

High Peak Hospicecare

Blythe House Hospice

Inspection report

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11 August 2016

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Ratings

Overall rating for this service	Good ●
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Is the service safe?	Good ●
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Is the service effective?	Good ●
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Is the service caring?	Good ●
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Is the service responsive?	Good ●
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Is the service well-led?	Good ●
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Summary of findings

Overall summary

This inspection took place on the 2 and 11 August 2016.

Blythe House Hospice had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered provider, they are 'registered persons.' Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Blythe House Hospice provides nursing, personal care and treatment, health diagnosis and screening associated with end of life and palliative care. A range of services were provided by the hospice to support people's care and treatment. This included a 'Living Well' service (support to enhance people's quality of life and coping strategies); an on-site walk in information and advice centre, pre-diagnosis and healthy lifestyle support, alternative therapies, bereavement and counselling support to adults and children and spiritual care. A hospice at home service was also launched in April 2016. This provided personal care to people in their own homes who choose to remain and receive care there at the end of their life.

People felt safe and their care, treatment and medicines were safely managed. People receiving care, relatives and staff knew how to raise or report any concerns they may have about people's safety. The provider's arrangements for staff recruitment and deployment helped to ensure people's safe care and treatment, and related support for their relative.

People's medicines were safely managed when required. Known risks to people's individual safety from their health condition, environment or any equipment used for their care were regularly assessed and reviewed with them in consultation with relevant external health professionals when required. The provider's arrangements for emergency planning, equipment and environmental maintenance and their remedial fire safety measures in progress helped to ensure people's safety at the service.

People and their families were completely satisfied, highly complimentary and appreciative of their holistic care, treatment and support. People's care was individually planned with them and consistently delivered to provide palliative care, treatment and alternative therapies that met with their needs and wishes. Staff worked in consultation with external health professionals when required for people's care and treatment. This helped to optimise people's health and comfort.

People and their families were informed and treated as equal partners in care. This was provided by a multi-disciplinary team of staff and volunteers who were trained and supported for their role and responsibilities. Approaches to learning, development and end of life care education helped to ensure people received care that met with nationally recognised standards concerned with palliative and end of life care.

Staff understood and followed the Mental Capacity Act 2005 (MCA) to ensure that people's consent or appropriate authorisation was obtained for their care and treatment. People's preferred priorities or

advanced decisions made for their care and treatment were appropriately determined and accounted for.

People commended the quality and choice of meals provided at the day hospice. People were supported to eat food and drink they enjoyed, which met their health requirements and personal choices. Staff understood and followed people's nutritional and related health requirements.

People and their families all spoke highly of their care and positive relationships held with staff. People felt staff treated them with the utmost care, respect, kindness and compassion and as equal partners in their care. Staff were highly motivated to make a positive difference to people's care experience; they took time to understand how people's illness affected their lives and what was important to them and their family for their care.

People's rights, choices, confidentiality and involvement in their care were consistently promoted. Staff and volunteers were skilled communicators and committed ensure people were appropriately informed, involvement and empowered in care. People's preferred care priorities and decisions about their care and treatment were appropriately shared with other care provider's. This helped to protect people from receiving care that did not meet their needs or wishes.

People, their families and staff were provided with the multi faith spiritual, emotional and bereavement support they needed. An integrated, comprehensive range of therapeutic care, bereavement counselling, information and practical support enabled people and their families to receive the care and support they needed to live well. Motivated, caring and qualified staff and volunteers, together with suitably equipped and dedicated private space supported this. Recent national care recognition awards achieved reflected this.

The service was flexible and responsive to people needs and preferences. People received timely, flexible and individualised care tailored to their known wishes, needs and lifestyle preferences. The provider and staff communicated and engaged with people and their families in a way that met their diverse needs, was meaningful to them and helped to inform and optimise their care experience.

The service took a key role in the local community to build links and support networks for people's care. Regular service reviews, partnership and collaborative working with external care providers and commissioners helped to ensure people and their families consistently received the right care at the right time and place.

People's views, concerns and complaints were regularly sought, listened to and acted on. Their views about the service and those of their families, staff and volunteers were used to make improvements to people's care when required. Further improvements were planned to introduce independent patient and staff surveys to enhance this process.

The service was well managed with an open and inclusive culture where people, their families, staff and volunteers felt recognised, listened to, valued and welcomed. Senior management and board trustees were visible and regularly engaged with people, their families and staff. Staff and volunteers were happy and proud to work at the hospice and felt they made a positive difference to people's care experience. The registered manager's inclusive approach; service communication and fund raising policy helped to inform service strategy and improvement.

There were clear management arrangements, lines of reporting and decision making for the operation and direction of the service. These were understood and followed by staff and volunteers who were informed,

supported and supervised to perform their related roles and responsibilities.

Regular checks were made of the quality and safety of people's care and the service environment. Where appropriate a range of local and nationally recognised standards and measures were used to inform this process. Findings from this were used to inform and make service improvements when required.

