and working with other agencies to address this. Internal processes including regular safeguarding supervision where complex cases and situations could be discussed.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients on wards and transporting patients after death.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Furnishings were wipeable or had removable and washable coverings so they could be cleaned if soiled. Disposable curtains were used in treatment areas and were changed in line with the provider policy. Curtains we viewed had been changed in the last few months and were visibly clean.

The service generally performed well for cleanliness. Cleaning standards were monitored by the registered manager and any issues raised with the cleaning contractor by the owner of the site. Regular audits were carried out. Patient Led Assessments of the Care Environment (PLACE) had been undertaken before the pandemic, where the service performed well in relation to cleanliness. There were plans for a repeat health and safety and infection prevention and control (IPAC) audit visit in June 2022.

The director of clinical services visited monthly and observed the environment and cleanliness, completing touchpoint feedback reviews periodically. A clinical commissioning group (CCG) infection control nurse had carried out an informal review of the unit in February 2022 and there were plans for them to undertake a formal external infection prevention and control audit in the coming months.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. These were routinely monitored by the manager to ensure compliance with cleaning schedules. We saw that records were appropriately completed.

Staff followed infection control principles including the use of personal protective equipment (PPE). Hand hygiene and donning and doffing of PPE posters were seen on the unit. Handwashing facilities and hand sanitiser stations were available throughout the unit. We observed staff wearing appropriate PPE and hand washing regularly. One of the nurses on the unit was the infection control link nurse and they carried out infection control and monthly hand hygiene audits. The audits we reviewed showed 100% compliance with hand hygiene amongst all unit staff. Staff working in the hospice at home team had access to PPE, hand gel, wipes and paper towels for use when carrying out a home visit. We observed them using appropriate PPE and hand hygiene when visiting patients at home.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed staff thoroughly cleaning equipment in between patient contacts to reduce the risk of cross contamination.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. We observed staff quickly responding to patient's needs and call bells rarely needed to be used because of this. However, they were available and accessible.



Hospice services for adults

The design of the environment followed national guidance. The unit was accessed through a private entrance within the hospital grounds and the reception area was staffed throughout the day. Visitors signed in and wore visitor badges when on the unit. The unit had three treatment room spaces, two with chairs and another with a bed. There was a communal lounge area where day service activities took place, a communal treatment area and a quiet room where patients could meet with staff for private discussions. A garden area had recently been refurbished, creating a bright and peaceful space for patients and staff.

The hospice completed the Public Health England checklist and monitoring tool for COVID-19, specifically for outpatient areas. The audit showed compliance with COVID-19 guidance, including arrangements for social distancing, signage and supply of personal protective equipment and enhanced cleaning.

Staff carried out daily safety checks of specialist equipment. This included daily checks of emergency equipment, including oxygen, a defibrillator and emergency medicines. We saw that emergency equipment was replaced as needed, for example spare defibrillator pads had been ordered following use. Consumable equipment was regularly checked for stock levels and expiry dates. There were no expired items found during the inspection.

The service had enough suitable equipment to help them to safely care for patients. This included a wide range of seating, a hoist and standing aid for safe moving and handling of patients requiring assistance and medical infusion pumps. We saw that equipment requiring calibration or safety checks were part of a register that was monitored by staff. Equipment we checked had been appropriately maintained.

Staff disposed of clinical waste safely. There were systems to manage the appropriate segregation of clinical waste in line with infection prevention and control guidance, including the segregation of clinical and non-clinical waste. Sharps bins were stored securely and safely throughout the day centre and the majority were labelled and dated in line with guidance. One sharps bin was found to have an incomplete label in one of the treatment rooms, however, the registered manager replaced this during our inspection. Sharps bins we viewed had all been labelled within the last three months in line with guidance and the provider policy.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. They monitored patients closely for changes and conducted relevant assessments before commencing treatment. For example, we observed a nurse checking that a patient had a dental assessment booked which was a requirement of their cancer treatment. Staff carried out regular physiological observations including blood pressure, temperature and oxygen saturation as part of routine assessment processes.

Staff followed the provider's deteriorating patient protocol and where appropriate were able to administer basic life support and call emergency services. They used a situation, background, assessment, recommendation (SBAR) tool to communicate clinical risk and share information internally and with external services.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. The service used the Australian Karnofsky Performance Scale (AKPS) to assess patients' health status, where aspects of activity, work and self-care were assessed to identify when a patient's condition was



Hospice services for adults

deteriorating over time. In addition, they used the phase of illness (POI) and integrated palliative care outcome scale (IPOS) as part of the outcomes, assessment of complexities collaborative (OACC) measures. These measures used as part of the assessment process for patients enabled staff to measure the impact of treatment and care on patients' quality of life.

Staff knew about and dealt with any specific risk issues. Patient assessments included nutritional assessments, pressure area risks, risk of falls and oral care. In addition, risks relating to psychological, social, welfare and family support needs were assessed and reviewed on a continuous basis.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. There was evidence of comprehensive communication about patient's needs and clear records relating to all aspects of their care.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough nursing and support staff to keep patients safe. Both the treatment centre and hospice at home service managed staffing levels to meet the needs of patients. The unit manager had oversight of staffing and adjusted staffing to ensure patient needs were met. The hospice at home service was staffed by registered nurses and healthcare assistants and the hospice at home team lead clinical nurse specialist managed the rota to meet patient needs.

