High Peak Hospicecare

Blythe House Hospice

Inspection report

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

Ratings

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

Summary of findings

Overall summary

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

- The service was safe. Staff used safe working practices and followed risk assessments when providing care and support for people. Staff took time to engage with patients and families and patients felt listened to and felt safe. Relatives told us that staff were caring, supportive and respectful. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.
- The hospice at home staff worked closely with hospitals, community organisations and health and social care professionals to help ensure people received the right care at the right time.
- Volunteers went 'above and beyond' to visit people who lived alone to help with shopping, pet walking, took prescriptions to the pharmacy and friendly telephone check-ins.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. There were clear processes for managing risks, issues and performance. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community end of life care	Good 	We rated this service as good. See the overall summary above.

Summary of findings

Contents

Summary of this inspection

Background to Blythe House Hospice

Blythe House Hospice was founded in 1989 and is operated by High Peak Hospice Care. It 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 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 provides personal care to people in their own homes who choose to remain and receive care in their own home at the end of their life.

The community hub offers treatment and advice over the phone, online and through COVID-19 secure face-to-face meetings. Treatments and advise offered include; carer and family support, changes to treatment plan, symptom management and a range of other services.

Blythe House Hospice has a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like a 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.

We last inspected this hospice on 2 and 11 August 2016 and the report was published in February 2017. We previously rated the hospice as good.

We carried out this unannounced inspection on 28 June 2021. 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.

It was carried out by an inspector and a specialist advisor. The specialist advisor had significant experience of working within the field of palliative and end of life care.

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

At our inspection we observed how staff interacted with and supported people. We spoke with two people receiving care and treatment. We also spoke with a range of 15 management, clinical, therapy, volunteer, care and support staff, which included the registered manager. We spoke with two relatives of people who had received personal care in their own home from Blythe House hospice at home 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.

Summary of this inspection

How we carried out this inspection

During the inspection visit, the inspection team:

- Visited Blythe House Hospice and carried out a home visit to observe care being provided to a patient in their own home.
- Spoke with the registered manager, a trustee and two members of the senior management team.
- Spoke with a range of staff including management, clinical, therapy, volunteer, care and support staff, which included the registered manager.
- To get staff views about the service, we facilitated four focus groups for healthcare assistants, band 5, 6 and 7 nurses, counsellors and clinical staff and volunteers and unpaid counsellors. A total of 48 staff attended our focus groups.
- Spoke with two patients who were receiving care and treatment.
- Spoke with two relatives of people who had received personal care in their own home from Blythe House hospice at home service.
- Reviewed four care and treatment records for patients receiving care.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

Outstanding practice

We found the following outstanding practice:

- The Blythe House Hospice community volunteer programme set up a seven-day-a-week telephone helpline for the local community to call for support. The service embarked on a 'Here to Help' approach during the COVID-19 pandemic. There had been 2,000 episodes of volunteer activity since March 2020. Volunteers went 'above and beyond' to visit people who lived alone to help with shopping, pet walking, took prescriptions to the pharmacy and friendly telephone check-ins.
- The service received a community volunteer team recognition for passionate and determined team supporting people affected by cancer and was the Midlands regional winner for the Macmillan Cancer Support Service in March 2020.
- The service had a community hub which provided specialist palliative care and support to patients and carers throughout the pandemic. The service had invested in new technologies to switch from face-to-face contacts to telephone support to enable staff to continue to keep patients safe.
- The service employed a community engagement nurse who went into the community and spoke with healthcare professionals to raise awareness of Blythe House Hospice services and pathways. They also visited schools including a local school for pupils living with learning difficulties to talk about services such as children's counselling services available at the hospice.
- The hospice at home team delivered twice as much care during the pandemic. This reduced reliance on the acute sector and enabled people to die at home with their loved ones during lockdown and restrictions.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community end of life care	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Community end of life care

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

Are Community end of life care safe?

Good

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

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. At the time of the inspection, the average completion rate for all staff was 90.6%; the hospice's target for mandatory training completion was 90%.

The mandatory training was comprehensive and met the needs of patients and staff. The mandatory training programme included a range of modules covering subjects such as, but not limited to, fire safety, manual handling, information governance, infection prevention and control, conflict resolution, basic life support and safeguarding adults and children.

Clinical staff completed training on recognising and responding to patients living with mental health needs, learning disabilities, autism and dementia. Staff we spoke with said they received the training and support they needed for their role.

Managers monitored mandatory training and alerted staff when they needed to update their training. There was a dashboard in place to assist managers in monitoring training compliance.