The provider ensured established links and partnership working with key external health, higher education and care providers and also relevant national bodies concerned with end of life, palliative care and treatment. This helped to influence and support cross sector care and treatment provision, staff education, care practice, strategic planning and service improvement. Service planning took account of financial viability, work force planning considerations, local population and related health demands; to help inform and ensure the quality and shape of Blythe House Hospice service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

Risk management strategies; approaches to people's care in relation to their health condition, environment and medicines arrangements helped to ensure people received safe care and treatment. Staff recruitment, deployment, emergency planning and remedial fire safety measures in progress helped to ensure people's safety at the service.

Is the service effective?

Good ●

Staff understood and followed the Mental Capacity Act 2005 to obtain people's consent or appropriate authorisation for their care and treatment. Staff ensured people's equal partnership in their care and treatment, which met their assessed needs, priorities and choices. People and their families received care and support from a skilled multi-disciplinary team of staff and volunteers who were trained and supported for their role and responsibilities. This helped to optimise people's health and comfort and ensure they received care and treatment that met with nationally recognised standards concerned with palliative and end of life care. People were provided with quality meals they commended and enjoyed, which met their health requirements and personal choices.

Is the service caring?

Good ●

Staff and volunteers had established highly positive and meaningful relationships with people and their families, who they treated with the utmost care, kindness and compassion. People's equality, rights, choices and involvement in their care were consistently promoted. Staff understood and followed people's priorities and decisions for their care. Integrated, recognised and comprehensive care arrangements enabled people and their families to receive the care and support they needed to live well; delivered by highly motivated, skilled and compassionate staff.

Is the service responsive?

Good ●

People and their families received timely, co-ordinated care that was flexible, tailored to their lifestyle preferences and enabled their support outside the hospice. People views and complaints

about their care were consistently accounted for and used to inform care and service improvements. Timely service reviews, clear communication strategies, partnership collaborative working arrangements helped to inform, improve and optimise people's care experience, service provision and planning. This was done in a way that took account of people's diverse and changing needs; with consideration to local and national population care demands and trends for end of life, palliative care and treatment.

Is the service well-led?

Good ●

People, their relatives, staff and volunteers consistently described an open and inclusive management culture at the service, where they felt welcomed, valued and listened to. Staff and volunteers understood and followed their roles and responsibilities for people's care and safety. Management and governance arrangements ensured the quality, safety and financial viability of people's care, together with effective service planning and operation. External partnerships and working links with relevant expert, educational bodies, care providers and commissioners helped to influence cross sector care provision, inform and shape the hospice service.

Blythe House Hospice

Detailed findings

Background to this inspection

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

This inspection was unannounced on the 2 and 11 August 2016. It was carried out by an inspector, a specialist advisor and expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor held significant experience of working within the field of palliative and end of life care.

Before this inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We sent out questionnaires to people, their relatives and staff seeking their views about the service. We also contacted local health care commissioners, responsible for contracting and monitoring some people's care at the hospice.

At our inspection we observed how staff interacted with and supported people. We spoke with 10 people receiving care and treatment at Blythe House Day Hospice. We also spoke with a range of 18 management, clinical, therapy, volunteer, care, catering and support staff, which included the registered manager. We spoke with four relatives of people who had received personal care in their own home from Blythe House Hospice at Home Service, along with the service manager, care co-ordinator and six health care assistants for that service.

We looked at four people's care records and a range of other records relating to the management and operation of the service. For example, checks of the quality and safety of people's care, staff training and recruitment records, meeting minutes and complaints records.

Is the service safe?

Our findings

People and their relatives told us they felt safe at the service and when they received care from the service in their own homes. One person said, "I feel completely safe here." Another person told us, "I feel safe and confident to share my feelings with staff and other patients; Blythe House has been a great source of support and comfort to me." One person's relative said, "I have nothing but good to say about the service; staff are excellent; I know (person receiving care) is in safe hands."

People, relatives and staff felt that staff were visible and provided timely and safe care to people. The provider's recorded findings from their recent survey of people's views about the service, showed they felt safe when they received care at the service.

The provider's arrangements helped to protect people from harm and abuse. Information was routinely provided for people and displayed at the day hospice about how to raise any concerns they may have about their own or other people's care and safety. People we spoke with knew how and were confident to raise any related concerns if they needed to. All of the staff we spoke with told us they received the required training in relation to the protection of vulnerable adults and children. This included how to recognise and report any witnessed or suspected abuse, including reporting to external authorities concerned with this if required. The provider's training records and procedural guidance for staff also supported this.

Recognised recruitment procedures were followed, which helped to ensure staff were safe and suitable to work with people or children who received care from the service. The provider's records and discussions with staff showed that required employment checks were made before staff provided people's care. For example, checks of staff previous employment, work history and checks with the national vetting and barring scheme. This helped the provider to make safe recruitment decisions about an applicant's suitability.