There was a business continuity plan for when staffing levels were below the required numbers to effectively manage the treatment centre. In the past 12 months this had been instigated on two occasions due to COVID-19. Action was taken to ensure patient's treatment needs were met by adjusting treatment days and times.

Managers limited their use of bank and agency staff. Permanent staff covered the shifts at the treatment centre and worked flexibly to do this. There was collaborative working between departments, for example between the hospice at home team lead and the clinical nurse specialist. The unit manager provided additional clinical support when needed.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. The provider had access to a consultant in palliative medicine employed by Arthur Rank Hospice Charity to provide one session per week at the day centre. We were told that the medical cover for the service was under review as the current consultant was leaving. The review included involvement from the hospice, the treatment centre manager and the clinical commissioning group. The registered manager was actively involved in the consultation with relevant stakeholders about the future medical cover. Medical support for the hospice at home service was through patient's own GP, with additional specialist advice from the specialist palliative care consultant as required.

The service always had a consultant on call during evenings and weekends through the Arthur Rank Hospice Charity.



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Records

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

Patient notes were comprehensive, and all staff could access them easily. The service used an electronic patient record that could be accessed by staff at the treatment centre and the community services. We reviewed eight patient records and found these were contemporaneous and reflected the needs and wishes of patients. There was appropriate information within the records to keep patients safe and ensure information was recorded to meet their care needs.

When patients transferred to the hospice or other teams in the community, there were no delays in staff accessing their records. The electronic record system could be shared with other professionals with access such as GPs and other healthcare professionals using the same system. There were appropriate security and consent protocols in place for this.

Records were stored securely. The electronic record system was password protected and computers were appropriately shut down when unattended. The computer in the reception area had a privacy screen so that information could not be seen by patients and visitors attending the reception desk.

Medicines

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

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Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff worked closely with GPs and district nurses to prescribe and administer end of life care medicines to people. People with complex needs could be referred to palliative care consultants working off site for specialist input. The day centre held regular multidisciplinary meetings with GPs and district nurses to discuss a person's care.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff worked collaboratively with GPs and district nurses involved in peoples' care to review medicines in response to their needs. We reviewed eight medicines charts for people receiving supportive treatment at the day centre. Staff monitored the effectiveness of treatment and records showed that medicines were regularly reviewed.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

All medicines including oxygen were stored securely and staff monitored temperatures of refrigerators and rooms where medicines were stored. Prescription stationary was stored securely, and staff recorded its use.

Staff followed current national practice to check patients had the correct medicines.

Staff told us that they could communicate with GPs easily about people's medicines through their joint electronic systems.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff were informed of learning from incidents and safety alerts regularly through team meetings.



Hospice services for adults

Staff knew how to report incidents, and these were discussed in medicines management meetings with learning shared with staff. We saw an example of a recent incident that led to no harm, this had been investigated appropriately leading to change of procedure to prevent this from occurring again.

The service had recently held a teaching session about prescribing palliative medicines at a local GP surgery and had participated in a recent study about prescribing anticipatory medicines in the community.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff we spoke to were clear about what constituted an incident and how to report them in line with the service's policy.

The service had no never events or serious incidents reported in the last 12 months.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong and understood their responsibility to share information with patients and their relatives.

Staff received feedback from investigation of incidents, both internal and external to the service. The provider collated information about incidents and across all services and shared this with staff through a provider wide dashboard.

Staff met to discuss the feedback and look at improvements to patient care. This included reflective discussions about difficult cases, providing an opportunity for learning and improvement, as well as staff support.

Safety data was collated and reported through a monthly dashboard which was accessible to all staff. Reports were shared with staff at meetings and issues reviewed and improvements discussed.

There was evidence that changes had been made as a consequence of feedback. For example, issues in accessing blood prescriptions that resulted in treatment delays resulted in communication with the relevant acute NHS trust to ensure improvements.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Are Hospice services for adults effective?

Good



Our rating of effective stayed the same. We rated it as good.



Hospice services for adults

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies including the management of deteriorating patients and verification of expected death were aligned with best practice guidance.

Managers monitored national guidance and adopted this into policies and frameworks within the service. The Five Priorities of care at the end of life were incorporated into the care planning process and we saw that patients were assessed to ensure they were recognised when in the last days of life and that individual care plans were in place with involvement of the patient and those close to them.

National Institute for Health and Care Excellence guidance was reviewed as part of the service's clinical governance processes. We viewed meetings of minutes including treatment centre staff meetings where national guidance was on the agenda for routine review in relation to adopting new and revised guidance.

Patient records clearly showed that staff supported patients to make advance decisions regarding their care and treatment. Clear do not attempt cardiopulmonary resuscitation (DNACPR) decisions were recorded. Advance decisions and DNACPR included recorded discussions with patients and their relatives, in line with national guidance for the Resuscitation Council (UK).

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. There was a holistic approach to assessing patients' needs that included social, psychological and emotional needs.