Safeguarding

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

Nursing staff received training specific to their role on how to recognise and report abuse. We found that the proportion of staff involved in the care of patients were trained to safeguarding level 1 and 2 in children and adults was 84%. In addition to this, all staff required to complete safeguarding level 3 had done so.

Good

Community end of life care

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service had a safeguarding children policy which was reviewed in February 2021 and detailed all aspects of identifying and dealing with abuse including information on female genital mutilation. A safeguarding adult policy was also in place and had been reviewed in June 2021.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had a safeguarding lead, who managed any safeguarding alerts that needed to be made to the local authority. Staff knew how to contact the safeguarding lead and who to inform if they had concerns. A process was in place for obtaining advice or making urgent referrals to the local authority.

All care staff knew what to do if any safeguarding incidents were suspected. The Care Quality Commission (CQC) and local authorities were informed of any safeguarding alerts made by staff. In July 2020, the chief executive officer notified CQC of a safeguarding alert which had been made to the local authority.

Staff followed safe procedures for children visiting the service for counselling sessions. Parents or carers accompanied children who visited the service.

Cleanliness, infection control and hygiene

Staff used infection control measures when caring for patients both in their own homes and at the hospice.

Staff followed infection control principles including the use of personal protective equipment (PPE). All staff had been issued with a pack of equipment for infection, prevention and control when working in people's own homes. The pack contained PPE, including gloves, aprons, visors, masks and hand gel. This meant the provider had taken additional measures to protect staff and the people they worked with from the risks associated with infection control issues.

We observed staff being 'arms bare below the elbow' and wearing PPE while providing personal care to a patient receiving end-of-life care in their own home.

Blythe House Hospice building was visibly clean and had suitable furnishings which were clean and well-maintained. Staff kept a cleaning record detailing the areas that required cleaning and ensured these were signed by the member of staff completing the process.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We reviewed cleaning schedules and records from January to June 2021 and found no gaps.

We saw there was an infection prevention and control policy in place which had been reviewed in February 2021 and reflected relevant legislation and published professional guidance. The provider maintained and strengthened COVID-19 secure measures and everyone entering the building was always expected to wear a surgical mask. There was a hygiene station at the main entrance of the building which included a hand sanitiser, surgical masks and a bin to dispose of used surgical masks.

The service has had a robust testing regime in place since the second week of February. A routine test for COVID-19 was performed on all patient facing staff and volunteers on a weekly basis. In addition, a lateral flow testing programme commenced at the beginning of March 2021. The service required staff to test themselves twice a week and test kits were supplied to all staff and working volunteers.

Good

Community end of life care

The service participated in the government's PPE supply scheme and there was availability of sufficient PPE to ensure continuity of services.

Hospice at home staff had received additional fit testing for FFP3 masks as some of them were required to provide care to patients who had aerosol generating devices.

Staff cleaned equipment after patient contact. Staff used 70% alcohol wipes to clean reusable medical equipment such as blood pressure monitors.

Staff cleaned all clinical rooms after each patient and wiped all surfaces including desks and hard surfaces the patient had been in contact with as soon as they left the clinic room.

Staff asked patients and visitors to use the available hand sanitiser before exiting the building. All other regular touch points had been identified and an infection control plan put in place for each of them.

Environment and equipment

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

The design of the environment followed national guidance. There was one main entrance to the hospice which had automatic doors. Exiting the building required a button to be pushed to trigger the sliding door. The member of staff on reception cleaned the button with a disinfectant wipe every hour.

The main room used for groups and the quiet room were being refurbished at the time of our inspection. Fabric furnishings were being changed to wipeable ones and carpets removed in clinical areas for compliance with infection prevention and control practices.

Staff carried out safety checks of equipment. We reviewed the weekly check record of fire extinguishers, which were located throughout the hospice; these had been tested appropriately.

The service had suitable facilities to meet the needs of patients' families. Emergency exits were clearly signposted and free from obstruction.

The service had a policy for delivering clinical services during the pandemic and all rooms had been assessed for social distancing and had a maximum number of people allowed. Chairs in the clinical rooms had been placed at an appropriate distance from each other.

We reviewed the maintenance schedule from December 2020 to June 2021 and found staff carried out weekly checks on hot and cold-water outlets, hoist batteries, extractor fans and ladders used for maintenance to keep both patients and staff safe.

The service had enough suitable equipment to help them to safely care for patients. An automated external defibrillator was held in the main reception area. Emergency equipment was checked daily and all equipment checked during our inspection was up-to-date.

The utility room appeared cluttered with a box of urine bottles, tea kettle and other equipment stored in the same room. We raised this with senior staff who said equipment had been moved to the room due to ongoing refurbishment and agreed to take required action to mitigate any potential risk.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. They followed the new national guidance on cardiopulmonary resuscitation and rang the emergency service in the event of emergency.

