Alan Hudson Day Treatment Centre

Quality Report

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

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive?	Outstanding ☆
Are services well-led?	Good ●

Summary of findings

Letter from the Chief Inspector of Hospitals

Alan Hudson Day Treatment Centre is operated by Arthur Rank Hospice Charity. The service is a nurse led adult day treatment centre based in Wisbech. The service supports adults who are living with a life-limiting illness and their families. The centre's multi-disciplinary palliative care team provides a service which includes day therapy; treatment and clinical days (including haematology and oncology work); complementary and diversional therapies; and bereavement and support services. The day centre service manager also led the community hospice at home team. Additionally, the centre supports people and their families with outpatient visits and provides clinical advice and support to people receiving palliative care on an adjacent 16-bed ward within the local NHS hospital.

This was the service's first inspection by CQC using its new hospice core service framework with inspectors from the hospital's acute inspection team. The day treatment centre was previously inspected by CQC adult social care inspection teams using a different core service framework and inspection methodology. We carried out the unannounced part of the inspection on 7 January 2020. We did not inspect the provider's community based hospice at home provision, as this was inspected by CQC in December 2018 as part of Arthur Rank Hospice Charity comprehensive inspection. We also did not inspect any of the NHS based ward beds as these would form part of CQC's acute inspection of end of life services for that individual NHS trust.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The main service provided by this provider was an adult day treatment centre.

Services we rate.

Our rating of this service stayed the same. We rated it as **Outstanding** overall.

We found areas of outstanding practice:

- Staff treated patients and their families with compassion and kindness, respected their dignity and privacy, and went above and beyond expectations to meet their individual needs and wishes. Staff did all they could to support the emotional needs of patients and relatives to minimise their distress. Staff helped patients live their everyday life to its fullest.
- 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.
- The service manager promoted high standards and supported staff and volunteers to develop their skills. Staff understood the provider's strategy and values, and how to apply these in their work. Staff were highly motivated to provide high standards of care and support care for patients and relatives. There was a common focus within the teams on improving the quality and sustainability of care and patients and relatives' experiences. Staff and volunteers were proud to work at the service and felt respected, supported and valued. The provider 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 and used feedback to make additional improvements.

Summary of findings

Following this inspection, we told the service that it should make other improvements, even though a regulation had not been breached, to help the service improve.

Heidi Smoult
Deputy Chief Inspector of Hospitals

Overall summary

Day treatment for adult patients accessing palliative care was the only activity provided at this centre. We rated this service as good for safe, effective and well-led. Responsive and caring were rated as outstanding.

Summary of findings

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Outstanding ☆

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Services we looked at:
Hospice services for adults

Summary of this inspection

Background to Alan Hudson Day Treatment Centre

Alan Hudson Day Treatment Centre is operated by Arthur Rank Hospice Charity. The centre opened in 2006. It is a nurse led adult day treatment centre, based in Wisbech. The centre primarily serves the communities in Wisbech.

The day treatment centre has had the same registered manager in post since 2006.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,one other CQC inspector, and a specialist advisor with expertise in hospice and end of life care. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

Information about Alan Hudson Day Treatment Centre

The day treatment centre is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury.

During the inspection, we visited the day treatment centre. We spoke with six staff including registered nurses, reception staff, managers, chaplain and volunteers. We spoke with five patients and two relatives. During our inspection, we reviewed three sets of patient records from the six patients receiving care and treatment on the day of our inspection.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The most recent inspection of the service took place in July 2017, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity (1 October 2018 to 30 September 2019)

- In the reporting period October 2018 to September 2019, 151 patients aged between 18 and 65 years and 313 patients aged over 65 years used the service.
- 426 patients had life limiting conditions
- 21 were living with dementia
- 88 had mental health needs
- One had a learning disability
- 35 had sensory impairments
- Three had physical disabilities
- 363 patients were receiving palliative care

The service employed seven registered nurses, two health care assistants and three other non-clinical / administrative staff.

Track record on safety.

- Zero Never events.
- Nine incidents with no harm / near miss, six with low or minor harm, one with moderate harm, zero with severe harm, and zero deaths.
- Zero serious injuries.
- Zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA).
- Zero incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA).
- Zero incidences of hospital acquired Clostridium difficile (c.diff) complaints.

Services provided at the hospital under service level agreement:

Summary of this inspection

- The provider had a service level agreement with a local NHS trust for pharmacy support, portering, and device maintenance.
- Clinical and or non-clinical waste removal.
- The provision of blood and blood components.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

Our rating of safe went down. We rated it as **Good** because:

- 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.

Are services effective?

Good

Are services effective?

Our rating of effective went down. We rated it as **Good** because:

- Staff provided high quality care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it.
- The service manager monitored the effectiveness of the service and made sure staff were competent.
- Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to up to date information.

Are services caring?

Outstanding

Are services caring?

Our rating of caring stayed the same. We rated it as **Outstanding** because:

- Staff treated patients and their families with compassion and kindness, respected their dignity and privacy, and went above and beyond expectations to meet their individual needs and wishes.
- Staff did all they could to support the emotional needs of patients and relatives to minimise their distress. Staff helped patients live their everyday life to its fullest.

Summary of this inspection

Are services responsive?

Outstanding 

Our rating of responsive stayed the same. We rated it as **Outstanding** because:

- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

Are services well-led?

Good 

Our rating of well-led went down. We rated it as **Good** because:

- The service manager delivered and monitored services using reliable information systems and supported staff to develop their skills, knowledge and competencies to benefit patients.
- Staff understood the service's strategy and values, and how to apply these in their work.
- Staff felt highly respected, supported and valued. They were focused on the needs of patients receiving care.
- Staff were clear about their roles and accountabilities.
- The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

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 went down. 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. At the time of our inspection 100% of day centre staff were up to date with their mandatory training. All staff had protected time for the completion of mandatory training, this could be taken at home or in the work place. Staff completed additional training in dementia, mental capacity, understating mental health and supporting patients' spiritual needs.

The mandatory training was comprehensive and met the needs of patients and staff. The provider offered a comprehensive range of mandatory training through e-learning and face-to-face training sessions. Training included but was not limited to, basic life support, information governance, infection control, safeguarding, prevention of pressure ulcers and medicines management. Staff we spoke with understood the importance of keeping up to date with their mandatory training. Staff described training as thorough and relevant to their roles.

Managers monitored mandatory training and alerted staff when they needed to update their training. The manager had oversight of all staff training portfolios and accessed an electronic staff record system to manage staff training requirements. The electronic system highlighted any staff that were due for or out of date for their mandatory training. The manager explained they monitored training compliance during staff appraisals and one-to-one supervision.

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. The safeguarding policies for the provider had clear guidance for staff to recognise and respond to abuse. The chief executive officer (CEO) of Arthur Rank Hospice Charity (ARHC) was a qualified social worker and the safeguarding lead for the provider and completed level three PREVENT training for adults. PREVENT is about safeguarding and supporting those vulnerable to radicalisation.

The provider's safeguarding adult's policy referred to an out of date version in respect of the intercollegiate guidance Adult Safeguarding: Roles and Competencies for Health Care Staff. Following our inspection, the provider told us it had reviewed its safeguarding adult's procedure to incorporate the up to date guidance. The CEO had also completed level three safeguarding adults and children. The CEO and the registered manager for ARHC and the director of clinical services for the day centre had also scheduled to complete 'Working Together to Safeguards Adults at Risk' training provided by the local safeguarding adults and children partnership board.