Handover records showed that the needs of both patients and their relatives and carers were considered. Staff worked together to support those needs. Referrals for psychological support were made on an individual basis and there were psychological and family support services available through the provider hospice.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. There was a kitchen on the unit where staff and volunteers prepared refreshments for patients. Additional food, such as sandwiches were provided through an external provider, based on the needs and wishes of patients. Adjustments were made based on individual needs. We observed staff providing patients with refreshments and checking that their needs were met.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. They fully and accurately completed patients' fluid and nutrition charts where needed. Staff supported patients to eat and drink as appropriate and provided advice in relation to quality of life and enjoyment. We saw examples of staff supporting patients, including oral care and balancing risks in relating to nutrition.



Hospice services for adults

Staff referred patients to specialist support such as dietitians and speech and language therapists as required.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients on the treatment unit had assessments of their individual needs including monitoring of pain and the effectiveness of prescribed medicines. There were nurse prescribers working on the unit and mild preparations of pain relief such as paracetamol were able to be administered.

Where patients had ongoing issues with pain control staff liaised with GPs and other clinical staff within the community to ensure their pain relief needs were met. We saw evidence of this in the records we reviewed, this included hospice at home patients where patients needs changed over time. Records demonstrated that pain was routinely assessed, and staff provided advice to patients and relatives. Advice was given to district nurses regarding the administration of medicines via a sub cutaneous (under the skin) continuous infusions.

Patient outcomes

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

The service participated in relevant clinical audits. This included ongoing audit and monitoring of patient outcomes, as well as environmental and assurance audits. Patient records audits were carried out and these showed 100% completion in relation to the completion of patient outcome assessments.

Outcomes for patients were positive, consistent and met expectations. The service used recognised palliative care outcome measures such as the Outcome Assessment and Complexity Collaborative (OACC) suite of measures. The OACC includes the use of the Australian Karnofsky performance scale (AKPs) to assess activities of daily living, and the Integrated Palliative Care outcome scale (IPOS) to identify patients' most important concerns. These assessment measures helped staff to identify the phase of illness at any point during the patient's care which provided a basis for recognising deterioration or where death was likely within a few days.

Managers and staff used the results to improve patients' outcomes. Analysis of the use of the OACC measures was undertaken by comparing patients' first and most recent assessments using the measures. We reviewed the results from April 2021 to March 2022 which identified improvements in relation to patients supported by the treatment centre regarding pain control which saw a 22% improvement and constipation which saw a 25% improvement. Analysis also helped staff to identify areas where further improvements could be made, for example, in relation to patients' concerns about practical issues and worry for those close to them.

We saw action was taken to improve patients' outcomes. For example, we viewed records and were told of occasions where staff worked to better support patients around practical issues. These included staff working with patients to provide support and liaising with other agencies, for example, in relation to accessing equipment or benefits advice.

Managers and staff carried out a comprehensive programme of repeated audits to ensure action plans had been completed and improvements had been achieved. This included regular audits of infection prevention and control, hand hygiene, records audits and patient led assessment of care and the environment (PLACE).



Hospice services for adults

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff completed a comprehensive range of training in addition to mandatory training requirements, based on the needs of patients and the service. Training needs were identified as part of the appraisal process. Staff completed competency assessments, for example; medicines management for registered nurses, health care assistant competencies and spiritual care competencies.

Managers gave all new staff a full induction tailored to their role before they started work. There was a structured induction programme in place to ensure staff had the skills required for their role. This included dedicated time for mandatory training and specific activities and competencies that were signed off during the induction process. Staff shadowed more experienced staff members until they were competent and confident to work without supervision.

Managers supported staff to develop through yearly, constructive appraisals of their work. Data showed that 85% of clinical staff had received an appraisal in the last year. Changes to the appraisal process included the creation of an appraisal window where all staff would receive an appraisal within a three month window rather than throughout the year. All staff had an appraisal scheduled for this period to improve compliance to the aimed target of 100%. Records show that staff new to their role had a meeting set up to agree objectives when commencing in post.

Managers made sure staff attended team meetings or had access to notes when they could not attend. Notes of meetings were comprehensive, and information was shared through regular hospice newsletters to ensure staff kept up to date with changes and important information.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, two senior nurses had been supported to complete non-medical prescribing training and there were examples of additional training for staff in areas relevant to their roles. Examples of these also included advanced communication skills, end of life across all faiths and management of symptoms in advanced disease training. Staff had access to additional training through the Arthur Rank Hospice education programme. Senior staff had access to a management development programme which two members of the team had completed.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us they had opportunities for development, we saw that resources were provided, such as a journal club and staff accounts for access to research articles to support their development.

Managers identified poor staff performance promptly and supported staff to improve. There were clear staff performance processes in place and the service manager was supported by the Arthur Rank Hospice human resources department as required.

Managers recruited, trained and supported volunteers to support patients in the service.

Multidisciplinary working

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



Hospice services for adults

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Changes to the service during the pandemic included expansion of the hospice at home service and a more integrated service was provided within the treatment centre, supporting patients in the community as well as those accessing the treatment centre. Internal multidisciplinary meetings were held on a weekly basis, involving staff from the treatment centre and community services which included input from complementary and spiritual support staff. Nurses working within the community services regularly attended multidisciplinary team meetings with GPs and district nurses.