Staff fully understood people's requirements in relation to their safety needs and we saw they supported people safely when required. People's care records showed that risks to their safety associated with their health condition or environment were assessed before they received care; regularly reviewed with them and mostly updated when required. For example, in relation to potential risks to people from falls or any equipment used for their treatment, such as oxygen therapy. However, one person's falls risk assessment had not been updated following a recently identified spate of falls at home, which staff were aware of. We discussed this with the registered manager who agreed to take the required action required to mitigate any related risk from this.

Staff worked collaboratively with people receiving care, their relatives and any external healthcare providers or service commissioners to help ensure people's safety relating to their end of life and palliative care arrangements. People and relatives said that treatment, care options and related benefits and risks to people's health were discussed and agreed with them. Health care assistants who provided personal care to people in their own homes via the hospice at home service; told us how they followed the provider's training and relevant instructions from external health professionals concerned with people's safety needs when

required. For example, instructions for equipment use to help people to move safely or instructions for people's body positioning to help prevent skin sores. Staff also knew how to report or escalate any safety concerns arising from changes in people's health condition and the provider's operational procedures helped them to do so. This helped to ensure that people received safe care and treatment.

All of the people who attended the hospice retained and managed their own medicines. However, arrangements were in place for the safe receipt, storage and return of people's medicines, if they needed to be stored on people's behalf during their attendance for daily care at the hospice. Nursing staff responsible told us they received medicines training for the safe management and administration of people's medicines. This included individual competency checks and regular training updates. Staff understood the provider's operational procedures and their own professional practice standards to follow concerned with the safe management and administration of people's medicines. The registered manager regularly attended a local medicines network link group for related professional service leads.

Healthcare assistants who provided people's care were sometimes required to support them to self-administer their own medicines. For example, to help people with restricted movement, to obtain their medicines from its packaging. This care staff group told us they received instruction to enable them to do this safely and they understood the principles for safe medicines arrangements. For example, checking people were taking their medicines safely or at the correct time and reporting related safety concerns if required. The provider's related medicines policy and procedural guidance for staff to follow, supported and informed this. This helped to ensure nationally recognised practice standards were followed for the safe management of people's medicines.

The provider's arrangements helped to ensure that risks associated with people's care and treatment, staff working arrangements, the hospice environment and equipment used for people's care were regularly checked, monitored, reported and reviewed. Records and discussions told us this was done in consultation with all staff groups, senior management and hospice board members. This helped to ensure that related care, treatment and or other service safety measures were consistently understood and followed. For example, in relation to clinical incidents such as any medicines error, staff lone working, accidents and environmental health and safety. Throughout our inspection we saw the hospice environment was clean and well maintained with no related, observable hazards to people's safety.

Where there was potential for medical emergencies to occur in relation to people's health conditions, there were clear procedures to inform staff how to respond, which staff understood. This included, if life preserving equipment and procedures needed to be used or followed. Staff responsible, were also able to describe the provider's emergency procedures to follow in the event of a fire or other domestic emergency situation, such as a mains electricity power failure. Records also showed that further safety measures were completed or in progress following the provider's pro-active consultation with Derbyshire Fire and Rescue Service. This helped to ensure people's safety.

Is the service effective?

Our findings

People and their relatives told us they were highly satisfied with the care and treatment provided from staff Blythe House Day Hospice and their hospice at home service. One person said, "They are amazing; I can't fault them; they help me to live as well as I can." Another person told us, "The doctor here will see me any time between set appointments if I don't feel well; the care from staff here is truly amazing." Relatives comments included, "The service and quality of care staff are excellent; couldn't have asked for more;" and "Outstanding care and service with first class knowledgeable staff all round."

The provider's recorded findings from their recent survey of people's views about their care at the service showed people were satisfied with their care and treatment at Blythe House. One person commented, "As I rarely saw the same doctor twice at the hospital, I found the continuity of care provided at Blythe House was such a help."

People and their relatives were highly appreciative of the information, care, treatment and support they received at the service. This included support for people's healthy living and emotional health. For example walking and healthy eating groups; art, creative and mindfulness therapies. Mindfulness is an ancient Buddhist practice, which means paying attention in a non-judgmental and particular focused way to help increase awareness, clarity and acceptance of our present moment reality. One person told us about the particular benefits they experienced from this by practicing mindfulness, which they said helped them to, "Live in the moment and avoid ruminating on negative thoughts associated with their health condition." This helped to ensure people's physical emotional health.

The service operated a holistic approach to care from multi-disciplinary care team of staff and volunteers who were qualified, supported, trained for their role and worked closely together. A number of outpatient clinics were regularly run at the service by a range of visiting medical, nursing, therapist health professionals and experts to support people's care and treatment. For example, in relation to people's heart failure, respiratory disease, palliative care and lymphoedema treatment. Lymphoedema is a long term condition that causes swelling in the body's tissues, usually affecting the arms and legs. One person who used this service told us, "It has really helped me to move better, now the swelling is under control."

Routine contacts were established with relevant external health professionals involved in people's care, such as GP's, community specialist nurses and district nurses. For example, staff reported changes in people's health to external health professionals and followed their related instructions for people's care when required. People's relatives told us that hospice at home staff followed the agreed personal care instructions to help ensure people's comfort and support at their life end stage of care. Related records and feedback from people's relatives and external health professionals also supported this. For example, a relative told us, "Staff were absolutely brilliant; they worked with us and the district nurse and gave good, consistent care at all times."