The provider had considered all roles in respect of the intercollegiate guidance Adult Safeguarding: Roles and

Competencies for Health Care Staff 2018 and taken the decision to train day centre staff to level two in safeguarding adults and children. Data provided by the service showed day centre staff achieved 100% compliance with adult safeguarding level two and safeguarding children level two.

The provider could access the local multiagency safeguarding hub, and local authority for additional professional safeguarding advice.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff we spoke with knew the protected characteristics and gave examples of how to protect patients' rights. For example, one staff member explained how they were supporting a patient with a learning disability who needed additional support to access treatment. The manager of the service was particularly keen to ensure that staff were aware of the needs of groups who may be marginalised, for example migrant workers, and the travelling community. We noted leaflets available in the main reception for migrants, in alternative language formats, signposting them to care services and support networks.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff received training on how to recognise and report different forms of abuse, including domestic violence, female genital mutilation (FGM), modern slavery, child sexual abuse and domestic violence amongst other key areas.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff knew and could explain their responsibilities in relation to safeguarding, how to contact the safeguarding lead and make a safeguarding referral. We noted key guidance on safeguarding displayed on on the services intranet and safeguarding flow charts displayed in the staff offices. Staff gave examples of making safeguarding referrals regarding patients with concerns of over financial abuse, coercion and controlling behaviour.

All staff and volunteers working at the day centre had completed appropriate disclosure and barring service (DBS) checks. A DBS check is a record of a person's criminal convictions and cautions, carried out by the disclosure and barring service. We reviewed three sets of staff personnel records and noted that the DBS, reference checks and entitlement to work in the United Kingdom documents were all complete.

Staff followed safe procedures for children visiting the centre. The main service provided was for adults, children would not routinely visit the centre. Staff we spoke with explained that due to the nature of the environment and the treatments provided, it was not usual for children to visit the centre or stay for extended periods.

The service had posters displayed to inform patients they could request a chaperone to support them during any treatment or assessment.

Cleanliness, infection control and hygiene

Staff used infection control measures when supporting patients and families.

Areas were clean and had suitable furnishings which were clean and well-maintained. The day centre was visibly clean in all areas we inspected. Furniture had removable and washable covering to enable staff to replace these if they became soiled and privacy curtains were disposable and had been recently replaced in line with the providers infection prevention control (IPC) policy.

The registered manager monitored cleaning records and actively engaged in cleaning duties. The service had recruited a volunteer cleaner to enhance cleaning of items such as wheelchairs and other equipment. External cleaning provision was monitored by the service manager and cleaning was independently audited and inspected by the owners of the site.

The service generally performed well for cleanliness. Cleaning services were provided by an external service provider. The provider carried out routine audits in relation to infection prevention and control (IPC) showing no issues of concern in the 12 months prior to our inspection and 100% of staff were complaint with IPC training.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We checked cleaning schedules and noted records were up to date and reflected the various areas of the day centre that required cleaning. Cleaning staff used 'I am clean stickers' to indicate that cleaning had taken place, we noted these were in date and easily visible to staff.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were aware of and practiced IPC in line with the providers policy and national guidance. Handwashing facilities and hand sanitiser stations were readily available throughout the day centre and the hand hygiene guidance was displayed at all hand washing stations. We observed staff following hand hygiene, 'Bare below the Elbow' guidance, and wearing PPE such as gloves and aprons whilst delivering care in line with the providers policy. Staff did not wear a specific uniform, but wore smart, professional clothing. This made the environment feel less clinical and more relaxed.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff cleaned equipment thoroughly between patients to reduce the risk of cross contamination and restocked equipment where appropriate. The day centre had separate treatment rooms for patients with a possible infection. All patients were screened as part of their initial assessment to assess whether they had any infection.

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. The service used a mobile call alarm system to enable patients to call for assistance if necessary. Due to the size of the day centre, the number of staff and volunteers, we noted that any patient who sought attention was immediately supported.

The design of the environment followed national guidance. Access to the day centre was from a private entrance, staffed by reception staff throughout the day. All visitors had to sign in and wear an identity badge on arrival and reception staff knew who to expect throughout the day. The reception area was adjacent to a staff office, two private treatment rooms and unisex toilets. Patients could leave their belongings and coats in a private cloakroom and there was a large, visibly clean kitchen where staff prepared meals and drinks for patients. Patients could access treatment in the large lounge, with up to 11 seats (a mix of recliner and fixed seating) and an activities area to the rear of the lounge.

The service had suitable facilities to meet the needs of patients' families. Since our last inspection in July 2017, the provider had significantly invested in improving the physical environment for both patients and staff. This included developing additional treatment room space, to enable staff to prepare and store medications safely and privately. The service had also built a separate treatment space with a bed, handwashing facilities and privacy curtains. This space could be used for patients who wanted more privacy or patients that may feel unwell during treatment.

There was a new additional open space, which could be used for treatment, or as a quiet space with its own television, recliner and fixed back seating.

Staff carried out daily safety checks of specialist equipment. Staff had access to supplies of available, accessible and suitable equipment, including resuscitation equipment. Scheduled checks for emergency and non-emergency equipment had been followed and recorded. We checked 15 consumable items and found all to be in date.

The service had enough suitable equipment to help them to safely care for patients. The provider had purchased a hoist to enable staff to safely handle and move patients, this was an improvement on our last inspection. Patients had access to a wide range of seating, treatment couches and additional handling and moving equipment, for example a rotunda. This is a piece of equipment that enables staff to move patients safely whilst standing.

Staff disposed of clinical waste safely. The provider had effective systems and processes in place for the segregation and management of clinical and non-clinical waste. Staff had access to sharps bins throughout the day centre and we found them to be labelled and dated in line with providers IPC 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. Staff monitored patients for any changes in their general

well being and assessed them thoroughly prior to any commencement of treatment. Observations included blood pressure, temperate and oxygen saturation. If a patient deteriorated during treatment staff followed the provider's deteriorating patient policy and deteriorating patient flow chart, administered basic life support, oxygen where appropriate and called for emergency services. Data provided by the service showed 100% of day centre staff, including administration staff had completed basic life support training. Staff always took into account patient's wishes, advanced decisions and any do not attempt cardiopulmonary resuscitation (DNACPR) guidance whilst assessing and treating patients.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff assessed patients holistically in relation to planning and implementing the patient's treatment plans. On admission to the service, staff discussed symptoms with the patient and assessed the patient's functionality. Assessments included Australian-modified Karnofsky performance status (AKPS), phase of illness (POI) and integrated palliative care outcome scale (IPOS) all of which formed part of the outcomes, assessment of complexities collaborative (OACC) suite of measures. Staff regularly reviewed patients to establish effectiveness of input.

Staff knew about and dealt with any specific risk issues. We reviewed three records from six of the patients who were receiving treatment in the day centre at the time of our inspection. We found staff comprehensively completed nutritional assessment, pressure area care of waterlow (pressure areas were assessed, and equipment ordered if required), mouth care, emotional and psychological needs, social history, family or carer input of support, welfare, benefits and advice.

Staff shared key information to keep patients safe when handing over their care to others. We observed the daily handover of patient information between the manger and staff team.

Shift changes and handovers included all necessary key information to keep patients safe. The information included any additional patient histories, recent treatment, ongoing concerns and family involvement.

The staff had recently implemented a week forward and week backward discussion to look at what worked well or didn't and what resources were necessary for the week ahead.

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. Staffing levels were monitored by the service manager and arranged to reflect the number of patients attending daily. The day centres own staff could work additional bank shifts in order to maintain services and avoid cancellations if this was required, but this would not be a common occurrence.

If there were exceptional circumstances the manager would follow the provider's business continuity plan and close the unit if it was felt to be unsafe from a staffing levels perspective. This decision would have to be a senior manager's decision and only be taken when all mitigation processes had been explored.

