

Ashgate Hospice

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Inspection report

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Ratings

Overall rating for this service

Outstanding 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Outstanding 

Is the service responsive?

Outstanding 

Is the service well-led?

Outstanding 

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to pilot a new inspection process being introduced by the Care Quality Commission, which looks at the overall quality of the service. This inspection was unannounced, which meant the provider and staff at the service did not know we were visiting.

Ashgate Hospice is a independent registered charity for the delivery of care and treatment for people across the community of North Derbyshire. This is provided using the 21 bedded inpatient unit, the hospice at home service, the day hospice service and the lymphoedema service. Medical, nursing, therapy and palliative care clinical nurse specialists (CNS) are provided across the hospice's inpatient unit, day unit and community services, together with an in-reach service to the local acute hospital from the CNS team. People may also receive support from the hospice's transport service, a

Summary of findings

patient and family support bereavement service, a telephone advice line and a spiritual care service. All of these services provide specialist palliative and end of life care to people with progressive and advanced disease and a limited life expectancy.

At the beginning of our inspection there were 19 people using the inpatient unit. The average number of beds occupied on the hospice inpatient unit for the period 1 April 2013 to 31 March 2014 was 93%, which is higher than the national average of 80%. For the same time period the hospice community CNS service provided 1867 face to face and 4338 non face to face person care contacts and the hospice in-reach CNS services provided 4321 face to face contacts. The hospice at home service provided 1930 face to face and 411 non face to face contacts and the hospice spiritual care service provided 30 – 40 face to face contacts per week. The hospice lymphoedema service team received 307 referrals and the patient and family support service provided telephone advice and support to over 700 patients and carers.

Care, treatment and support was provided within the hospice environment and people's homes dependent upon their assessed needs and preferences.

There is a registered manager in post at this service. A registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law, as does the provider.

People were protected from harm and abuse and robust staff and volunteer recruitment procedures were followed for people's safety. There were sufficient staff and volunteers to meet people's individual needs and to respond flexibly to changes and unforeseen emergencies. Systems were effective to manage known risks associated with people's care and treatment needs. For example, to protect them from the risks associated with medicines, falls, pressure sores, poor nutrition and hospice acquired infections.

Staff followed and understood the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards 2009 (DoLS). These set out requirements to ensure, where appropriate, that decisions about people's care are made in their best interests when they are unable to do this for themselves.

People received care that was tailored to their individual needs. Both they and their relatives or carers were highly complimentary and satisfied with the care provided, which they often described as excellent, exceptional or outstanding. People were treated as equal partners in determining their care and treatment plans and their rights, wishes, preferences and diverse needs were respected. People, their families and staff felt that they mattered and that their views were taken seriously and acted on.

Staff treated people with care and compassion and were highly motivated and committed to providing people with the best possible palliative and end of life care. Staff worked with people and their families on an individual basis, to agree their care, involvement and support and to enable them to live as full a life as possible. People were supported to receive end of life care that met with their needs and wishes and to achieve a private, dignified and pain free death. People, their families and staff were provided with the emotional and bereavement support they needed.

People's medicines were effectively managed and they received effective care, treatment and support that met their needs in an environment designed to promote their comfort, emotional wellbeing and independence. Staff and volunteers received the training and support they needed and were highly motivated to perform their roles and deliver sustained outstanding care. Managers supported staff to undertake relevant research and development, to ensure best practice and make improvements in care when required.

Staff worked closely and in partnership with external health and social care professionals and providers and also health commissioners, educators and national organisations concerned with palliative and end of life care. This helped to ensure that people received the right care at the right time and that knowledge was appropriately shared and used to influence best practice for people's care.

Clear governance and management strategies were employed. This helped to ensure clear management oversight and scrutiny of the service against recognised practice and guidance. People and their families, staff and key stakeholders, were actively informed and involved in developing the service. Their views were used to continuously inform service improvements and

Summary of findings

development and to influence the management and running of the service. Care and strategic planning was coherent and inclusive to meet the diverse and changing care needs of the local population.