People's care records we looked at showed people's care was assessed, planned and delivered in a way that met with nationally recognised practice concerned with end of life and palliative care. For example, people's

individual needs assessments and care plans were holistic and personalised. They accounted for people's care, treatment needs and choices associated with their health diagnosis and condition. This included relevant assessment, symptom monitoring and management requirements, such as for pain, which staff understood. This helped to ensure people were supported to maintain their health; access and receive ongoing health care services concerned with their palliative and end of life care.

People and their relatives felt people received care from competent staff who understood their care requirements and support needs relating to their health diagnosis. We received many positive comments from them about this. For example, one person said, "Staff fully understand my condition; they treat me as a partner; my care is consistently provided as agreed." Collated results from the provider's most recent questionnaire type care survey with people and their relatives, showed that all respondents felt their care and treatment needs were, 'Very well met.' Comments received, included, "They gave me all the support I needed to enable me to take control of my life again," and "I receive a very joined up and personal service."

Staff and volunteers were trained and supported for their role. All grades of staff and volunteers we spoke with said they received the training and support they needed for their role and responsibilities, which related records showed. This included relevant specialist, communication and clinical skills training. One staff member told us, "Training is really good here; there's plenty and regular updates; it's always relevant to people's care and health conditions." A volunteer told us, "We are involved in all relevant training; it helps to understand and make sure people's care is consistent." Staff also told us that training and supervision arrangements provided them with regular opportunity to reflect, improve and develop their service specific knowledge, care practice and support. One staff member said, "Training and support here is excellent; it's comprehensive, ongoing and always relevant to role, care provision and individual personal development."

Our discussions with staff and records checked showed that all new staff and volunteers were required to complete a relevant comprehensive training programme before they started providing care and support at Blythe House. For example, this included working alongside more experienced staff, of a relevant grade and appropriate practice and competency checks. Staff and volunteers were supported to retain and develop their own service specific learning for their role. This included through regular refresher training, new or further learning to degree level. Staff leads were established for identified areas of care, such dementia and staff were actively encouraged to share their learning and where relevant, teach and support each other. End of life care education was regularly provided for staff via regional end of life care facilitators. This helped to ensure that the hospice care team provided care within nationally recognised standards concerned with palliative and end of life care.

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

People can only be deprived of their liberty to receive care and treatment when is in their best interests and legally authorised under the MCA. Staff received training in and they understood and followed the principles of the MCA. Staff told us that all of the people receiving care had the capacity to make day to day decisions for them self. Staff were able to describe how they sought people's consent by offering information and choices to support their decision making. For example, by discussing people's care and treatment options with them and obtaining their written agreement to this, which related records showed. During our inspection we observed that staff gave relevant explanations and sought people's agreement when required before they provided care. For example, when people needed support to move or eat and drink.

People's consent was obtained for other matters relating to their care and treatment, such as information sharing or photography for personal identification purposes. Discussions held with people and care plans we looked at showed this. This also included any important advanced decisions they had made about their care and treatment, such as in the event of any worsening of their health condition or for their preferred priorities for their care.

All of the people we spoke commended the quality, choice and availability of food provided at the day hospice. Examples of people's comments about this included, "First class menu and first class company;" "The food is very good quality; always a choice and portions to suit." We observed that lunchtime was a relaxed and social occasion where most people and staff chose to eat together in the main dining area. People were free to choose where they sat to eat their meal and dining tables were attractively and practically set.

Discussions with the cook, food menus and people's care records showed meals were planned to cater for people's individual choices and known dietary requirements associated with people's health needs. For example, dairy, gluten free or diabetic diets. Children who attended the service for therapy or counselling; did so on a sessional basis only. They were provided with access to drinks and snacks, which also took account of individual choice and known health requirements. People's dietary requirements were assessed by nursing staff before meals were provided. Related instructions were then shared and regularly reviewed with the cook to inform menu planning and individual dietary requirements.

Some people had a reduced appetite or difficulty eating and drinking. All of the people we spoke with confirmed that food was freshly prepared and provided in portion sizes and the correct consistency to suit their wishes and known dietary requirements. We saw people who needed assistance to enable them to eat and drink were supported by nursing staff or provided with any equipment they needed when required. For example, adapted cutlery and crockery, which helped people to eat and drink independently. This showed that staff understood and promoted people's nutrition and hydration.

Is the service caring?

Our findings

People and relatives spoke highly of staff, their relationships with them and felt staff treated them with the utmost care, kindness and compassion. They said that staff knew people well, were sensitive and tuned to understand what was important to them in relation to their care and treatment. People and relatives made many positive comments about this, which included, "Nothing different is needed; excellent, caring; in fact amazing staff; a complete lifeline," "Absolutely fantastic; they are so kind and caring" and "It's care in partnership; they (staff) understand what's important to me; the emotional distress as well as the physical; no one blames you for feeling what you feel." All of the people and relatives we spoke with said they would recommend the service to family and friends if needed. Their views about this were often supported further, with words such as, 'most definitely' or 'with no hesitation' or 'doubt.'