Treatment centre and community staff worked closely with hospital and community based professionals including physiotherapists, social workers, dieticians and occupational therapists on an individual patient basis.

Staff worked across health care disciplines and with other agencies when required to care for patients. Hospice at home and treatment centre nurses regularly acted as coordinators when responding to patient's care needs, liaising with other professionals to address concerns around treatment, social and family support needs.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. They liaised with patient's GPs to do this.

Health promotion

Staff gave patients practical support to help them live well until they died.

The service had relevant information promoting health and wellbeing. This included advice and support on nutrition, pain control, social, emotional and spiritual needs. Staff cared for patients using a holistic approach and regularly monitored patients' wellbeing.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We saw evidence of mental capacity assessments in patient records, staff had received mental capacity act training in order to complete the assessments.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff explaining to patients what they were going to do and providing information to enable patients to make informed decisions.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff demonstrated a good understanding of best interest decision making processes. We viewed the records of one patient who had been assessed as not having the capacity to make a decision about where they would be cared for in the last days of life. Their record showed a best interest meeting had been held with the patient's family and a decision taken to care for them at home with support from the hospice at home team and night service.

Staff made sure patients consented to treatment based on all the information available. Written literature was given to patients explaining treatments they had been prescribed. Staff took time to explain processes and any potential side effects or risks.



Hospice services for adults

Staff clearly recorded consent in the patients' records. We saw evidence of patient consent to receive personal care recorded in the records of patients being supported in the community by the hospice at home team. As part of the patient assessment process staff recorded patients' consent to share information with other professionals as part of their ongoing treatment and care.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. They had received training in relation to the legislation and understood the principles of mental capacity assessments. This included clear recognition of the types of decisions patients were able to make and those where decisions needed to be made in the best interest of patients.

Are Hospice services for adults caring?

Outstanding



Our rating of caring stayed the same. We rated it as outstanding.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. There was a strong patient centred culture within the unit. We consistently observed respectful and considerate interactions between staff and patients and saw that patient need was prioritised. This included adjusting treatment times for patients who were upset and needed time to talk to staff or fit in a complementary therapy session to help them relax.

Patients said staff treated them well and with kindness. Feedback and thank you cards from patients and family showed that staff treated patients well. For example, cards referenced the 'love and kindness' shown, 'care for the whole family' and staff seeing a patient and family beyond their finish time to meet the patient's needs. Patients consistently told us that staff treated them well and went above and beyond to meet their needs. Examples included that staff helped patients and family members to feel less alone, to talk through their fears and focus on quality of life, helped them to access additional support and took time to ask them about social and emotional concerns alongside the physical.

Staff followed policy to keep patient care and treatment confidential. They were discreet in their interactions and offered patients a private space if they needed to talk.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff took a holistic view of patients' needs, spending equal time supporting patients around emotional, psychological and spiritual needs as they did their physical needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients had access to a chaplain who provided support to patients of all faiths and none. Staff had completed additional training in understanding and meeting the spiritual needs of patients and completed spiritual care competencies.



Hospice services for adults

Staff recognised the holistic support needs of patients and identified where there was a gap in support services for them, particularly around some of their social needs. Staff truly understood how social issues impacted on palliative and end of life care. They worked together as a team to meet those needs, coordinating discussions with other professionals in order to get patients the support they needed.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff taking time to explain things to patients and those close to them. This included providing information about the end of life experience and the options for care and support. Records clearly demonstrated that information was given to patients to help them make decisions. We consistently heard from patients and family members that staff gave them the time they needed to talk things through. We were told of examples where staff had stayed beyond the end of their shift to ensure that people's needs were met.

A bereavement service was available for those close to patients who had died whilst under the care of the service. The bereavement support service was facilitated by the patient and family support team. Staff included a chaplain, complementary therapist and a volunteer chaplain. The support provided also incorporated one to one support where needed from a psychologist.

Relatives of patients who had died while being supported by the service were followed up with a bereavement call soon after. This involved a telephone call or visit as appropriate.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff were quick to respond when they noticed someone was upset or not their usual self. They offered a private space to talk and suggested alternative ways to help the patient cope emotionally. This included complementary therapies that were available to patients within the living well service, accessing the treatment centre and for those at home who were unable to attend the unit or who were receiving hospice at home care.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff attended advanced communication skills training and we observed them having difficult conversations with patients and family members about death and dying. Staff took time to explain what could be expected and provided advice on how they could support patients and those close to them.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We observed examples of holistic care being delivered by staff and heard examples of when they had gone over and above what was expected to meet the needs of patients and those close to them.

An example of additional family support was when a patient who had rapidly deteriorated at home died while being transferred to hospital. Ambulance staff contacted the service at the request of the family. It was not possible for the family to spend the time they wanted with the deceased patient in the ambulance or for the patient to be returned home. Staff at the treatment centre responded quickly and asked the ambulance to redirect them there so they could support the family and ensure they had the space to say their goodbyes in a familiar and supportive environment. Staff arranged for the bedroom on the unit to be available and supported the transfer of the patient while protecting other patients accessing the service from being impacted. Staff supported the family to be with their loved one and gave them the time needed to deal with the shock and understand the next steps and what to do.