The managers could adjust staffing levels daily according to the needs of patients. The provider prioritised treatment schedules based on staffing levels and competencies, to avoid unnecessary hospital admissions and ensure quality of life.

The number of nurses and healthcare assistants matched the planned numbers. At the time of our inspection staffing levels were appropriate to the number of patients accessing the service.

Medical staffing

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.

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. Since our last inspection in July 2017, the provider had moved to use electronic patient records. We reviewed three patient records and found these to be contemporaneous, accurate and reflecting the patients current needs and wishes. Records contained all the necessary information to keep patients safe and promote their wellbeing.

When patients transferred to a new team, there were no delays in staff accessing their records. If staff needed to share information with other interested parties, the electronic record system could be accessed with the appropriate protocols by general practitioners and other health care professionals that used the same electronic records system.

Records were stored securely. Staff ensured computer screens were switched off between use and all computers were in closed staff office spaces. Access to the patient records was via a password protected system. Staff did use some paper based documents, for example medication records, we did not observe any paper based records left in open view in any of the patient areas.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff followed the provider's policy and guidance in relation to the administration, disposal and storage of medication. All patients had an initial assessment that covered allergies, full set of physical observations and wore a wrist band to show these had been completed prior to any treatment. The provider had a service level agreement with a local NHS trust for pharmacy support. Appropriate risk assessments were in place for medication, storage areas were locked and visibly clean. All appropriate staff completed the provider's medication training and the service manager was a nurse prescriber.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Patients attended the day centre for individual courses of treatments, usually intravenous (IV) to help them manage their palliative condition. Staff monitored the effectiveness of treatments and records showed that medications were regularly reviewed. Data provided showed 100% of the nursing staff had competed transfusion competencies to support IV medications and transfusion services.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. The provider did not store controlled medicines on site. All IV medication was stored appropriately, and medication refrigeration temperatures were checked routinely by staff with no gaps in records. The blood refrigeration temperatures were monitored remotely by an external provider and would send and alert to staff if temperatures dropped or a fault occurred. Oxygen was stored appropriately, in date and secure.

Staff followed current national practice to check patients had the correct medicines. Patients could request simple pain relief, for example paracetamol. However, staff always ensured that they checked with the patient and where necessary the general practitioner before any additional medication was given.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff we spoke with knew how to report medicine errors or incidents and had appropriate governance systems to share learning with all relevant staff. We tracked an incident where the patient was given the wrong type of medication that led to no patient harm. The incident was fully investigated, duty of candour followed, and learning shared via team meetings and training updates.

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 with during our inspection were clear on the need to report incidents and near misses appropriately. All staff knew the provider had an incident

reporting policy and understood the process for submitting an incident notification. Staff were open and transparent and fully committed to reporting incidents and share learning to improve services.

Staff raised concerns and reported incidents and near misses in line with provider policy. The provider recorded all incidents within the service and where necessary reported these appropriately to external stakeholders.

Never Events

The service had no never events in the twelve months leading up to our inspection.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

In accordance with the Serious Incident Framework 2015, the service/hospice reported no serious incidents (SIs) in its service which met the reporting criteria set by NHS England from 1 October 2018 to 30 September 2019. During the same period the provider recorded nine incidents with no harm / near miss, six with low or minor harm, one with moderate harm, zero with severe harm, and zero deaths.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff understood duty of candour and how to apply this following an incident. The manager explained how honesty and transparency were important as this helped the provider learn when things went wrong. Incidents we reviewed referenced to duty of candour and patients and families were informed when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff could request individual feedback on incidents at the time they completed the incident notification. Information regarding incidents was shared during staff handovers, via emails, team meetings and provider newsletters. The provider had an intranet which could be used to share information and highlight changes in practice or current concerns.

Staff met to discuss the feedback and look at improvements to patient care. We reviewed staff meeting records from October 2019 that demonstrated staff discussed how to make improvements based on feedback from incidents. The provider had a quality dashboard that enabled staff to review trends and themes in incidents. The service manager used incident data to improve services and minimise any ongoing risks. Most incidents related to third party issues for example patient transport being late or not turning up, and medication issues that may relate to the provision of medication from the external pharmacy provider.

There was evidence that changes had been made as a result of feedback. We reviewed an incident that caused no harm to the patient and involved the patient being given none irradiated blood. Irradiated blood is blood that has been treated with radiation (by x-rays or other forms of radioactivity) to prevent Transfusion- Associated Graft-versus-Host Disease (TA-GvHD). Irradiation does not cause significant damage to normal red cells or platelets and irradiated transfusions are as effective as blood which has not been irradiated. Although irradiated blood is recommended for patients, if they receive non-irradiated blood the risk of TA-GvHD is very small.

The incident had been fully investigated, staff had received additional training and duty of candour had been followed. The service manager reviewed every incident and escalated these appropriately to the senior leadership team. Learning from incidents in the wider Arthur Rank Hospice Charity were also shared with the day centre team, for joint learning and to minimise any occurrences within the day centre.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We reviewed three incidents during our inspection, all of which had been investigated appropriately and actions put in place to reduce any further risk of reoccurrence. Incident reviews showed that patients and families were informed when things went wrong.

Safety Thermometer (or equivalent)

The service used the outcomes of safety monitoring to improve safety. Staff collected safety information and shared it with staff, patients and visitors. The provider

maintained a quality dash board where it could review all of its current safety performance. Information from the dashboard was shared with staff during staff meetings and via internal provider newsletters.

Are hospice services for adults effective?
(for example, treatment is effective)

Good

Our rating of effective went down. We rated it as **good.**

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 followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed 10 policies and procedures, for example risk management policy, standard operating procedure for medications management, care of dying person guidance and anticipatory prescribing policy for patients with terminal illness, all of which were in date and contained current best practice guidance.

Staff were aware of all patients who had made advanced decisions regarding their care and treatment and which patients had do not attempt cardiopulmonary resuscitation (DNACPR) in place. We noted advanced decisions and DNACPR involved discussions with patients and their relatives, this was in line with national guidance from the Resuscitation Council (UK).

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We observed a staff handover and found this to be comprehensive and focused on the patient's individual needs. Staff had a genuine understanding and empathy for the patients and their family, tailoring the service to reflect choices and promoting non-judgemental care planning with a holistic focus. As patients may access the service on a few occasions, patients and their families built up relationships with other patients and their respective families. Handovers referred to the impact of care and treatment, and the death of other patients. Staff considered the psychological and emotional impact of the death and treatment regimes, providing additional support, for example bereavement services in order to promote patient and family wellbeing.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. 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. Patients had access to meals, snacks and routine hydration during their visit to the day centre. Volunteers played a key role in providing this service and used the day centre kitchen to prepare meals and drinks. The meals were provided from an external service provider, in large trollies; staff or volunteers then held these in the kitchen until ready to be served.

The provider made adjustments for any specific dietary or cultural needs and meal times had a family focus, bringing patients together to have meals over conversations and sharing their experiences. Patients told us that meals and drinks were always of a very high standard and they could request anything in reason, including, milkshakes, teas and coffees.

Staff fully and accurately completed patients' fluid and nutrition charts where needed and used a nationally recognised screening tool to monitor patients at risk of malnutrition. We reviewed three records from six of the patients who were receiving treatment in the day centre at the time of our inspection. We found staff comprehensively completed nutritional assessments in all of the appropriate records.