The provider used a wide range of methods to determine the quality and safety of people's care and made

improvements when required. This included checking their service against, and also pioneering recognised standards for palliative and end of life care. This, together with recognition and good practice awards received by the service, assured that high quality, safe and innovative care was being provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

People were protected from harm and abuse and their medicines were safely and consistently managed. Research and guidance and checks were used to make sure that people's care and treatment was safe.

Recruitment procedures and staffing and volunteer arrangements were robust and ensured people's safety.

Staff followed and understood the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009.

Good



Is the service effective?

The service was effective.

People received effective care, treatment and support from from a multi-disciplinary team, who received the training and support they needed to perform their roles.

Staff worked closely with external organisations, commissioners and health and social care professionals in a way that ensured people received the right care at the right time. Staff were supported to undertake relevant research and development, which influenced best practice for people's care and treatment, both locally and nationally.

People were appropriately supported and encouraged to eat and drink a balanced diet that met their individual needs, preferences and wishes. Professional advice was sought and followed for people's nutrition where required .

Good



Is the service caring?

The service was caring.

People were treated with the utmost care and compassion and were enabled to live as full a life as possible. People, their families and staff mattered and their views about the care and treatment provided were sought, respected and acted on.

People received private, dignified and pain free end of life care and support, that met with their needs and wishes from highly motivated and committed staff. People, their families and staff were provided with the emotional and bereavement support they needed, both during and after end of life care.

Outstanding



Is the service responsive?

The service was responsive.

The service was proactive to ensure a holistic approach to people's care and treatment. Staff obtained people's consent to their care and supported them to receive appropriate end of life care where they chose.

Outstanding



Summary of findings

Effective information, communication systems and collaborative working, meant that people's care and treatment was consistent, flexible and properly informed to meet their needs.

Feedback was regularly sought from people who used, visited or had an interest in the service, to monitor and improve the quality of people's care.

Is the service well-led?

The service was well led.

Staff worked in partnership with key organisations to influence, inform and agree best care practice for people's end of life care. Staff were supported to continuously check, influence, innovate and improve their practice for the quality and safety of people's care.

Senior leadership was visible and strong. Clear governance and management strategies informed and involved people, their carers and stakeholders in service development and continuous improvement.

Strategic planning for the service was coherent and considered the diverse and changing care needs of the local population. Quality checks and recognition and good practice awards received by the service, assured that high quality, innovative and safe care was being provided.

Outstanding



Ashgate Hospice

Detailed findings

Background to this inspection

This inspection was undertaken by an adult social care inspector, a pharmacist inspector and also specialist advisor with experience of palliative and end of life care.

Before our inspection we reviewed the information we held about this service. This included the last inspection report, notifications, the provider information return (PIR) and Healthwatch Derbyshire's report of their visits to the hospice in March and April 2014. At our last inspection in July 2013, we found that the legal requirements and regulations associated with the Health and Social Care Act 2008 were fully met. The PIR is information we have asked the provider to send to show us how they are providing a safe, effective, caring, responsive and well led service.

Notifications tell us about key incidents that happen in the hospice, which the provider is required by law to tell us about. Healthwatch is a consumer champion that hears what adults, young people and children have to say about local health and social services.

At our inspection we spoke with six people receiving inpatient care, six visiting relatives and five people receiving care in the day hospice. We also spoke with five people receiving care in their own homes and six relatives of people who received the same, either from the community nurse specialist or the hospice at home teams.

We spoke with a range of 30 nursing, medical, therapy, care and support staff and volunteers across most of the services provided by the hospice. We also spoke with the registered manager, the hospice chief executive officer and three other senior management and clinical staff leads. Following our inspection we spoke with local health authority commissioners, responsible for contracting and monitoring people's care at the hospice.

We looked at five people's care records to see if they were accurate and up to date. We also looked at records relating to the management of the service. They included checks of the quality and safety of people's care; minutes of meetings, staff and care surveys and complaints records.

Is the service safe?