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 cardiac arrest.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly. Initial assessment for all patients on admission and reviewed throughout.

Staff knew about and dealt with any specific risk issues. Staff followed instructions for people's body positioning to help prevent skin sores. We observed end of life care being provided to a patient in their own home and staff used pressure relieving equipment to 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 people received safe care and treatment.

Staff shared key information to keep patients safe when handing over their care to others. Staff knew how to escalate medical emergencies, and hospice at home health care assistants said they would contact 111 out of hours in the event of any health care related issues such as falls.

Hospice at home carers rang the on-call team from 7am to 10pm and contacted 111 out of hours when a patient was deteriorating. They also received support from district nurses and a neighbouring hospice.

Staffing

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

The service had enough nursing and support staff to keep patients safe. The hospice at home service had 40 staff providing 24-hour services. Most hospice at home staff worked zero-hour contracts. A proposal was submitted in April 2021 to offer a small number of fixed hours contracts for hospice at home healthcare assistants. The aim was to improve capacity particularly around weekends.

Managers made sure all bank staff had a full induction and understood the service. They provided personal support to ensure they could meet the individual needs of people receiving care.

The service employed 39 substantive staff. They had 35 bank staff on zero hours contract and 100 volunteers.

Good

Community end of life care

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed. The hospice at home staffing was acknowledged as a risk in the risk register. As a result, hospice at home staffing had been redesigned to minimise future risks and two new nurses were being recruited to make the team more robust. The services ensured continuity of carer wherever possible depending on the patient's condition and staff availability.

The managers could adjust staffing levels daily according to the needs of patients. There were no staff shortages.

The service had enough medical staff to keep patients safe. One of the three consultants in palliative care medicine covering High Peak District worked as a trustee for the service and provided outpatient clinics.

The number of nurses and healthcare assistants matched the planned numbers. The ratio of hospice at home support workers was monitored by a care coordinator.

The service had low vacancy rates. New staff had been recruited with some due to commence in August at the time of our inspection.

The service had low turnover rates. A healthcare assistant had retired, a shop cleaner had moved to a job with more hours and there had been three voluntary redundancies.

The service had low sickness rates. One part-time staff was off sick at the time of our inspection.

The community hub had therapy staff who had been in post since April 2021 and provided complimentary therapy on an 'as required' basis.

The service had a recruitment policy, which provided a framework for the recruitment and selection of staff and volunteers to work with vulnerable people. A range of checks were carried out including proof of identity, written references, and checks with the Disclosure and Barring Service (DBS).

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 required employment checks were made before staff provided people's care. For example, checks of staff previous employment, work history and checks with the DBS. This helped the provider to make safe recruitment decisions about an applicant's suitability.

Records

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

Patient notes were comprehensive and all staff could access them easily. We reviewed four electronic patient records and one paper end of life care and communication record. All the records we reviewed were comprehensive, clear and included relevant risk and clinical assessments.

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 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.

Records were stored securely. Patient notes were kept in the patient home as well as the office base. Updates about the patient's condition were communicated to the appropriate community nursing team as required.

The hospice at home coordinator had weekly meetings with volunteers. Volunteers collected notes of patients who had passed away from their homes. The hospice archived these notes for one year.

The hospice had undertaken an audit of 23 sets of written patient notes in May 2019 and found 22 out of 23 had referral forms and two out of 23 patients had no consent forms in their notes. Both patients who were seen without a consent form signed the forms during their next visit. The audit identified actions which included an ongoing annual audit.

Medicines

The service used systems and processes to safely administer medicines.

Staff followed systems and processes when safely administering medicines. Healthcare assistants who provided peoples' 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 instructions 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 service did not store medicines on site. 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.

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 their behalf during their attendance for daily care at the hospice.

We found that medicines for people who used the service had been prescribed by their own GP, out of hour's doctor or by the palliative care team.

Incidents

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

Staff knew what incidents to report and how to report them. There was an incident reporting system in place and staff knew how to use it.

Staff raised concerns and reported incidents and near misses in line with provider's policy. The hospice had an accident, near miss and incidents reporting policy and operational procedure.