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. If a patient complained of pain whilst at the day centre staff would assess their pain using a simple zero to

ten pain score to measure a patient's pain. Staff could give patients basic pain relief, for example paracetamol and the service manager was a nurse prescriber. However, as patients were receiving individualised treatment staff would always review patient records to check they were able to have additional medication and where necessary check details with the patient's general practitioner (GP).

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. The service had audit and quality cycles that monitored and audited the quality of the services and the outcomes for patients receiving care and treatment. The service had a dedicated local audit progamme in place.

Staff used key tools in the management of palliative care to improve patient outcome measures. These included Australia-modified Karnofsky performance scale (AKPs), which is a measure of patients' overall performance status or ability to perform activities of daily living. We observed staff discussed this detail in handover meetings and made adjustments in the patient routine in order to improve their wellbeing.

Within day therapy staff used the integrated palliative care outcome scale (IPOS) to capture patients most important concerns, both in relation to symptoms, but also extending to information needs, practical concerns, anxiety or low mood, family anxieties and overall feeling of being at peace.

Staff used the IPOS tool to assess patients prior to commencing day therapy, this was sent out with the welcome letter for the patient to bring in on their first attendance and reassessed at six weeks and then again after 12 weeks. Problems highlighted in the IPOS were developed into care plans. A decision was made after 12 weeks using the results of this tool as to whether the patient then continued to attend day therapy, was transferred to the social group or signposted elsewhere and discharged with a safety net plan that the patient can re refer if required.

Staff used this tool to plan care, treatment and support to comprehensively meet the individual needs of patients. The service routinely used the outcome assessment and complexity collaborative (OACC) scores. These were stored within a universal IT system shared with GP's and other health professionals to assess what care mattered most to patients and their relatives at the end of life.

The provider purchased a bespoke IT package to manipulate OACC data from the universal IT patient record system. It consisted of two main elements: firstly, a timeline tool that was accessed directly from a patient's IT based care record and displayed graphs of the patient's IPOS scores/symptoms within Excel. Staff used this data in MDT meetings, handovers, and when personalising patient care as patient needs were easily identified. Secondly, a reporting tool that ran outside of a patient's record through the reporting function in the universal IT system that analysed all patient OACC data across the the whole of the Arthur Rank Hospice Charity. The system would help guide quality development and improvement projects, as staff could use data to measure improvement in patient symptoms, as well as highlight areas for development within the service.

Staff captured each patient's preferred place of care and preferred place of death within both their holistic assessment and by using the local Clinical Commissioning Group (CCG) end of life care template. This information was shared with other professional services, for example out of hours services, 111, ambulance and acute trust, helping to avoid inappropriate admissions as well as guide patient care.

Within the providers monthly dashboard, staff monitored what percentage of patients were able to achieve their preferred place of death. During September, October and December 2019 and January 2020 100% of patients achieved their preferred place of death. Eighty-percent of patients achieved their preferred place of death in November 2019 because one of the patients wanted to be admitted into the local NHS trust and there was no bed availability.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service participated in a wide range of audits including infection, prevention and control, record keeping, patient led assessment of care (PLACE) and

hand hygiene. Results from audit were shared with the day centre staff team, clinical care board and escalated where necessary within the service governance structure for action and improvement.

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 which was complemented by additional training in order to support patient needs. The service manager recognised that the development of staff skills, knowledge and competencies was integral to ensuring high quality care, improving access to services and promoting positive outcomes for patients. For example, the service manager was a nurse prescriber. Another nurse had completed additional training in assessing patients. This enabled them to carry out a comprehensive patient assessment to support the patient treatment plan or seek additional medical advice if there had been significant changes in the patient's condition.

Managers gave all new staff a full induction tailored to their role before they started work. The provider had a structured induction programme for staff to ensure they had the skills needed for their roles. The service's induction programme included ensuring new staff could access the computer systems and dedicated time to complete mandatory training. The induction programme was supported by individualised induction packs for staff. The packs included an induction timeline, e-learning requirements and activities which were signed off by the manager when completed.

Managers supported staff to develop through yearly, constructive appraisals of their work. Data showed 100% of day centre staff had completed their annual appraisal.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Staff we spoke with told us they looked forward to appraisal and the opportunity to discuss their development. Staff said the service manager fostered a positive approach to appraisals, encouraging staff to focus on their individual development needs and how they could link these to improving the services for patients.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff routinely attended team meetings and meeting minutes we reviewed showed that the meetings covered a wide range of topics including staff development and training opportunities.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The service manager had oversight of staff development activities and opportunities across the provider's wider services and actively encouraged staff to develop their skills and knowledge. Staff we spoke with described the service manager as focused on improving the service and quality by enabling staff to complete additional qualifications and competencies.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. The manager had contact with the staff team daily and understood their individual strengths and weaknesses. During supervision sessions and appraisals, the service manager would seek opportunities to challenge staff and offer them additional training to improve on areas where they lacked confidence or required additional support. We noted an example of one member of staff who was having particular difficulties with one area of practice. The service manager had given the staff member additional time and mentoring to improve their confidence and enable them to meet the required performance levels.

Managers made sure staff received any specialist training for their role. The service manager consistently looked at ways to offer staff additional training to improve services for patients and access to treatment. Throughout our inspection, we noted staff had completed additional training to meet the needs of patients.

Managers identified poor staff performance promptly and supported staff to improve. The service manager had clear understanding of how to use the provider's performance management processes. However, the

manager explained how they would seek to resolve any issues with staff before reaching the formal stage. Staff we spoke with said the manager sought feedback on their own performance and how they were leading the service.

Managers recruited, trained and supported volunteers to support patients in the service. Volunteers were recruited by the Arthur Rank Hospice Charity. We spoke with the provider's human resources director who explained the volunteer recruitment process and training they received. Volunteers had disclosure and barring service checks, references and interviews to ensure they met the specific volunteer requirements. Volunteers were a corner stone of the service and highly valued by staff, the patients and their families. Volunteers received training in various aspects of palliative care, including dementia awareness and safeguarding.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Day centre staff attended various meetings across the local community and engaged with local general practitioner (GP) services to promote, and community based services to engage providers in palliative care services. Staff were focused on using 'joined up" services to provide the best care and treatment for patients and routinely engaged with a wide range of health care professionals to meet patient needs.

The day centre staff collaborated with occupational therapists, physiotherapists, and dieticians within hospitals and the community in order to provide a joined up service for the patients.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support. Patients and their families had access to a wide range of information to promote healthy life styles. We noted information available throughout the day centre on how to access services, for example a foot care practitioner and complimentary therapy.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff completed comprehensive assessments for all patients which took into account the physical, psychological, social, cultural and spiritual needs. Staff understood the importance of engaging patients' families in the treatment process and their importance in maintaining and encouraging the patient's life style when leaving the centre.

Consent and Mental Capacity Act

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke with understood the principles of capacity and consent and explained how they would ensure patients gave consent prior to any treatment. Data provided by the service showed 100% of staff had completed Mental Capacity Act training and 100% had completed dementia training modules level one and two. Patients attending the day centre did so as they were receiving ongoing treatment or therapy, staff explained it would be highly unusual for a patient to come to the centre who lacked the ability to consent to their treatment.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Throughout our inspection we noted staff sought the consent of patients prior to the administration of any treatment.

Staff made sure patients consented to treatment based on all the information available. We observed staff explaining in detail what they were going to do and why and any impact this may have on the patient.

Staff clearly recorded consent in the patients' records. We observed staff providing care and treatment and seeking patient consent and recording this in the patient's records.

Are hospice services for adults caring?

Outstanding ☆

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

Compassionate care

Hospice services for adults

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. The service provided a holistic person centred culture that took all aspects of the patient's care into consideration when delivering treatment or complimentary therapy. We observed consistent mutually respectful interactions with patients, ensuring that patients were comfortable and providing reassurance at times of need.