Our findings

All of the people we spoke with told us they felt safe receiving care. One person on the inpatient unit told us, “The nurse sat with me the other night because I felt frightened; I was so reassured, it made me feel safe.” Another person said, “I feel completely safe; they (staff) really know what they are doing; They’re always attentive, especially when I’m in pain.” One person receiving care from the community nurse specialist said, “She makes me feel safe and she gives me time to think things through.”

We found that people were central to identifying any potential risks to their safety from their chosen care and treatment and how they would be managed. Most people we spoke with made specific reference to this aspect of their care as remarkable. One person said of the hospice community specialist nurse, “I could talk things through, question and agree my care; they were not adversarial in any way; that’s one of the best things about the hospice’s approach to care - independence.”

Risks to people’s safety, associated with their medical conditions, were assessed, monitored and reviewed in a way that met with recognised guidance. Changes to people’s care were made when required, to protect them from harm. For example, changes had been made to the hospice inpatient admission assessment and screening process, for the use of specified medical treatment for people at risk of blood clots. This meant that national guidance and best practice was being followed to protect people from unnecessary harm.

The hospice had begun to participate in national checks of patient falls, medicines errors and pressure ulcers for the period from April to July 2014. Records for the first measured period showed that the hospice compared lower than the expected average for these against other hospices of a similar size. Management records showed that no one receiving care at Ashgate Hospice had acquired infections during 2014.

Medicines were consistently managed by staff in a way that was safe. Accurate records were kept of medicines prescribed for and given to people. These showed us that people who used the service received their medicines at the times that they needed them. Medicines, including oxygen and controlled drugs were correctly stored, so as to protect people using the service and to ensure that the

medicines would be effective when used. When people wished to self-administer their own medicines independently they were supported to do this and the risks of them doing so were assessed.

To protect people who lack the mental capacity to make some important decisions about their care and treatment because of their medical condition, the correct procedures are followed when medicines need to be administered covertly in the person’s best interests. For example, to protect them from pain. Covert medication refers to medication that is hidden in food or beverages. Checks were completed to schedule for general medicines and for controlled drugs. Action plans were produced from these and evidence was seen for changes in practice as a result of the findings when required.

People told us that staff always sought their consent for their care and treatment. One person said, “I have always been asked for my consent on any occasion and when they needed to discuss my care with others. “

Staff responsible for assessing people’s capacity to consent to their care and treatment, understood the principles of the Mental Capacity Act 2005 (MCA) and demonstrated an awareness of the Deprivation of Liberty Safeguards 2009 (DoLS). The MCA sets out the legal requirements for assessment and decision making to protect people who do not have the capacity to make decisions or give valid consent. DoLS must be adhered to, if a person without mental capacity needs to have their freedom restricted in any way, to keep them safe. We found that people’s rights were being protected and that managers checked the assessment and decision making process to ensure this was properly followed.

Procedures were in place to enable staff to report any concerns they may have about people’s safety, together with clear lines of accountability for safeguarding adults and children who are vulnerable. People using the service, staff and volunteers knew how to recognise and report abuse. Staff and volunteers were provided with guidance and training, which included multi-agency arrangements for safeguarding and the roles of volunteers in safeguarding adults and children. This helped staff and volunteers to safeguard people who came into contact with the service where required.

There were sufficient staff to meet people’s needs. All of the people we spoke with said that staff were highly visible and

Is the service safe?

that they always received the care and support they needed, in a timely manner. Managers and records showed that staffing arrangements were closely monitored and acted on when required, to make sure that they were sufficient to keep people safe and to meet their needs. Staff that we spoke with confirmed this.

Staff and volunteers described robust recruitment procedures, which helped to make sure they were suitable

to provide people's care and support. Records we looked at reflected this Arrangements were in place to cover sickness and absence through the use of experienced internal bank staff. Contingency arrangements were in place for unexpected events and unforeseen emergencies, such as adverse weather conditions.

Is the service effective?