People's rights, choices and involvement in their care were consistently ensured. People and relatives overwhelmingly said that staff consistently treated them with respect and ensured their choices, involvement and rights in care. One person said, "Staff listen; they give me time to sort my thoughts out; they never presume or judge; its respect and first class care all the way." A relative spoke with us about the hospice at home service and told us, "They are brilliant, caring; they regularly provide a male care staff; which is important."

Another person's relative told us, "Staff are so respectful; dignity is never compromised." The relative went on to tell us how the 'hospice staff stepped in straight away,' to ensure the person remained in their own home for their care. The relative said, "I couldn't have coped any more on my own; they went the extra mile and were so compassionate, caring and understanding; it's wasn't just a job to them." All of the staff we spoke with understood the provider's aim and values for people's care; which aimed to ensure people's rights, choices and involvement in care through kindness, empathy, compassion and respect.

We observed staff were consistently caring and mindful of people's privacy, dignity and confidentiality. For example, care was taken to ensure visitors were aware of times and areas where people, their children or other family members were engaged in therapeutic discussion or counselling. All of the staff and volunteers we spoke with were highly committed to providing people's care and support at the service and often told us they were 'more than proud' to work there. One staff member said, "It's like a family; care and respect runs right through the service." Records showed that all staff were assessed at interview for being caring people and received regular training in equality, diversity and human rights. Case studies were also presented in management and staff meetings to share and review good caring practice at the service. This helped to ensure a caring service from Blythe House Hospice.

All senior nurses at Blythe house received foundation and advanced level communications training, which one nurse said, 'Helps to ensure we have the right conversations with people at the right time.' Further nationally recognised training was introduced in 2016, known as Sage and Thyme, relevant to all grades of staff or volunteers. The training teaches the core skills required to notice, listen, hear and respond to people who are experiencing distress; in a way that empowers people and helps them to find their own solutions. It is based on published research evidence about effective communication skills. Staff and volunteers we

spoke with felt this had made a key difference to their confidence and approach to people's care. For example, they told us this enabled them to 'provide care without disempowering people.'

Throughout our inspection we observed staff were mindful, courteous and respectful in their conversations and approaches with people at all times. During our discussion with staff they consistently demonstrated a high level of care, awareness and commitment to provide people's care in a way that continuously involved and empowered them. One person told us, "I am more at peace with myself, since I came here; staff have really helped me to make some difficult decisions." Another person told us, "Staff are amazing; it's like they already know what's worrying you before you realise it yourself; they don't tell you; they always ask the right questions to help you get things into perspective; their care has been such a relief for me." This showed staff were compassionate, caring and highly motivated to make a positive difference to people's care experience.

People were involved and informed to agree their care and treatment and staff respected and acted on their views. People and relatives described many instances to us, which showed staff took time to understand how people's illness affected their lives and what was important to them and their family. For example, one person told us, "I was struggling before I came here; they (staff) have done so much - from sorting my pain relief to helping me with housing; it's been such a relief, they are truly wonderful people caring people."

Another person was particularly impressed with the caring nature of management and staff at the hospice, which they described as, 'Often goes above and beyond care.' They told us how the hospice staff had helped them to secure alternative housing with related environmental adaptations and adjustments. This helped to accommodate the equipment used for their care and maintain their health and independence. This showed a caring culture where staff consistently strove to promote people's views and empowerment in relation to their care and treatment.

People's care records showed that their preferred priorities for their care were discussed, agreed and regularly reviewed with them and their relevant family members. Staff were spoke with understood this and relevant information relating to people's preferred care priorities was appropriately shared with other care providers with an interest. For example, in the event of a person's health condition worsening, or for their care at the end stage of their life; known as advance care plans. This meant people were protected from receiving care that did not meet their needs or wishes, such as unnecessary hospital admission.

The provider's caring arrangements helped to ensure the emotional wellbeing of people who received care, their families and staff. Assessment and agreement of people's emotional, spiritual needs and family involvements were recorded in people's care records and regularly reviewed with them. One person told us how both they and their family members were supported emotionally and practically by hospice management, care and support team. This included transport and access to the hospice to attend their separate counselling and therapy support sessions. The person said this helped to alleviate their feelings of stress, guilt and worry relating to their health diagnosis. They said, "It's not easy coping with ill health, but staff always listen; they work with us and they really care for all of us."

Staff and volunteers told us about arrangements for their emotional and spiritual support, which included a range of support mechanisms from individual counselling, spiritual care; peer and management support. One staff member told us how they had benefitted from this and added, "I'm so proud of the service; I have never experienced such good quality 'all round care.' A volunteer told us, "Compassion goes right to the top here." A multi-faith room at the hospice provided a dedicated private space for people, staff and volunteers to use for personal reflection, prayer and quiet time. One person said, "It's good to know there is space for reflection alone, if I need it." A staff member told us, "It's a brilliant; it's open to everyone here."