Hospice services for adults

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff followed national and best practice guidance in comprehensively assessing the needs of patients and those close to them. They took time to explain treatment and care options to them, supporting them to access additional care as they needed it. We observed staff giving patients and those close to them the time they needed to ask questions, making suggestions and giving explanations in a way that was easy to understand.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We reviewed patient records where information about methods of communication were recorded to best meet the needs of patients. For example, where a patient was no longer able to communicate verbally there were clear instructions to communicate using email, messaging and through a family member. Staff had access to picture prompts to help communicate with patients who did not speak English or had other communication difficulties.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The provider actively encouraged feedback on the service. Feedback forms were available on the unit and feedback was collated and used for learning, improvement and to ensure staff were aware of the impact they were having on patients and those close to them. We reviewed patient feedback results and saw that 100% of those completed showed that patients felt involved in their treatment and care as much as they wanted to be. Patients were consistently positive about their experience of the service. Patients were able to feedback and provide suggestions on how to improve the service and the facilities provided.

Staff supported patients to make advance decisions about their care. This was part of the ongoing assessment process that patients went through as part of their care. We reviewed a records audit that showed 73% of patients had an advance care plan in place, of the remaining 27% it was deemed not appropriate for advance care plan discussion at that time due to other issues that the patient was facing. However, plans to revisit advance care planning were in place for all patients as this was part of the ongoing assessment process. We observed this in action, with staff interacting with patients and family members around their wishes and how they wanted to be supported, including their preferred place of care. All records we reviewed showed that patients had been supported to develop an advance care plan where relevant.

Staff supported patients to make informed decisions about their care. This was an ongoing process and evident in every interaction we observed. Staff took time to provide patients with information to make decisions and where necessary they referred or signposted them to other services or information, they could access that would help them.

Patients gave positive feedback about the service. Feedback was consistently positive from both patients and their loved ones. One relative told us they were 'amazed at the difference in care made', they told us they 'never feel hurried' and the service was 'second to none'. Other patients told us the service had a 'family feel', was a 'brilliant service', they 'couldn't wish for better staff', 'they make such a difference and I love coming here', and 'staff are lovely, friendly and open'.

The unit received over 400 direct compliments from patients and relatives in the past two years. These detailed how staff cared for patients and those close to them. Comments included describing the care as 'exceptional' and the staff as kind, caring and gentle.



Hospice services for adults

Patient feedback results we reviewed showed that 100% of patients felt that they were treated with dignity and respect.

Are Hospice services for adults responsive?

Outstanding



Our rating of responsive stayed the same. We rated it as outstanding.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. The provider, service manager and staff recognised the health inequalities within the local community and were flexible and responsive in how they supported patients. A widening access group was in place and had a comprehensive action plan to ensure that the provider was engaging with groups who may not access hospice care, including those from minority ethnic communities, the gypsy and traveller community and people who were homeless. The group met bi-monthly to embed equality, diversity and inclusion across the hospice and they met bi-monthly. Four areas of focus had been identified. These were sex and sexual orientation, religion, ethnicity, and disability. The provider was an active member of the local clinical commissioning group (CCG) led transformation of end of life care programme board where tackling health inequalities was a key part of this work. They participated in cross system working to ensure services were accessible to and meet the needs of people with a learning disability and their families.

The service actively participated in a local diverse communities' forum. The work of the forum was focused on improving prospects for people living in the local community which included job clubs, training and support for families.

Staff demonstrated a comprehensive understanding of the local population, gaps in service and community needs. The service supported local rural communities with higher than average deprivation. As a team, staff worked to ensure that patients were not disadvantaged and took action to support patients to meet their needs. Nurses took on care coordination for patients, seeking support from other professionals and organisations as needed to ensure relevant support for social, housing and legal matters. Feedback from visiting professionals included, that whilst there was a continuing gap in health equalities within the location, they believed that the gap had reduced because of the support from the service.

The living well service provided support for patients on two days each week. This included facilitated activities, complementary therapies and emotional support. Patients could access the service for an eight week support programme. Patients accessed the treatment centre locally to their homes, receiving treatment, support and diagnostic testing as part of care received from regional NHS trusts. The hospice at home service supported patients in the last months and weeks of life. Services were designed around the needs of the local population and there was recognition of local health inequalities and staff coordinated care with other services to support these needs.

The hospice at home service had previously provided limited support across the region as part of a pilot and was expanded from August 2020 to cover the whole of Cambridgeshire for patients who were suitable for fast track



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continuing healthcare funding. The service provided up to three hour long visits a day to patients wishing to die in their own homes. In addition, they provided up to 72 hours of 'crisis' intervention so that care could be set up to avoid any unnecessary admissions to hospital. The service was developed to replace a previous commissioned service that was provided by domiciliary care agencies, largely providing up to four short visits a day.

Facilities and premises were appropriate for the services being delivered. A communal lounge area was used for the provision of the living well service where group activities were held. There were seated treatment rooms and one treatment 'bedroom'. A further communal area was available with high backed chairs and a television. There was a 'counselling' room for one to one support and a refurbished outside area providing a peaceful environment that could be used for patients and staff.