Our findings

All of the people receiving care and their carers that we spoke with were highly complimentary about the care and treatment provided and the clean, pleasant hospital inpatient environment. Many people commented that staff and volunteers helped them to be as independent as possible. People commonly described their care and support as either brilliant, exceptional, outstanding or excellent. One person in the inpatient unit told us, “I couldn’t get out of bed before, but they are helping me to get going so I can get back home.” “My pain is now controlled and I have the equipment I need, like this grab stick; they’re totally professional and excellent in every way.”

People told us that staff were competent when they provided their care and treatment and always completed their agreed care. One person said, “I’ve had five lots of inpatient stays at the hospice and they always treat me as an equal partner; they discuss my care plan with me and always listen and act on what I say.” Another person who received personal care from the hospice at home team, told us, “They are so efficient, my care is always consistent.”

We received many comments from people telling us that they received ‘joined up care,’ from the hospice team and from the right staff at the times they needed it. They also told us, that when needed, staff shared relevant information about their care with other health professionals and services. One person receiving care from the community nurse specialist said, “She knows where her expertise ends and is very resourceful at engaging other professionals in the team.” One person receiving hospice at home personal care told us, “They are very receptive to the slightest change and what I say; they always respond and act to make sure that the appropriate professionals who can meet my needs, see me when required.” Another person receiving care in the hospice inpatient unit said, “This is my third admission; they always get me right and sort my pain, so I can go home.”

People received care from a multi-disciplinary staff team who were qualified, supported and trained to meet their needs. Twenty four hour medical and nursing support was provided to the hospice inpatient unit. The medical team provided a daily patient round, a 9am to 5pm medical presence and on call medical support. A multi-disciplinary, holistic approach to care was used across the hospice

services. For example, as well as specialist palliative care nurses, people had access to therapy staff, including physio, occupational, complementary and art therapists. Emotional, spiritual and personal care and support was provided for people and their carers via the patient and family support team. This included aftercare following a person’s death and an onsite chaplaincy service. Records of recent comments about these services were all highly complimentary. Links with a local community health provider’s heart failure care team were established. A dedicated team of palliative care nurse specialists provided advice, training, care and support to people and staff at the local acute hospital where they were based.

The day hospice provided a gym to support people with their exercise and mobility and a lymphoedema clinic operated from there. The clinic provided care, advice and training to people and health staff across the local and extended community. This included a link service with another hospice located in the High Peak area of North Derbyshire. Lymphoedema is a long term condition that causes swelling in the body’s tissues, usually affecting the arms and legs. One person’s relative told us, “Getting the swelling controlled has made so much difference to his comfort and independence and what he can do; it’s been a real boost for him.” A staff member said, “If it means a person can get a boot on to play another game of football with their grandchild, then that’s a result.”

Staff were trained to assemble and use equipment required for people’s care. We spoke with the relative of one person who received care from the hospice at home team. They told us that the person was not able to eat and drink because of their medical condition and said, “He has the same care staff; they know exactly what his care needs are and how to set up his PEG.” This is a commonly used abbreviation for Percutaneous endoscopic gastrostomy. It is the delivery of a nutritionally complete food preparation directly into the stomach, through a surgically fitted device. Staff responsible for administering the person’s nutrition in this way, had received specialist training to ensure that it was given safely. Relevant staff also provided training and instruction in the community to people’s carers at home to make sure they knew how to correctly use any equipment provided there for people’s care. For example, hoists that are used to move people who were not able to move independently.

Is the service effective?

Everyone we spoke with in the hospice inpatient unit highly commended the quality, choice and availability of food provided. Comments received included, “Brilliant, high quality food with plenty of choice,” and “Excellent food and amazing choice; I can have anything I fancy, when I fancy it, even if it’s ice cream in the middle of the night.” Another person said, “I had not been eating properly at home on my own, but they have sorted out support for my meals for when I go home; that’s a such a relief.”