People, their children and relatives were supported and informed to access a range of therapeutic care, practical support services across the hospice and local community settings, to suit their preferences and needs. For example, art and complementary therapies, led walks, mindfulness, bereavement counselling and spiritual support. An onsite information centre provided a wealth of information about the hospice service and related community care and support services. For example, how to access benefits, social work and advocacy services or 'Stepping Stones', which provided support for anyone who had left the service, but still required some level of contact and support outside the service. A carer's support group had been recently established at the hospice during 2016, which was well received and attended. The hospice volunteer transport and the hospice at home 'sitting service' helped people's relatives to attend when required. This showed that people, relatives and staff were supported, informed to live well.

Blythe House Hospice offered a well-established and comprehensive counselling and bereavement support service. This was provided in groups and through individual programs delivered by a range of professional, qualified staff and volunteer counsellors; to address the needs of anyone bereaved. The counsellors specialised in a range of palliative care and bereavement counselling to provide the support required. For example, counselling and support for people's children and relatives who had been bereaved due to a sudden or traumatic death. Nurses and care staff employed at the service received varying levels of bereavement training up to advanced level, commensurate with their role to support people's care in this way. Counselling at home and a befriending service was also offered. This helped to ensure that people, their relatives and those who were isolated or alone; received the care and additional support they needed.

Counselling programmes were tailored and flexible to individual needs through a range of mechanisms. For example, via on-going assessment, engagement or appropriate referral, to ensure relevant support for as long as required. Bereavement counselling and support was delivered with BBC Children in Need to provide expert care. Rooms were appropriately set up and equipped at the hospice for children and young people who attended for bereavement support. The hospice also extended the service via local schools and agencies. This helped to meet the significant service demand, which enabled people and their families to receive the care and support they needed from skilled, motivated staff.

The service had achieved a number of good practice and funding awards during recent months from a range of nationally recognised organisations, such as McMillan, Hospice UK and BBC Children in Need. These were in recognition of the service commitment to caring, innovative practice, which included care and bereavement support and the related care environment

Is the service responsive?

Our findings

People received timely and highly individualised care tailored to their wishes, needs and lifestyle preferences. We received many positive comments from people and relatives about the care provided. One person said, "It's timely, not rushed; they look at what's important, what matters and tailor your care to suit you; brilliant;" and "They went through my symptoms, worries and fears, helped me to get some perspective and supported my care decisions." Another person told us, "Staff are sensitive and thoughtful; it's almost as though they know what's bothering you before you've worked it out yourself; they ask the question or start the conversation that helps; I don't know how they do it."

Discussions we held with people, relatives and staff confirmed the provider's recorded findings from their recent survey of people's views about their care and support. This showed that staff consistently supported people in a way that helped them to feel comfortable to discuss their health condition and share their related feelings and experiences with others if they needed and wished to do so. At our inspection people told us, "Staff are always there for me when I need to talk about things that worry me." Another person told us, "We share with each other; the support I get from staff and the people here is second to none; when you need it the most." This showed staff mindful and consistently engaged and supported people in a way that was meaningful to them.

During our inspection we observed people received timely support when they needed it. For example, staff told us about one person who could easily become anxious when they needed to move because of their health condition. We observed staff supported the person in a way that was meaningful to them, which helped to reduce the person's distress. For example, they reassured and reminded the person what usually worked well, which enabled the person to move comfortably.

Relatives of people who received care from hospice staff in their own homes told us this was timely and flexible. For example, one person's relative said, "They are on time and have provided care at short notice when needed." Another relative told us, "Staff were flexible when needed the most; they stayed beyond the planned care time when their (person receiving care) condition worsened; they were absolutely wonderful." The hospice at home care staff told us, "We are flexible; that's the nature our care work; we have really good support from management, which helps." The provider's records showed that all people referred for care, who expressed a wish to receive this in a way that enabled them to die at home, were supported to do so. This showed that people's care was flexible and responsive to their individual care requirements.

People and relatives told us staff regularly took time to discuss people's daily living, lifestyle preferences and choices concerned with their care. This included people's known future care wishes or any advance care plans relating to their end of life care and treatment, which staff understood. For example, in the event of any worsening in people's health condition or where they wished to receive their end of life care; such as in their own home. One person told us, "They have a copy and I have a copy; they know exactly what I want to happen, if I get worse." People's care records showed their physical, emotional health care needs and related care preferences were assessed, agreed with them before they received care and regularly reviewed. People's known future care wishes and any advance care plans relating to their end of life care and

treatment were also recorded. This showed that staff were proactive to agree people's care with them.

Management and staff proactively engaged with external health and social care providers and commissioners to enable ongoing service development and improvements for people's care. For example, local health care commissioners told us, "The team are proactive in developing their services to meet the needs of the patient population;" and "Their collaborative working with external health care providers has helped to develop a local personal care model to help fast track people when required to the right care at the right time." This enabled people to access the end of life and palliative care they needed at the time they needed it.