The service had systems to help care for patients in need of additional support or specialist intervention. This included staff responding to additional support needs by liaising with other professionals such as social and voluntary care services. There were numerous examples where staff had done this. One involved a patient who was not known to the service who attended the unit without a referral, looking for help. The patient had social issues as well as a recent cancer diagnosis and other mental health issues. Staff took time out of their planned work-day to support the patient. They made referrals as needed and supported them to access benefits and housing advice. Due to the nature of the patient's issues, it was difficult for them to access support and a clear trusting relationship had developed with the treatment centre staff. When support from other services was difficult to access, staff worked closely with a local homeless charity and other organisations to provide support for the patient. This involved staff attending meetings on the patient's behalf and going above and beyond what was expected to support the patient. Staff supported them by liaising with local housing services to expedite somewhere for them to live and applying for funding grants on their behalf to furnish their new home. Communication with the housing trust was primarily through the nursing staff on the unit as the patient found it difficult to answer calls and commit to activities. Nursing staff acted as coordinators in accessing appropriate housing and support for this patient. The unit was a first port of call for the patient and staff went beyond their remit to support them to improve their quality of life and address social concerns while building trust to enable them to access services.

Other successful support provided by the unit included support for a homeless patient through liaison with the same local charity and support to get the patient to their home country at the end of their life. The service worked closely with the local travelling community and other services to improve access to palliative and end of life care, adapting the way they worked to provide support within the community.

Nursing staff also supported a patient to access legal and social support regarding their complex family situation and support for their children. This included one of the clinical nurse specialists attending appointments with the patient to try and sort out their will and plan for their children.

Managers monitored and took action to minimise missed appointments. The service managed patient appointments and had developed close relationships with patients and relatives, building rapport and supporting them to attend appointments. This included support with transport. Managers ensured that patients who did not attend appointments were contacted. Staff followed up on missed appointments and worked closely with patients and those close to them to schedule appointments at times that were suitable. There was flexibility within the appointment system, including scope to deal with on the day requests for support.



Hospice services for adults

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. We viewed patient records that demonstrated enhanced support for patients with additional needs, including patients with learning disabilities. We saw that support was individualised and encompassed the whole family, with overnight support from the hospice at home team when care needs were complex and family members needed a break. Volunteers working on the unit completed dementia friend training to better support patients with dementia.

Staff supported patients living with dementia and learning disabilities by using individualised care plans that included preferences, what was important to them and methods to support symptom management that were personal to the individual patients.

There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met these needs, which was accessible and promoted equality for people living in vulnerable circumstances and with complex needs.

We heard numerous stories and saw examples of where staff had acted to meet the social needs of patients. This included examples where staff had supported patients to access grants, and in some cases where grant applications had not been successful, they had looked at other ways to source funding for essential items. This included working with the provider hospice's fundraising team and micro grant system. Examples included where a member of the fundraising team asked local businesses for help in funding a specialist mattress for a patient. A hospice at home healthcare assistant had sought funding for the husband of a patient in hospital. This was for cooking equipment so that he could cook easy meals as he didn't usually cook. This enabled the patient to change their mind about their preferred place of care and go home at the end of life. Staff applied to the micro grant fund for a new chair for a patient at home as theirs was broken.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff used communication cards, specialist communication apps and assisted technology, and picture prompts when necessary to enhance communication with these patients.

The service had information leaflets available in languages spoken by the patients and local community. Leaflets were available within the unit and included information to support people at the end of life and their families, including what to expect and how to access additional support.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff could access translation services for patients and their families where this was required.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff could order food that met the needs and preferences of individual patients. Staff recognised the importance of food and drink in relation to quality of life and took action to ensure patients had a choice of food and drink to meet their needs. We were told of a patient who had been finding it difficult to eat due to increasing symptoms. However, one day they felt able to eat and told staff they would like to eat fish and chips. A member of the hospice at home team went out and bought fish and chips for them and stayed and ate with them.



Hospice services for adults

Staff had access to communication aids to help patients become partners in their care and treatment.

Access and flow

Patients could access the specialist palliative care service when they needed it.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Patients accessed the service following a referral from their consultant, GP or community team. We also saw that staff supported patients who self-referred.

The service collated a monthly dashboard that included monitoring of referrals and waiting times for the treatment centre and the hospice at home service. They had key performance (KPIs) indicators for the responsiveness of services.

The treatment centre had varying KPIs dependant on the type of service patients accessed. For example, contact after referral to the living well service was within seven days, whereas contact for treatment services was within two working days. Data between January and March 2022 showed that 90% of patients referred to the treatment centre were contacted within the target timeline.

The criteria for access to the hospice at home service was for patients to be entering the terminal phase of life, usually expected to be in the last three months of life. Service leads triaged patients based on need and met twice a day with commissioners as part of the triage process. They had a target for patients to be contacted within four hours of referral. Between January and March 2022 93% of patients were contacted within four hours, with an average wait of two hours and 28 minutes. As one of the aims of the hospice at home service was to support patients to die at home there was 70% target for this. March 2022 data showed that 84% of patients who died had died at home.