Throughout our inspection, we observed staff treated patients with compassion, dignity and respect. Staff we spoke with were aware of the importance of treating patients and their visitors in a sensitive and compassionate manner. All staff we spoke with had a genuine desire to want to provide the best possible care for patients.

It was clear that during their time at the day centre, patients and their relatives built strong and caring relationships with the staff and volunteers. These relationships were highly valued by the provider and the service manager fostered a culture of mutual respect and empathy for the patients in the service.

Patients said staff treated them well and with kindness. Patient and relatives' feedback on the service was consistently positive saying that staff and volunteers always treated them with dignity and respect. Patients told us that staff went the extra mile in providing their care and that it exceeded their expectations.

The service displayed an abundance of thank you cards and messages from patients and their relatives. Patients comments included, "Always a cheery voice for me on the end of the phone, thankfully my husband is in no more pain". Another patient told us "I couldn't wish for better treatment" and another said, "The people here are like family, I can talk to them and discuss things privately. I can't do this at home, my family wouldn't understand me, and I wouldn't want them to be upset."

Staff followed policy to keep patient care and treatment confidential.

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

Patients were active partners in their care. Nursing staff really listened to the wishes of their patients and advocated for them. Care plans demonstrated that staff encouraged patients and those close to them to actively express their choices and wishes whilst at the day centre and staff would adjust their care plan accordingly.

We reviewed a patient's feedback which said, "They would be extremely likely to recommend our service as 'very professional approach to all aspects of treatment, but always delivered in a total caring, loving way, ensuring the needs of the patient are taken into account and understood.'

A patient was discharged from the local hospital and a family member brought them straight to the day treatment centre stating the patient could barely transfer and they were concerned the patient couldn't cope. Day treatment centre staff liaised with the discharging hospital and found that the patient had been assessed as safe to discharge. However, on arrival at the day treatment centre the patient said they did not want to return to hospital and worried they would not be able to manage at home. Whilst at the day treatment centre the patient was incontinent, and staff sensitively reassured and assisted the patient with their personal care despite them not being a routine patient. Staff spoke to the local NHS trust and did an emergency referral for admission for further rehabilitation and discharge planning. The patient and family were extremely grateful saying "Thank you so much for keeping my sister safe, I have so much confidence in you".

A patient who spoke little English came into the day treatment centre and explained to staff that their dentures had snapped in half. The day treatment centre receptionist listened to the patient's concerns, provided reassurance and organised for their dentures to be repaired.

Staff took blood tests from patients who should normally attend a phlebotomy department. However, patients

preferred to attend the day treatment centre because they felt more welcomed and at ease. Staff very rarely turned these patients away and always made them feel at ease and accommodated their wish although staff had to explain the patient may have to wait as they did not have a planned appointment.

A patient that was not a patient of the day treatment centre approached staff asking if they could can help as their bank account had been accessed and they had no money. Staff supported the patient and helped them to contact their bank and police to deal with their situation.

The day treatment centre volunteers often took patients who attended the social group to their general practitioners' surgery on site or outpatient appointments whilst they are attending the social group. The volunteers did not have to do this as they are there to assist with the social group but were happy to help the patient this way.

Staff received a phone call from a distressed family who did not live in the day treatment centres usual catchment area. The family were concerned about a patient's agitation and pain. Staff supported the family and listened to their concerns. The staff called the district nursing team and offered advice on symptom management, then called the hospice at home team and arranged night support and admission to an inpatient unit when a bed became available.

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 a patient asking staff for feedback following a basic care assessment, as this assessment had caused the patient significant concern. Staff provided sensitive and compassionate support and took time to explain the impact of the assessment.

Staff supported a bereaved relative who walked into the day treatment centre unplanned at 4.30pm, when the unit should close. Staff kept the centre open and gave the relative time to talk and the time they needed to discuss their feelings and find reassurance.

Staff handover meetings routinely referenced to the additional care needs of patients, recognising the impact of their condition on their emotional and psychological wellbeing. We observed a handover where staff discussed the recent death of a patient, how this may affect other patients in the service and how they would provide additional support to any patients or relatives affected.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed staff comforting a patient whose friend had recently died whilst accessing the service. Staff showed compassion and empathy, offering additional time before their treatment to enable them to discuss their feelings and express their grief.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff completed conflict resolution training and spiritual awareness training to help them deal with difficult conversations and situations. We observed one member of staff supporting a patient that was distressed. The staff member calmly listened to the patient and offered reassurance and an opportunity to express their concerns. The member of staff provided additional information and guidance to help the patient understand the information they had just received and encouraged them to allow themselves time to understand what had changed and why.

Staff gave an example of a patient who was very angry and felt let down by a hospital that was providing their treatment. The patient called the day centre, very angry having had a recent cancer diagnosis, they were very scared and looking to get a blood test done. The day centre team invited them in for the tests, listened to the patient's issues and spent time offering reassurance and helping them to understand their diagnosis. The patient was now a regular visitor to the day centre and had built a great rapport with the staff and volunteers.

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. Staff gave an example of a recently bereaved person who staff encouraged to use the complimentary therapy and bereavement services due to concerns for their emotional wellbeing. The person went on to attend complimentary

therapy sessions and actively participate in the bereavement group, which led to them going on to volunteer in a local school and regain their self-confidence.

Staff gave examples of supporting a patient attending day therapy to pay their bills and fill out paperwork whilst in day therapy as they were unable to do this independently. Staff contacted bailiffs on behalf of a patient due to their social situation and distress, this was above and beyond the usual day therapy support staff would normally offer.

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 completed comprehensive assessments of the patients' needs which also included any information from close relatives which may need to be taken into account. Patients and relatives, we spoke with told us they were fully engaged in theirs or their loved one's care. The service promoted holistic care, that empowered patients to make decisions and have a voice in their treatment. We routinely heard staff and volunteers asking the patients and their relatives "How are you doing", or "Is there anything you need".

A patient who spoke English as a second language had been discharged from hospital the day before attending the day treatment centre and had no understanding of what their medication was for or how to take it. The patient wanted to return to their home country to die. The patient was self-medicating with tablets they had acquired. The provider used an interpreter to carefully provide clear information regarding the medication both verbally and written. Staff arranged volunteer transport to bring the patient to the day treatment centre, rather than using their only method of transport which was a bicycle. Staff provided a detailed letter to support the patients flight home and explain why they were carrying medication. This ensured the patient had all the necessary support to obtain care on their return to their home country.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff and volunteers understood the patients' needs exceptionally well, building strong caring relationships. This enabled them to fully understand any patient communication issues and develop ways of encouraging communication. We noted one patient that was very softly spoken, staff sat with them at an appropriate distance and listened patiently until the patient had explained what they wanted. The service employed an activities coordinator to provide activities to day centre patients. During these sessions staff and volunteers encouraged patients to express themselves through art, words and creative activities.

The staff team supported a patient who was visually impaired and had been physically assaulted by their carer. The staff arranged a meeting in the day treatment centre where the patient felt safe and liaised with social services and sensory support teams to carry out a specialist review of medication, support the patient to access grants, and made a referral to fire department for personal safety support. The day treatment centre team continued to support the patient despite them temporarily moving out of area to stay with their family. This facilitated attendance for urgent radiotherapy and access to other health services they would have been unable to attend.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The provider welcomed and actively encouraged feedback on its service. Feedback forms were located in the main reception area and we noted staff had made changes within the service based on patient feedback, for example lowering the volume on the television during treatment sessions.