The provider regularly reviewed and planned their service strategy against existing local and national service provision, trends and demands. In April 2016, in response to this, the provider launched their personal care 'hospice at home' service to support local people who wished to receive care at the end of their life in their own home. Two people's relatives told us, "The hospice listened and followed our wishes for care at home; they were marvellous," and "Staff were flexible, they never rushed; it made such a difference; they gave me back some 'me time.'" This enabled people to access the end of life and palliative care they needed at the time they needed it.

A group of care staff from the hospice at home service explained how they worked collaboratively with other services to support people's end of life care. This included regular meetings with the district nursing team to report and discuss any concerns or changes in people's health and potential personal care requirements with them and also the relevant GP. For example, in relation to the management of increased pain, discomfort or distress or for any care equipment requirements. This showed how staff consistently supported people's consistent and co-ordinated end of life care that met with their individual needs and wishes

Blythe House hospice provided a team of dedicated staff, volunteers and a range of facilities and equipment to support people's care needs. This included helping people, their families and children to understand, come to terms with and live well in relation to people's life limiting health condition and prognosis. People and their families consistently told us they were highly appreciative of the care and support they received in relation to this from staff at Blythe House Hospice. This included support to participate in relevant recreational, social activities and a range of therapies, either on a one to one or group basis. For example, complementary and art therapies, meditation and mindfulness; which were all facilitated and led at Blythe House by qualified, experienced facilitators. Mindfulness is the art of practicing care and compassion for ourselves and others.

Two people told us they particularly enjoyed doing art therapy at the service. One of them felt this had helped them to put into practice what they had learned from the mindfulness course, which they attended there. Many people said they particularly enjoyed the opportunity to relax, share and socialise with others at the day hospice. One person said, "It's really good to get out of the house; it helps me feel like a person, not just an illness; I do crafts I enjoy and have me time." Another person told us the companionship and openness they experienced at the service had enabled their openness and ability to talk about things there that mattered to them; which they found to be 'of real value.'

Dedicated support groups were established and regularly attended by people living with breast or prostate cancer. A range of weekly outpatient clinics were held by relevant external health professionals at the hospice, which helped people to get the specialist advice, care and treatment they needed locally. During our inspection we observed that people were sensitively supported by staff to engage and participate in this way and as relevant to them, either individually or with others.

The hospice information centre provided a range of information and support for people and their family carers. This helped them to understand the hospice service and other related sources of information and support in the local community. The service took a key role in the local community in a way that enabled them to build links, services and support networks to further inform and support people in a way that was meaningful and helpful to them. This was done via a range of methods, such as through community outreach. For example, a regular 'drop in' clinic was established at the local premises of a well-known chemist chain. This enabled people and their relatives to access the information and support they needed at the time they chose.

Staff working at the information centre told us they had established a considerable level of engagement and support, through their outreach work, with 'hard to reach' groups, such as farmers and people with learning disabilities. Records showed this resulted in their uptake of related or tailored care, support and ongoing engagement with the service. For example, regular support groups enabled people to meet and share their experiences relating to their health condition with others who were similar to themselves. People told us this helped to reduce their feelings of isolation, vulnerability or fear. One person told us, "The information they gave me helped me to understand and feel confident to use the service; I've gained so much from the support here." Staff also told us about training and support provided by the hospice to support local school children with learning disabilities to work with nurses at the hospice regular coffee mornings, where they acted as joint facilitators.

A monthly benefits clinic was held for people who were bereaved or living with a life limiting illness from within the locality; who were otherwise unable to access this type of service without having to travel significant distances across county boundaries. The service liaised with relevant external agencies to enable tailored and timely support for people. For example, this enabled a bereaved relative, whose first language was not English to receive the information and support they needed to enable them to negotiate required financial matters following the death of their spouse. An established support group was open for all carers in the High Peak, not just those connected with Blythe House. This meant the provider recognised the demographic challenges that may otherwise prevent carers from accessing this type of service and the potential impact on local health demands from this. This showed the service sought to engage with people, their families and the wider community. This was done in flexible, individualised and innovative ways that helped to ensure their diverse needs care were met.

Clear and accessible information was provided for people about the service, which could be made available in alternative formats to aid people's understanding. For example, large print or easy read picture format. This included how to make suggestions, comments or complaints about the service. People and their family members said they had no complaints about the care and treatment provided. All felt that their views about their care were sought, taken seriously, listened to and acted on when required. For example, summary findings from the provider's 'Just One Thing' survey with people, families, staff and volunteers showed they were asked to suggest one key service improvement they would like to see made.

Prioritised improvements were made from the 'Just One Thing' survey. This included improvements to onsite storage, environmental signage, the provision of drinking glasses, which were lighter weight and easier for people to use and improvements to media, information and communications strategy for the service. For example, from this a range of newsletters and service information posters were provided across the service and the provider's website updated to give clearer service information and signposting. Other service improvements from complaints and suggestions included revised car parking arrangements, to enable closer car parking for people receiving treatment at the hospice for their ease and comfort. Subsequent feedback from people, their families and also from local care commissioners showed they were appreciative of service improvements made from this.