The service identified patients' preferred place of care at the end of life. Data showed that between January and March 2022 an average of 95% of patients died in their preferred place of care. This was an improvement since the expansion of the hospice at home service. For example, an 11% improvement since the first quarter of 2021/22 where 84% of patients achieved their preferred place of death.

Patients with complex care needs at the end of life, being cared for at home had access to an overnight service from the hospice at home team. There was no specific target for this, however, there had been 84-night visits in March 2022.

Managers and staff worked to make sure patients did not stay longer than they needed to. The living well programme was for an eight week duration, although patients could access the service for treatment and tests for as long as they needed to. The hospice at home service monitored the average length of stay within the service, between January and March 2022 this was an average of 10 days.

Managers worked to keep the number of cancelled treatments to a minimum. Patients we spoke with told us they rarely had their appointments cancelled. Staff told us they rearranged appointments as quickly as possible on the rare occasion they needed to be rescheduled. Examples of this included where staffing had been impacted by COVID-19 or where patient need warranted changes to appointment times.

Staff responded quickly to changes in patient's needs so that they could access appropriate care as soon as possible. We observed this in practice during the inspection where a family called, concerned about a patient's level of comfort at



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home. The hospice at home clinical nurse specialist (CNS) went out to visit as the palliative care CNS was already on a visit. We were told of a patient who had a prescription in transit, however, they were experiencing symptoms and staff wanted to manage their symptoms as quickly as possible. A member of the team spoke to the pharmacy to find out the location of the delivery and drove out to look for them so they could quickly get the prescription to the patient.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. There was patient information available on how to complain and a complaints form for patients to use. Patients we spoke to told us they would speak to the nursing staff or service manager should they need to complain, although none of them had needed to.

Staff understood the policy on complaints and knew how to handle them. Staff understood the complaints policy and told us they would refer complaints to senior staff.

Managers investigated complaints and identified themes. Complaints were collated and monitored as part of the Arthur Rank Hospice quality early warning trigger tool. We reviewed the most recent three months trigger tool results and saw that there had been no complaints relating to the Alan Hudson Treatment Centre. We viewed the response to a complaint in 2021, involving a relative's concerns about the care their loved one received. We saw that a thorough investigation had been held, that staff involved in the care had written statements and that clinical expertise had been sought to provide assurance that the standards of care were as expected. The director of clinical services had offered to meet with the complainant to discuss their concerns further.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff told us they aimed to resolve complaints or concerns quickly. The process for formal complaints management included an acknowledgement within three days. All complaints were investigated, and the chief executive officer of Arthur Rank Hospice had oversight of all complaints.

Managers shared feedback from complaints with staff and learning was used to improve the service. Patient feedback including any complaints was routinely discussed at staff meetings and used to identify learning to improve care and the services provided.

Staff could give examples of how they used patient feedback to improve daily practice. We saw evidence that feedback was actively sought, and patient suggestions and concerns were listened to. Action was taken where appropriate, for example, in relation to improving the environment.

Are Hospice services for adults well-led?

Good



Our rating of well-led stayed the same. We rated it as good.



Hospice services for adults

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The service manager and senior nurses demonstrated the skills, capacity and capability to deliver a responsive and sustainable service. Service leads understood the issues and challenges within the service and demonstrated a comprehensive understanding of the priorities for supporting patients within the local community. They worked collaboratively with partner organisations and professionals to deliver high-quality, patient centred services.

Staff told us that leaders were visible and approachable, and we saw that they supported staff to provide responsive services that were flexible to the needs of patients and those close to them.

Staff had opportunities to develop their leadership skills and we saw that senior staff had completed training on a management development programme. The service manager was attending a six month 'leading beyond boundaries' programme.

Vision and Strategy

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

As part of the Arthur Rank Hospice Charity the Alan Hudson Day Treatment Centre was incorporated into the vision and strategy of the charity. The service vision was focused on 'Making Every Moment Count: supporting people with a life-limiting illness, caring for people and their loved ones at the end of life'.

The hospice strategy 2022-2027 had been developed with the involvement of staff and other stakeholders, including members of the local community. The strategy was also aligned with national guidance and priorities and annual operational plans were developed to support the delivery of the strategy. There were clear strategic priorities and identified outcomes. These included improved quality of life and emotional wellbeing for people and their loved ones, increased health equality, sustainable service provision and a highly engaged and motivated team.

Staff told us they were involved in the development of services. For example, we observed staff meeting with the director of clinical services to review the development of the living well service.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke to told us they enjoyed working at the service and felt supported by the service manager and senior leaders. Staff were consistently proud to work for the service and there was a collaborative and focused team approach to supporting patients, those close to them and each other. They were valued within their roles and had opportunities to develop their careers. Training was available, including in relation to management development and career progression.



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Staff told us they were able to raise concerns and they felt confident they would be addressed. They could raise concerns through a variety of methods such as the management structure of the service, the confidential employee assist programme and a member of the board of trustees who was the whistleblowing champion. They had freedom to speak up guardians at operational and trustee level. Patients and family members were encouraged to raise concerns and we saw that leaders responded to these with kindness and compassion.