Staff supported patients to make advanced decisions about their care. Staff we spoke with explained that some patients had made advance decisions about their care, but others were not sure of the process or indeed how their diagnosis would affect their life expectancy. Staff explained they would often have discussions with patients and relatives and sign post them towards appropriate services, for example back to the general practitioner, counselling services or the bereavement support group.

Outstanding ☆

Hospice services for adults

We reviewed a patient story for a patient who attended the day treatment centre following a diagnosis of lung cancer. The staff supported the patient to complete advanced care planning and although the patient wanted to die at home, they were aware that this may not be possible as they lived alone. The patient's condition deteriorated, and they started to struggle with personal care, they were very independent and reluctant to accept help. The team offered support visits from their hospice at home team who chatted over coffee, provided relief from isolation and built up a strong rapport with the patient. This gave the patient confidence and security knowing there was support at home. The patient accessed support from the day treatment centre community nurse specialist (CNS) who the patient had met whilst at day therapy. The CNS monitored and managed the patient's pain and any other symptoms and facilitated communication with the patient's family, who commented they were "Very grateful for the support they were receiving."

Staff supported patients to make informed decisions about their care. We observed staff actively encouraging patients to make decisions about their care. One patient explained how they had been concerned regarding their treatment and how this may give them pain. Staff provided additional reassurance and time to consider the treatment before progressing. The patient told us after treatment that they had felt no pain, and staff had provided additional reassurance whist providing the treatment.

Patients gave positive feedback about the service. Patient and relatives' feedback was universally positive regarding their loved one's care and treatment. We spoke with the relative of one patient who told us the day centre had provided them a life line, and the ability to leave their loved one in a safe place where staff knew them well. They told us the day centre staff had been amazing and that their loved one looked forward to coming to the centre and they had an opportunity to meet friends and socialise, they said it felt like they were leading a 'normal life'.

Staff truly understood the social impact of a palliative condition on patients and their families. Their holistic approach enabled them to provide care and treatment that minimised any social impact and enabled patients to be socially active, meet other people in similar situations, make friends to share their feelings and experiences.

The staff provided a follow up bereavement call following a patient's death. Staff from the day centre would call the patient's loved ones and ask if they wanted to attend the bereavement group and ask if they needed any additional support. The staff also sent a hand written bereavement card to the deceased patient's loved ones following any patient death.

A patient was unsure about whether to have a portacath inserted instead of their peripherally inserted central catheter (PICC) line, despite being assured by staff that they could support this and explaining the positives and negatives of the change. A portacath is a small medical device that provides direct access to a patient's central vein. A PICC line is used for providing patients long-term intravenous (IV) antibiotics, nutrition or medications, and for taking blood. Staff arranged for a colleague to visit the patient, as they had a portacath themselves, so they could explain their experience of how this would be done and to provide reassurance to the patient.

Are hospice services for adults responsive to people's needs?

(for example, to feedback?)

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 service reflected the needs of the population served and promoted access, choice and continuity of treatment. The service offered day services for patients living with long term conditions and supported patients and their relatives to manage

their conditions. The service manager was passionate about meeting the needs of local people and actively working with commissioners to provide a service to marginalised/isolated groups.

The provider had signed up to the local council's equality pledge, was a Disability Confident Employer and signed up to Time to Change and were producing an action plan to develop more inclusive services. The providers equality diversity and inclusion (EDI) used 'Care Committed to Me', Hospice UK publication as a basis for developing their EDI action plan.

The provider had worked alongside the lead nurse from the local CCG who worked with traveller families to engage with the EDI group and identify a nurse in the provider's community teams to be the link nurse and build relationships with the community to ensure services are accessible.

Locally the day centre manager was working with a social enterprise and registered charity helping homeless people in Fenland. The provider was working with volunteers to support clients referred by this charity, with transport for example, to assist access to medical appointments. The provider gave an example where they worked collaboratively with the charity and their translator to support a palliative patient with complex pain management and social problems. Staff optimised the patient's pain control, administered a blood transfusion, and enabled them to access medication to ensure they were repatriated abroad to die in their preferred place of death.

The service manager actively engaged with external professionals and multidisciplinary (MDT) staff teams. The service attended local palliative care meetings, MDT training and was in the process of developing palliative care hubs to meet the needs of local people by bringing other professionals together to deliver a holistic local palliative service.

Facilities and premises were appropriate for the services being delivered. Since our last inspection in July 2017, the provider had substantially invested in upgrading the physical environment for patients, staff and volunteers. The changes had significantly enhanced the environment in order to provide the services on offer.

The service had systems to help care for patients in need of additional support or specialist intervention. Following the environmental upgrades patients could access a private treatment room with a bed, privacy curtains and handwashing facilities. This meant any patients needing one-to-one support or a patient who may become unwell during treatment had access to a private space. This was an improvement from our last inspection.

Managers monitored and took action to minimise missed appointments. The service managed patient appointments and established close relationships with patients and relatives. Patients who failed to make appointments were discussed at the daily handover meeting, including any reason for non-attendance.

Managers ensured that patients who did not attend appointments were contacted. Where appropriate staff always followed up on missed appointments to check on the patient's wellbeing and look at any barriers to accessing the service.

The day centre had a dedicated hairdressing salon where patients could relax and have their hair cut or styled whilst at the day centre. The hairdresser did this on a volunteer basis and any donations were donated to the charity to support its activities.

Since our last inspection, the day centre had established a bereavement and family support group user group. All members of the group had family members who were cared for by the day centre team and it was an opportunity to discuss their individual needs and also look at ways to improve the service.

Staff gave an example of a patient who was attending for adjuvant treatment who had been declining scans at an acute hospital and subsequent oncology intervention. Staff spent additional time with the patient and established this was because of patient transport and having to wait around for so long and being uncomfortable. The staff made arrangements for their volunteer driver to take the patient for their scan. This facilitated them having a scan, without long waits and discomfort.

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.

The service had information leaflets available in languages spoken by the patients and local community. Leaflets were available in a wide range of languages and accessible in the main reception area. We noted that information in relation to supporting dying people, changes in life and caring for someone through death were displayed within the day centre.

The provider agreed the following diversity statement at their EDI group meeting in July 2019, which comprised of colleagues from across the organisation and one of the charity's trustees. "Arthur Rank Hospice is committed to inclusivity, respect, fairness, engagement and equality of opportunity for our patients and their families, our staff and trustees, our volunteers and our supporters. We value the strength that comes with difference and the positive contribution that diversity brings to our community".

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 families who spoke English as a second language.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Patient's had access to meals, snacks and routine hydration during their visit to the day centre. Staff would make reasonable adjustments and order specific items for patients if they had any specific dietary or cultural needs.

Patient records showed that staff completed holistic assessments which took into account the patient's spiritual, religious, psychological, emotional and social needs.

The provider offered complimentary therapies to patients to support them through their treatment. Patients could access a private room where a complimentary therapist offered gentle massage, reflexology adapted for patients, aromatherapy and therapeutic touch. Staff would also use the therapy sessions to support patients who were needle phobic, or to help patients to relax prior to treatments. Staff gave an example of warming a patient's hands prior to inserting a cannula for treatment, this made the canula easier to insert and more comfortable for the patient.

The service had an activities coordinator who provided activities for patients with the support of the staff and volunteers. Patients engaged in various arts and crafts, often finding for the first time that they had abilities they were unaware of. These sessions formed a large part of the social atmosphere for the day centre, providing a focal point for conversation, sharing information and experiences. Patients and relatives, we spoke with found these sessions highly valuable in supporting patients and said they provided a welcome distraction from the treatment they were receiving. Patients were proud of the art or sculptures they had made, we could see the genuine joy and sense of accomplishment patients got from these activities. The opportunity to be creative and spend time with the day centre teams and the other patients truly made a huge difference to patient well-being.