Staff promoted the importance of good nutrition and hydration. They supported people to eat and drink foods they enjoyed and to maintain a balanced diet where possible. Some people who used the service had a reduced appetite or difficulty eating and drinking. All people we spoke with said that their food was freshly prepared in portion sizes and consistencies to suit their wishes and needs. We saw that aids and adaptations, such as specialist plates and cups, were used to help people eat and drink independently when required. Hospice inpatient care plan records showed that people’s weights were monitored. Where concerns were identified with people’s nutrition, relevant health care professionals were consulted and staff followed their advice and instructions where required. This meant that people received nutrition and hydration that met with known guidance and people’s needs and preferences.

All grades of staff and volunteers we spoke with said they received the training, support and development opportunities they needed for their role and responsibilities. This included advanced clinical skills training and access to bespoke counselling when required, which staff said, helped to build their emotional resilience. All new staff were required to complete a robust training programme before they started providing care. This included working alongside more experienced staff, of a relevant grade where appropriate.

The manager and clinical staff were encouraged and supported to undertake research and development to inform, influence and improve people’s care where required. Staff had presented some of their work locally, nationally or internationally and used it to influence clinical and best practice standards in the care of people with life limiting conditions. For example, advanced breast cancer and motor neurone disease. From this, training was also delivered internally to all medical and clinical staff at the hospice to support agreed practice changes in people’s best interests.



Is the service caring?

Our findings

Everyone receiving care or their relatives that we spoke with were highly complimentary and completely satisfied with their care. They said that without a doubt they would recommend the service to their friends and family, if they ever needed to. Words commonly used by people to describe their care included, absolutely brilliant, exceptional, outstanding and excellent. At the inpatient unit, we saw that staff interacted with people in a compassionate, respectful and caring manner and took time to maintain their dignity and privacy.

People said they had good relationships with staff who took time with them, understood their needs and preferences, treated them with respect and ensured their dignity. One person receiving care from the hospice community specialist nurse said, "I have the same nurse, which is very important to me; She knows my condition and how I am, and has helped to address my pain and nausea; I am totally confident in her and get proper advice and support, which is vital to me." The relatives of two people told us about their experiences of the hospice at home service. One said, "Absolutely wonderful and so caring; I can't thank them enough for what they've done; their support means I can get out each week; it gives me much needed respite as a full time carer and has relieved me of a lot of worry." The other said, "He's treated with absolute dignity and respect; a truly wonderful caring service; 10 out of 10; in fact, I'd say they give 110%."

Staff champion roles were introduced to support both staff and people's relatives to ensure that people received as good a quality of life as possible. For example, a volunteer champion, co-ordinator and dignity in care champion and a new carer's champion. Staff were highly motivated in their roles and showed their commitment and enthusiasm to providing the best possible quality of end of life care and support for people. A key phrase used by staff when we asked them to describe their role was, "Enabling people to live a full a life as possible."

People receiving care told us in many ways that staff paid attention to the detail of their lives, how their illness affected them and matters that were important to them. One person said, "Nothing is too much trouble, its more than just about the illness, they really care for you." Another person receiving hospice at home care told us, "A staff

member from the hospice rang me spontaneously yesterday and offered to do a 'benefits check' for me; I didn't even have to ask; they were so helpful; the hospice cares for me, not just my condition."

People's families were supported to visit the hospice at times to suit them and also the person receiving care. Dedicated facilities were provided for people's visitors, which included a conservatory lounge, a rest area with fresh food and free refreshments and a children's playroom. When people needed end of life care, they received this in private. Their families were supported to stay overnight either in an overnight stay room or by use of 'put up' beds. One person told us, "My daughter has stayed with me the last two nights and staff are making sure that I am comfortable and pain free; they are just so caring and can't do enough for me." The same person's relative said, "We couldn't wish for better; the staff supporting us know mum's needs and wishes; they are so professional and respectful; they never rush mum and never rush us, they give us all the time we need."

The service proactively engaged with other health and social care providers and commissioners to enable on-going service development and improvements for people's care. For example, engagement in a local joint leadership alliance for end of life care had influenced a revised approach, to be used across the local health community, for the discussion and recording of people's agreed end of life care and wishes, with appropriate involvement of their families. This was important to enable people to receive care and treatment that met with their known end of life care choices and wishes.