Those working within the service were focused on the needs of patients and those close to them. There was a recognition across all grades of staff that high quality palliative and end of life care was essential to meet the needs of diverse and disadvantaged groups within the local community. Staff consistently took action to meet patients' needs with a view to ensuring maximum comfort and quality of life. They responded quickly to requests for support and worked with compassion and kindness.

The provider fostered a culture of openness and honesty. Staff had an understanding of the duty of candour and understood the requirement for openness and honesty with patients and those close to them when things went wrong.

The service promoted equality and diversity in daily work. They been accredited as committed (level one) to the government's disability confident scheme. The widening access group had developed an action plan to promote equality and diversity. Actions included promoting workforce equality.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective governance structures, processes and systems of accountability and a clear governance framework to support the delivery of the hospice strategy, of which the Alan Hudson Day Treatment Centre was a central part. The hospice senior leadership team were accountable to the board of trustees. Service leads reported to the board of trustees through board papers submitted, including a regular clinical services executive summary report. Quarterly board agenda items included progress reports and activities relating to areas of hospice management such as progress against the strategy, minutes of committee meetings, risk management and the quality of services.

A member of the board of trustees chaired the clinical governance committee and quarterly meetings were held. We saw that issues around quality and risk were discussed at these meetings. A quarterly quality development group meeting was chaired by the hospice chief executive officer with attendance from managers and senior staff, including the day treatment centre service manager. We saw that issues such as clinical audit, service development and policy approvals were discussed at these meetings. Senior leaders met twice weekly to discuss service and operational issues; these meetings had been held daily at the height of the pandemic. Treatment centre and hospice at home team meetings were held regularly and we saw evidence that all aspects of service performance were discussed.

Staff were clear about their roles and accountabilities and who to report to. Staff were committed to improving the quality of service and maintaining high standards of care. They were involved in discussions about the performance of the service and were encouraged to report issues and work together to learn and develop the service.

There are were arrangements in place to manage and monitor contracts and service level agreements with partners and third-party providers. Quality and key performance indicators were used to review services and related contracts.



Hospice services for adults

Management of risk, issues and performance

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

There were clear processes for identifying and managing risks. Operational and strategic risk registers were maintained. There were effective business continuity plans in place. We saw that during the COVID-19 pandemic risks had been managed by arranging for patients to have treatment in their own homes rather than attending the unit. We also saw that some services such as the bereavement support had been transferred to a virtual format.

Performance was monitored through a monthly dashboard of collated information relating to incidents, performance indicators, activity levels, patient feedback, staffing and other risks. Services were allocated a risk score as part of the quality early warning trigger tool which was then allocated a risk score. We saw that the Alan Hudson Day Treatment Centre was identified as a low risk.

The service had a business continuity plan in the event of disruption of service. They had been flexible in re-arranging patient appointments with minimal disruption when these had to be postponed due to one event of COVID-19 related staff absences resulting in the temporary closure of the service. In addition, at the start of the pandemic they arranged for patients to receive treatments in their homes.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Data dashboards and a quality early warning trigger tool were used to collate data which was shared with staff as part of ongoing monitoring of the service. There was open discussion at staff meetings about data and how this influenced service development. Performance reports were comprehensive and provided enough detail and analysed data and this was used to demonstrate the effectiveness of services and identify areas for improvement.

Staff had up to date and comprehensive information about patient's treatment and care. They used an integrated patient record system that was accessible to other providers involved in their care who were using the same information system. This included GPs, hospital and community services. There were clear and standardised information governance processes that ensured the security of patient information. Computers were encrypted and password protected, and we observed staff maintaining the confidentiality of patient records.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

There were a range of fora and networks that the service participated in to ensure engagement with the local community. This included a widening access group, engagement with other hospices, multidisciplinary team meetings with GPs and community services, close working with other local charities, commissioners and networks.



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The service actively engaged staff in decision making and they were involved in monitoring and evaluating the performance of services. We saw evidence of this during inspection, in relation to their involvement in a development meeting for the living well service.

Alan Hudson Day Treatment Centre staff were encouraged to complete the Arthur Rank Hospice annual survey. In 2021 the service had achieved gold accreditation with the 'Best Employers Eastern Region' staff survey because of the positive results of the survey. Results were used to identify areas for improvement and to reflect on areas of positive feedback.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

There was a range of quality improvement activities within the hospice and staff actively participated in these. We saw that services were regularly reviewed to ensure they met the needs of patients and the local community. There were clear quality improvement aims within the annual quality account that included safety, patient experience and effectiveness. The quality account was reviewed and updated annually.

The service manager and treatment centre staff regularly reviewed services. For example, we saw that they had reviewed the strengths and weaknesses of the services and how these had been impacted by the COVID-19 pandemic. Analysis included that a strength of the service had been the support for patients in their own homes. This included the expansion of the hospice at home service and providing treatment in patient's own homes to reduce the footfall through the clinic at the height of the pandemic. In addition, a review of the day treatment centre saw a restructure and development of a more focused service, rebranded as the living well service.

There were clear processes for learning from complaints and things that went wrong. All staff were involved in discussions and learning, including reviewing patient feedback.