As part of the physical changes to the environment, the provider had created a quiet / multifaith room where patients could meditate, pray or have privacy between treatments. Staff had placed a tree of life sculpture on a wall, where patients or relatives could hang small labels in the shape of leaves from its branches. We noted patients and families used the labels to write down a prayer or record a thought or comment. Inside the room was a storage area where the chaplain kept religious items that could be removed at any time depending if the patient had a particular faith or none. Keeping the items stored away respected the space as a none denominational space accessible to all.

Staff gave an example of a patient who smoked cigarettes and was wheelchair bound. Staff had identified that the patient had a number of cigarette burns, caused by mobility and dexterity issues. The staff contacted the local fire service with the patients consent. The fire service visited the patient's home and provided a risk assessment and additional fire blankets to promote their safety.

The chaplain formed close relationships with the patients and relatives. The chaplain had delivered funeral services for patients from the day centre and been with them during last days of life to offer comfort and support to the patient and their families.

The day centre had a small library of books, that explained life limiting conditions in simple ways. Some of the books were also aimed at children and young people and written in a simple format so they could understand

life limiting conditions. Patients and relatives could take these books home and use them to explain life limiting conditions to children and young people, so they could understand symptoms and treatments.

Staff had access to information on local support agencies and charities that provided services for patients. These included local mental health support and financial services amongst others. Staff understood the impact of palliative illnesses in terms of social and employment changes. They could signpost patients to support with energy bills and financial advice.

Staff gave an example of a vulnerable patient who was partially sighted and struggling with the heating at home. Staff supported the patient to access a financial grant for additional heating.

The service had equipment that was suitable for use by bariatric patients, including a hoist and seating.

The service manager encouraged staff to complete additional training, competencies and improve their skills to meet the needs of patients. This enabled the staff to meet a wider range of patients' needs and limit barriers that may have restricted patients accessing the treatment in a timely way.

Access and flow

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

Managers and staff worked to make sure patients did not access the service longer than they needed to. Patients accessed the service following a referral from their own general practitioner or community nursing teams. Patients usually accessed a 12 week programme dependent on the treatment regime and how well the patient's condition was managed. Staff worked closely with the patients, relatives and others for example the patient's GP to monitor the patient's progress and if they needed to stop or extend the treatments.

We spoke with patients regarding access to the service. One patient told us they never had any issues accessing the service and staff always managed to get them an appointment.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes. The service manager monitored all patient activity and actively sought to provide services to meet the individual needs of the patients. One patient told us they had asked staff for help seeing a dietitian and the staff had arranged this quickly, which meant the patient didn't wait long for additional support.

When patients had their appointments or treatments cancelled at the last minute, managers made sure they were rearranged as soon as possible. If it was necessary to change a treatment session or appointment the provider did this without delay to ensure the patient was aware and could make changes to their day or agree to come on an alternative day.

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.

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with told us they had not needed to make a complaint but felt comfortable speaking to the staff about any concerns they may have.

The service clearly displayed information about how to raise a concern in patient areas. The provider displayed its complaints and feedback process in key areas within the day centre

Staff understood the policy on complaints and knew how to handle them. All staff we spoke with knew the provider's complaints process and how to use this to deal with any issues raised.

Managers investigated complaints and identified themes. At the time of our inspection, the service hadn't received any formal complaints. However, the manager and staff team understood the provider's complaints policy and how to implement this.

Staff could give examples of how they used patient feedback to improve daily practice. Staff gave an example of a patient leaving the complimentary therapy room and seeing a deceased patient being taken through the corridor by the undertakers. The patient had been really upset by this and raised a concern to the staff. The staff had worked with the local NHS hospital and undertakers to agree a communication protocol to avoid this happening again.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff we spoke with knew the provider's complaints policy and how to use this if they received a complaint. Staff told us that they had not received any formal complaints in the 12 months leading up to our inspection.

Managers shared feedback from complaints with staff and learning was used to improve the service. The service had not had any formal complaints in the 12 months leading up to our inspection. The service manager told us that if a complaint was received, they would share this with the staff during staff handovers or at a team meeting. Learning from complaints in the wider Arthur Rank Hospice Charity was shared with staff including any learning to minimise any similar complaints in the future.

Are hospice services for adults well-led?

Good

Our rating of well-led went down. We rated it as **good.**

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 demonstrated high levels of experience, capacity and capability needed to deliver excellent and sustainable care within the service. The manager understood the issues, challenges and priorities in the service, and beyond, and was proactively seeking to address them. For example, engaging the local general practitioners and other care providers in the palliative care hubs. They worked collaboratively with partner organisations, stakeholders and other agencies to deliver a high-quality, patient and family-centred service.

The provider had a clear management structure with defined lines of responsibility and accountability. The service manager had detailed oversight of the day-to-day management of the day centre. The service manager was supported by the senior leadership team from the Arthur Rank Hospice Charity who were in turn accountable to the Charity's chief executive officer and its board of trustees.

Staff we spoke with were unanimously positive about the manager of the service describing them as highly supportive, committed and passionate about the service provided. Staff told us the manager was highly visible, approachable to both staff, patients and stakeholders and we observed this during the inspection.

The service provided ongoing training and development opportunities for staff. This was driven by the manager looking at ways of providing additional treatment and reducing any barriers patients and their families may face when seeking care or treatment. For example, staff had completed additional training in assessing patients' needs and prescribing medications to reduce waiting times and improve patient outcomes.

Vision and strategy

The service had an overarching strategy for what it wanted to achieve and an operational plan to turn it into action developed with all relevant stakeholders. The strategy was fully aligned with plans in the wider health economy and there was a demonstrated commitment to system-wide collaboration and leadership.

Arthur Rank Hospice Charity had a clear strategy and operational plan underpinned by a core set of values, with quality and sustainability as top priorities. The day centre manager, staff team and volunteers embraced the Charity's strategy and operational plan and were focused on providing high-quality palliative care services for patients and those close to them living with life-limiting conditions.

The service had an established set of values, which were to provide:

- Flexible, individual and responsive focussed specialist palliative care
- Integrity, compassion and professionalism
- Valuing and investing in our workforce
- Equality of service
- Prudence in the management of our resources

Outstanding ☆

Hospice services for adults

During our inspection we noted Arthur Rank Hospice Charity's strategy and operational plan were displayed within the day centre. All staff we spoke with knew the main details of the overarching strategy and operational plan. The manager was highly committed to imbedding the Charity's values and ensuring staff delivered on its operational priorities. The manager was also keen to develop local services for local people and was passionate about ensuring patients were not marginalised due to their social or economic situation.

Arthur Rank Hospice Charity had a five-year strategy from 2017 to 2022. This had been developed in collaboration with staff, patients and external partners, and was aligned to national recommendations for palliative and end of life care. The strategy recognised the challenges presented by a growing and ageing population, with more people receiving complex diagnosis and requiring palliative care services. The strategy set out how the Charity planned to deliver services which met the needs of more people and enabled them to access personalised, palliative care and treatment.

Culture

Staff were highly motivated to provide the highest standards of care they could for their patients and supporting their families. There was a common focus on improving the quality and sustainability of care and people's experiences. Staff felt highly respected, supported and valued. The service had an open and progressive culture where patients, their families and staff could raise concerns without fear.

All staff and volunteers we spoke with were passionate about the care and support they provided and were extremely proud to work or volunteer at the day centre. Staff and volunteers told us they loved their roles and were committed to providing outstanding care for patients and those close to them. Throughout our inspection, we observed positive and respectful interactions between staff, volunteers and patients and families. Staff told us they all supported and cared for each other and treated each other with respect.