People said they were always consulted about their care and treatment and their views were respected and acted on. People's care records we looked at reflected this. Systems were in place to determine people's care and treatment in the event of their sudden collapse and for their end stage of life. These are known as advanced care plans. This meant that people were protected from receiving end of life care that did not meet their needs or wishes. Systems and guidance were also in place for staff to follow for the protection, handling and processing of personal confidential information relating to people's care. Staff recognised and understood these.

Assessment and agreement of people's emotional and spiritual needs and those of their carers, were shown in people's care plans, which were regularly reviewed with



Is the service caring?

people and their families. One person told us, “I am always asked about every aspect; what I say is taken seriously, in a respectful and sympathetic manner.” Another person’s relative told us, “It’s not easy coping with ill health, but staff always listen; they work with us and they really care for both of us.”

People and their family members could access a range of support services across the hospice and community setting to suit people’s preferences and needs. For example, art and complementary therapist support and a family bereavement support group. The hospice employed a full time chaplain who provided spiritual and bereavement care and support to people and their carers and worked closely with the family support and bereavement team. Published comments about the bereavement support services were all positive and showed that people felt they had benefitted from the support they received.

New posts had been recruited to, which provided carer’s champions for both the hospice and community setting. Their aim was to support people’s carers and families and act as a link and feedback people’s voice to influence the running of the service. People’ views about their care were sought by a range of other ways. This included the use of comments card boxes visibly located in patient areas and patients forum meetings held at the hospice. The registered manager advised that the hospice was working with a national company to design an independent patient experience survey. This was due to be used annually from 2014, to gain people’s views and experiences about their care, to help to monitor trends and improvements that may be needed.



Is the service responsive?

Our findings

People told us that staff always responded promptly when people needed care and support and acted on their wishes for their care and treatment. Two people receiving care in the inpatient unit said, “Staff always come when I use my call bell; if they need to get another staff member to help me; they explain;” and “They tried a different medicine for me last night for my pain; I had the best nights sleep in ages.” Another person explained they had a reduced appetite, but sometimes desired a particular food at a particular time. They said “My appetite’s not so good, but if I fancy something particular they are very obliging; even jelly and ice cream at night.”

People’s consent was obtained for their care and to share relevant information about this with other health care professionals, such as their own GP when required. Where people could not consent to their care, staff were able to describe how decisions were made in their best interests and people’s care records we looked at reflected this. Hospice community nurse specialists held regular meetings with people’s GP’s and district nurses, to share the most up to date information about each persons’ condition. This helped to make sure that decisions about people’s care and treatment were properly informed, and that where there were any changes in a person’s condition, the right care would be provided. A shared electronic patient record enabled all staff involved in people’s care to quickly and easily see up to date information about their needs, care and treatment.

People’s future care wishes were recorded in their care plans. This included where and how people wished to receive their end of life care and support. For example, in their own home, or the hospice in patient unit. One person in the inpatient unit, who was at their life end stage of care told us, “They’re clear with me about my prognosis; they give me open and honest feedback to my questions and fully consult me about my wishes.”

One person’s care had been specifically tailored to meet their needs with regard to their learning disability condition. This was done in consultation with them and included their parent and a local specialist community health learning disability service, who were regularly involved in their care. Staff said this helped them to ensure that the person received the care they needed it in a way that met with their diverse needs and choices. The service

operational development objectives for 2014-2019 reflected known directives and challenges for delivering specialist palliative and end of life care to meet the diverse and changing needs of the local population. This included people living with dementia and younger adults.

The day hospice provided dedicated staff and a range of facilities and equipment to support people’s care needs and also their participation in hobbies and interests of their choice. One person told us they enjoyed doing crafts and a group of people said they looked forward to spending time to socialise with each other at the day hospice, which they all said they enjoyed. One person said, “It’s really good to get away from the same four walls at home and have a good chat with each other.” Another person said, “I always enjoy a beer here and being with others; and it gives my wife a break and some time for herself.” Complimentary and art therapies and a gymnasium also provided controlled and individually prescribed activities to meet with people’s assessed needs.