Accessible comment cards and post boxes located were used to seek people's views. Feedback from these and from a complaint received had resulted in a review to improve car parking provision for people using the hospice service. The registered manager told us the hospice was seeking to develop an independent patient experience survey to help gain people's views about their care and monitor trends or improvements that may be needed. The registered manager also told us that an annual staff survey was planned via national organisation, who helped registered charities including hospice services, to work more effectively with their staff and create an organisation where they love to work. All of the staff and volunteers we spoke with at our inspection told us they were happy; loved working at Blythe House Hospice and would recommend the service to family and friends. This showed the provider valued, listened and learned from staff and people's experience, comments and complaints about the service.

Is the service well-led?

Our findings

People, relatives, staff and volunteers were extremely positive about the management and leadership of the service. All described an open, inclusive culture and were all highly confident to recommend the hospice service to family and friends. We received many positive comments, which included, "The service is really well managed; the manager listens, has an open door and always has time – brilliant;" "Very thoroughly managed; I feel welcome and valued."

Staff and volunteers were happy and proud to work at the hospice and felt they made a positive difference to people's care experience. We received many positive comments from them about management and service improvements since the appointment of the registered manager, which everyone was pleased and motivated by. This included, "Communication, direction and service strategy are all developing for the better;" "There is more focus on service improvement; communications have improved massively; it's inclusive and we are recognised in the process."

The hospice senior management team were visible and available to staff, people using the service and others with an interest there. For example, people's families, external health professionals and care commissioners. Staff, volunteers and people receiving care made positive reference about the visibility of the board trustees, service managers and their engagement with them. This helped to promote confidence and understanding in relation to the management and leadership of the service.

There were clear and defined management arrangements for the service. Staff and volunteers told us that team meetings were regularly held with them to inform and support people's care. Staff also said that managers were always available for discussion, information or advice relating to people's care. This included access for community staff and volunteers to 'drop in' at the service or make telephone contact with managers based there. A planned rota for call management arrangements was in place to support the hospice at home staff team out of normal working hours. Staff said they received regular supervision and formal appraisal of their work. They also said they could access emotional and formal counselling support if required. This helped to ensure that staff understood and were effectively supported to perform their roles and responsibilities for people's care.

There were clear lines of accountability for communication and reporting in relation to people's care, which staff understood. For example, reporting concerns about people's safety, acting on related care improvements or making practice changes when required. The provider's governance and management arrangements supported this because there were clear operational procedures for staff to follow. This included defined communication and service monitoring arrangements through to hospice board level. Related records, such as meeting minutes and service development plans showed key information relating to service strategy, care provision and any related changes or improvements were regularly discussed and communicated with staff. This meant that the board and senior managers knew about and took responsibility for things that happened in the service.

The registered manager told us they regularly checked the quality and safety of people's care. For example,

in relation to care and treatment approaches, service information, referrals and specialist care activity and the hospice environment. The service audit plan for 2016-17 showed that a range of local and nationally recognised standards and measures were used to inform this process. People's views were also regularly sought about the quality of care provided. Findings from regular service checks and people's views obtained were used to inform service improvements when required. Recent improvements were made from this to people's care, environment, facilities and equipment. This included the development of communication in care through related staff training measures, establishment of a carer's support group and equipment storage provision. Further measures were planned to check the effectiveness of people's care. For example, in relation to anxiety management care provision, holistic care needs assessment and the hospice at home service. This helped to ensure the quality and safety of people's care through nationally recognised practice standards concerned with hospice, end of life and palliative care.

Partnership working was established with key organisations and agencies, which helped to influence and support care provision. This included local general hospitals and care homes, local authority safeguarding teams and clinical commissioning groups. This regularly occurred across geographical boundaries where people could often travel to receive secondary care. Links were also established with universities and other relevant national organisations and bodies concerned with end of life, palliative care and life limiting illness. Staff regularly spoke about and presented their work at the hospice, to relevant external organisations, bodies and other health care providers. For example, in relation to the hospice 'Living Well' service for people and their families to live well with the impact of life limiting health conditions. 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 and health professionals told us the meetings were a good opportunity to share professional and best practice knowledge. This helped to support both cross boundary and cross sector care and treatment provision, staff education, care practice and service improvement.

The provider's strategic plan 2016-19, showed service goals, values and operational objectives that reflected known directives and challenges for delivering specialist palliative and end of life care. The plan included key service objectives for meeting the diverse, changing care needs and demand of the local population, together with related workforce planning considerations. For example, to meet the needs of people living with dementia or in hard to reach rural areas; bereaved children and young adults. This strategy linked to the provider's considerable fund raising and voluntary income strategies, which was important to ensure that it would be realistic and financially viable. A two year funded proposal with MacMillan Cancer Support aimed to identify further opportunities for volunteers to work with Blythe House Hospice across all their departments. This helped to inform and ensure the quality and shape of care and service delivery from Blythe House Hospice.