Staff we spoke with told us they felt supported, respected and valued by the service manager and other senior managers who came to the day centre always thanked them for their hard work. Staff and volunteers described the culture within the service as being open and positive.

Leaders were highly visible, accessible and supportive. The service manager promoted an 'open door' culture and encouraged staff to speak up and have their say. Staff told us they felt confident to voice any concerns or issues they had to the service manager and also to raise a concern with the wider senior management team if they felt it necessary.

The provider had specific arrangements in place to ensure staff could raise concerns safely and without fear of reprisal, including a whistleblowing policy which staff could access from the providers intranet.

The service centred on the needs of patients and those close to them. Staff described many examples of ways they met the individual needs and wishes of patients and helped them to live each day to their fullest. Many of the volunteers who worked at the day centre were relatives of patients who had been cared for by the service. This demonstrated how positively former service users felt about the service and the care and treatment they provided.

The manager spoke with pride about the service staff and volunteers delivered daily. They celebrated staff success by sharing positive feedback received and positive contributions made by staff.

The provider had a strong focus on the safety and wellbeing of staff. Measures were in place to protect the safety of staff who worked alone and within teams in the local community.

The provider fostered a culture of openness and honesty, especially if things went wrong. The service had processes to ensure the duty of candour was met, including training for staff. The manager and staff understood the duty of candour and confirmed they were encouraged to be open and honest with patients, families and carers when thigs went wrong.

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 to support the delivery of high quality services and patient safety.

Quality and risk information in relation to the service was reviewed at a senior level by the Arthur Rank Hospice Charity board of trustees and senior leadership teams. A clinical care board met every four weeks, the day centre manager fed any risks, quality or performance issues to this board for scrutiny. We reviewed board meeting records from June and September 2019 and found these comprehensively covered areas of risk and performance. The clinical care board included key staff from across the Arthur Rank Hospice Charity teams including, clinical staff, educators, support staff and external stakeholders where appropriate. The clinical care board reported to the clinical governance committee which met every two months and consisted of the charity's trustees and senior leadership staff. The charity's board of trustees met every two months to review information from the clinical care board and clinical governance committee.

Key information reported into the clinical care board included medications management, infection prevention and control, research, staff and patient forum feedback.

Staff were clear about their roles and had a clear understanding of their accountabilities and maintaining quality within the service. Staff were committed to improving the quality of service provision and maintaining high standards of care. Staff knew how to report incidents and told us they were encouraged by the service manager to report incidents and learn from incident reviews when things went wrong.

Managing risks, 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.

The service had clear and effective processes for identifying, recording, managing and mitigating risks. The day centre had a local risk register which included a description of each risk, the potential impact of the risk and the risk owner, alongside mitigating actions and controls in place to minimise the risk. Each risk was scored according to the likelihood of the risk occurring and its potential impact. At the time of our inspection, two risks were detailed on the risk register; one of which related to funding for the service, the other related to the risk of only having one consultant session per week at the day centre. The risk register was routinely reviewed, and action had been taken to minimise each risk. Risks were reviewed regularly at team meetings and monthly governance meetings. There was alignment between the recorded risks and what staff identified as risks within the service.

The service reported its risk and performance into the wider Arthur Rank Hospice Charity governance processes and the Arthur Rank Hospice senior team and its trustees had senior oversight of risks and performance within the service.

The provider used feedback from incidents, performance and audit to drive through change and continually improve the quality of the service.

Incidents reported were reviewed regularly by senior staff and where necessary, investigations were initiated to identify any themes and actions needed to minimise recurrence.

The provider had a comprehensive programme of clinical and internal audit. This was used to monitor quality and operational processes, and results were used to identify where improvement action should be taken. Staff confirmed they received feedback from audits at team meetings, handovers and during their one-to one sessions.

The service had an up to date business continuity management plan which was accessible to staff and detailed what action should be taken and by who, in the event of a critical incident involving loss of building, information technology or staff. Emergency contact numbers for managers and services was included.

Managing information

The service invested in best practice information systems. Staff could easily 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.

There was a holistic understanding of performance which sufficiently covered and integrated people's views with

information on quality, operations and finances. Clear and robust service performance measures were reported and monitored. Staff had access to quality and performance data through feedback from governance meetings and quality and performance reports. Reports were detailed and included data on a range of performance and quality indicators, such as incidents, staffing, service user feedback, complaints and patient feedback.

The provider had effective arrangements in place to ensure data and statutory notifications were submitted to external bodies as required, such as the local service commissioners and the Care Quality Commission (CQC). The provider promoted transparency and openness with all stakeholders about performance and risk.

Staff had access to up-to-date and comprehensive information regarding patients' care and treatment. The electronic patient record system was the same as that used by local general practitioners (GPs). There were arrangements to ensure confidentiality of patient information held electronically and staff were aware of how to use and store confidential information.

Computers and laptops were encrypted, and password protected to prevent unauthorised persons from accessing confidential patient information.

Engagement

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

People's views and experiences were at the heart of the service and used to shape and improve the service and culture. Patients, families and carers were encouraged to share their views to help improve services. Feedback was reviewed by staff and used to inform improvements and learning, where possible. For example, staff used the 'you said – we did' to improve services. Patients had said that one of the televisions was constantly blaring and causing a distraction, the staff had responded by offering radio stations as an option and an additional television in the new quiet lounge area.

The service manager actively engaged with external professionals and multidisciplinary (MDT) staff teams. The service aimed to attend palliative care meetings, MDT training and develop palliative care hubs to meet the needs of local people by bringing other professionals together to deliver a holistic local palliative service.

There were high levels of engagement with patients, families and carers, partner organisations and the public. For example, families and carers were invited to attend the day centre for an annual day of remembrance, where people could come together to reflect and remember their loved ones.

Since our last inspection, the day centre had established a bereavement and family support group user group. All members of the group had family members who were cared for by the day centre and it was an opportunity to engage with the service and feedback on what worked well and any areas for improvement.

The views of staff were sought and acted on by the provider. Day centre staff were invited to participate in the annual staff survey.

From discussions with staff and observations made during the inspection, it was evident to the inspection team that staff were highly engaged with and motivated within the service. They told us they felt confident to raise concerns and were encouraged to come up with ways in which services could be improved. Information was shared with staff in a variety of ways, such as handovers, newsletters, email, noticeboards and staff events.

The service had recently arranged a Christmas dinner event for patients. We noted a feedback letter from a patient which said, "I had a magical party".

Learning, continuous improvement and innovation

The provider had significantly upgraded its physical environment in order to provide additional space for treatment, therapies, storage and staff offices.

The provider explored different ways to improve patients access to services, for example providing additional training opportunities for staff.

Outstanding practice and areas for improvement

Outstanding practice

Services were delivered in a way to ensure flexibility, choice and continuity of care and were tailored to meet patients' individual needs and wishes. Following the environmental upgrades patients could access a private treatment room with a bed, privacy curtains and handwashing facilities. This meant any patients needing one-to-one support or a patient who may become unwell during treatment had access to a private space. This was an improvement from our last inspection.

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. Staff gave an example of a patient who smoked cigarettes and was wheelchair bound. Staff had identified that the patient had a number of cigarette burns, caused by mobility issues. The staff contacted the local fire service with the patients consent. The fire service visited the patient's home and provided a risk assessment and additional fire blankets to promote their safety.

Areas for improvement

Action the provider SHOULD take to improve

The provider should develop a strategy for promoting inclusion for patients with a learning disability or Autism.