A staff group we spoke with told us about their active discharge planning arrangements, to support people in their end of life care who chose to go home; sometimes after a period of rehabilitation and symptom control. All of the staff group felt that this enabled care agencies, equipment, anticipatory medicines, home assessments and financial considerations to be fully explored with people. This reflected what two people told us about their planned care arrangements post discharge. The arrangements also helped to make sure that people received the support they needed after their discharge home. Anticipatory medicines were subject to people’s assessed needs and could be administered out of hours by the district nurse if required, to help prevent the person being unnecessarily admitted to hospital. This meant that people’s care and support was planned in a proactive way with people’s involvement.

An on site equipment store at the hospice inpatient unit and volunteer operated transport meant that, items such as personal moving and handling equipment could be promptly provided to people in their own homes at the time they needed it. One person receiving hospice at home care told us, “I had been waiting weeks for a wheelchair to be provided from another local healthcare service, but as soon as the hospice knew, they sent an occupational therapist to me straight away; I had the chair within two days; so now I can get about; how good is that!”



Is the service responsive?

A range of information was provided for people and their carers, which helped them to understand the hospice and relevant external support services and agencies. Clear and accessible information was provided for people about how to make suggestions or complaints about their care. People and their family members said they had no complaints about the care and treatment provided. All felt that their opinions, comments and views about their care were taken seriously, listened to and acted on when required. One person said, "Nothing is too much trouble; staff are interested in what you think and value what you say." Patient and carer forum meetings were held at the hospice and accessible comments cards with post boxes were also used to seek people's views.

Feedback from the patient and carer forum meetings and comment cards had resulted in work to develop food availability and choice at the hospice for people's visitors and also to improve car parking provision. The registered

manager told us the hospice was working with a national company to design an independent patient experience survey. This was due to be used annually from 2014, to gain people's views and experiences about their care, to help to monitor trends and improvements that may be needed.

The service proactively engaged with other health and social care providers and commissioners to enable on-going service development and improvements for people's care. For example, engagement in a local joint leadership alliance for end of life care had influenced a revised approach, to be used across the local health community, for the discussion and recording of people's agreed end of life care and wishes, with appropriate involvement of their families. This was important to enable people to receive care and treatment that was appropriate to and met with their known end of life care choices and wishes.



Is the service well-led?

Our findings

People receiving care, their families and friends and staff working at the hospice were all highly positive when they told us about the care provided and the management of the hospice services. Many of the volunteers we spoke with told us they had experienced 'excellent' care for their own family members, which in turn led them to become volunteers. All of the staff and volunteers we spoke with, described a positive and inclusive culture at the hospice. They were all very proud to work at the hospice and felt they made real difference there; and highly confident to recommend the hospice as a place of care to friends and families.

There was a defined governance and management structure in place, which staff understood. This provided clear lines of responsibility and authority for decision making about the management, operation and direction of the hospice and its services. The hospice management team were visible and available to staff and people using the service and those with an interest there. The manager said they aimed to visit each service area most days. Staff told us that team meetings were regularly held and senior manager's were visible and approachable in the relevant service areas. The senior management team provided regular drop in and information sessions for staff, who told us that they received regular supervision and formal appraisal of their work. They also said they could access emotional and formal counselling support when required. Staff were pleased about the plans for improving the visibility of the board and service directors and their engagement with staff and volunteers. This included periodic quality visits to the hospice service areas and teams.

Staff understood their rights, roles and responsibilities for reporting concerns about people's care and were supported by management to do so. For example, there were clear procedures and monitoring arrangements through to hospice board level, which staff knew and understood in the event of serious accidents and incidents relating to people's care. Records showed that all incidents were analysed and communicated to staff. This meant that the board and managers knew about and took responsibility for things that happened in the service, to safeguard people from harm.

People, staff and key stakeholders were actively informed and involved in the development, improvement and the management and running of the service. Staff were invited to complete a staff survey each year, with one in progress at the time of our inspection. The results from the last survey published during the autumn of 2013, showed overwhelmingly positive results and some areas where improvements were needed. We spoke with staff about some of the improvements that were detailed in a recorded action plan from the survey. For example, a staff behaviour code and handbook had been implemented, emphasising the service values and aims for people's care and also for staff conduct. Staff and volunteers that we spoke with knew and understood these and they were clear about their roles and responsibilities for people's care.

Service reviews in progress that were influenced by people's views, included a review of outsourced hospice patient transport arrangements and the patient and family support and bereavement service. Plans were also in progress to invite patient and volunteer representatives to the hospice board meetings, to further influence operational policy and direction.

The service worked in partnership with key organisations, including the local authority, safeguarding teams, and clinical commissioning groups, to support care provision, service development and joined-up care. Links were established with the local general hospital, universities and also relevant national organisations to support and inform palliative and end of life care and staff training and development. The hospice also worked closely with a large local NHS community health care provider to influence, inform and agree best care practice. Staff attended multidisciplinary meetings with GP's and district nurses to discuss the end of life care needs of people in the local area. Staff told us the meetings were a good opportunity to share professional and best practice knowledge.

Senior leadership was visible, strong and innovative and sought continuously to promote best practice. All staff we spoke with described a caring and dynamic organisation that continuously sought to improve people's experience of their care and treatment. Senior staff were well supported in relevant roles outside the service, to support and inform people's care. For example, the director of clinical services



Is the service well-led?

was part of an national executive clinical leadership group in hospice and palliative care. One of the medical consultants was president of a national association for palliative care that influences strategy and standards.

Before our inspection, the specialist hospice lymphoedema service team held a study day for external community health professionals, seeking to improve and inform best practice across the area. Six of the hospice patients with this condition were involved in workshops held on the day. Participants' feedback showed that patient involvement was innovative and really helped everyone's learning. This in turn generated interest from local health service commissioners and resulted in the hospice's subsequent submission of a business case to expand their lymphoedema service, to meet local demand to provide a greater outreach to people across North Derbyshire.

Robust systems operated for checking the quality and safety of the people's care. This covered all aspects of the service, including the environment and equipment used for people's care. Where improvements were needed, actions were recorded and scheduled for completion. Action plans showed, which staff were responsible for checking progress and for completing these. Managers also regularly checked the registration states of all professional staff to ensure they were registered as fit to practice.

Proactive staff and volunteer workforce planning was in progress to enable the hospice service to support more people to receive palliative and end of life care in their own homes, in order to meet with known projected service demands. A service review of the day unit had been carried out over a 12 month period, which resulted in additional support being implemented for people's carers. This included access to therapies, financial advice and links to the patient and family support team for emotional support.

The hospice strategic plan was being developed for 2014-2019. This showed service goals and operational objectives that reflected known directives and challenges for delivering specialist palliative and end of life care. The strategy included objectives for meeting the diverse and changing care needs of the local population, with particular focus on people living with dementia and younger adults. It linked to the hospice's fund raising and voluntary income strategies, which was important to ensure that it would be realistic and financially viable. The strategy also included views from the hospice staff and volunteers; progressing to external stakeholders later in the year.

The hospice quality account report was published annually and provided information to the public, commissioners and other interested parties about the quality of the healthcare services provided by the hospice. We looked at the quality account for the period 1 April 2013 to 31 March 2014. This assured that a high quality of care was being provided by the hospice service and reflected the feedback we received from the local health commissioners and Healthwatch consumer champion.

The service had received various recognition or good practice awards during 2014, for the quality of care and support provided for people using the service. This included a Volunteer of the Year Award, Charity Retailer of the Year 2014 and a grant award to support of vulnerable people in the community and the appointment of a welfare benefits officer to provide people with advice and support. The hospice has also achieved positive recognition of the standard of hospice care from Healthwatch, cited in the report of their visit during 2014.