The service had no never events. From May 2020 to May 2021, the service reported no incidents classified as never events for hospice at home services. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Good

Community end of life care

Staff reported safety incidents clearly and in line with provider's policy. The clinical commissioning group's (CCG) quality assurance dashboard for Blythe House Hospice recommended monitoring of all patient safety incidents with identification of themes and trends where appropriate for escalation including near misses. The provider discussed safety incidents with the local CCG quarterly and evidence reviewed showed no serious incidents were reported from 2019 to 2020.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The service reported three clinical incidents and four non-clinical incidents from May 2020 to May 2021. One pertained to a patient who had a fall outside the car park entrance of the hospice and the second involved a patient who highlighted issues in the communication between internal services and external agencies. A review of the second incident highlighted areas which needed to be addressed.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Senior staff applied duty of candour regulations to ensure openness, transparency and candour.

Staff received feedback from investigation of incidents. Learning was shared during team meetings and newsletters.

Are Community end of life care effective?

Good

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. A process was in place for policies to be updated with any new or amended guidance. The database provided staff with up-to-date links to policy documents.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Awareness of the requirements of the acts was included in mandatory clinical core skills training on consent.

Patients had an individualised plan of care which, if the patient was at their end of life, was supported by the individualised care and communication record for a person in the last days or hours of life. This was in line with the National Institute of Health and Care Excellence (NICE) quality standard QS13, end of life care for adults, and national guideline NG31 care of dying adults in the last days of life.

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 nursing, therapist health professionals and experts to support people's care and treatment. For example, in relation to peoples' 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.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health in their own homes. They used special feeding and hydration techniques when necessary.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. All malnutrition universal screening tools (MUST) scores were assessed by the community nurse as the primary care provider. Any actions required because of the MUST score were documented and followed by the Blythe House hospice at home staff.

Staff completed patients' fluid and nutrition charts where needed.

The service had a kitchen in place and use to provide nutrition and hydration to patients attending the Living Well Service (LWS) and children who attended the service for therapy or counselling. This was stopped due to the COVID-19 pandemic as most of the services were provided virtually and the LWS had been remodelled. All kitchen staff were made redundant.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The community nursing team prepared and administered anticipatory medicines.

Patients received pain relief soon after requesting it. Hospice at home staff who cared for patients in their own homes received instruction to enable them to do this safely and understood the principles for safe medicines arrangements.

Staff administered and recorded pain relief accurately. All medicines were prescribed by the general practitioner and managed by the community nursing team.

Patient outcomes

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

The service participated in relevant national clinical audits.Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices. The service audited the number of referrals received with ReSPECT forms in place. Of the 196 hospice at home referrals, 178 had ReSPECT forms in place, eight had no respect forms and the service received 10 referrals with unknown ReSPECT status.

Good

Community end of life care

Outcomes for patients were positive, consistent and met expectations, such as national standards. Staff carried out an audit on end of life preferences on 35 patients who attended the Living Well Services in April 2020. All 35 (100%) patients had a holistic needs assessment at their initial assessment appointment with a nurse with palliative care experience. Evidence of Advanced Care Planning discussions was seen in 89% of patient notes and 57% of those patients were given the chance to revisit this and subsequently review their decisions.

Managers and staff used the results to improve patients' outcomes. Evaluation feedback from the hospice at home in the last five years showed 94% of patients received care at their preferred place of care and 98% of patients were cared for at their preferred place of death.

Managers used information from the audits to improve care and treatment. Staff had started to implement a revised children's anxiety and depression scale as an outcome measure for children's services.

Managers shared and made sure staff understood information from the audits. Audit result were discussed during staff meetings.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff and volunteers were trained and supported in 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.

Managers gave all new staff a full induction tailored to their role before they started work. We saw the provider had recently recruited a new occupational therapist and physiotherapist and their induction included health and safety and fire evacuation.

Managers supported staff to develop through yearly, constructive appraisals of their work. Figures provided showed 83.3% staff had been appraised.

Staff attended an advanced symptoms management day training which was organised by the chief executive officer.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Nursing staff said they had monthly one-to-one meetings with the business support manager and discussed any gaps identified.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Association of Palliative Day Services and association of social workers organised virtual conferences which staff attended.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. One of the community engagement staff said the service had paid for them to attend extra training to enable them to carry out their role.

Managers made sure staff received any specialist training for their role. Hospice at home staff attended training days for lymphatic drainage, changing/emptying stoma bags, emptying catheter bags and management of oxygen therapy.

Managers recruited, trained and supported volunteers to support patients in the service. Volunteers were provided with a structured induction programme.

Multidisciplinary working

Staff worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The hospice maintained effective and frequent communication with community nurses and the local clinical commissioning group.

Staff worked across health care disciplines and with other agencies when required to care for patients. With patient consent, relevant information and consultation records was shared with appropriate professionals in the community; for example, patients' GPs, hospital consultants, or the hospital specialist palliative care team. This ensured that all professionals responsible for a patient's care had all their relevant clinical information should the patient be admitted to hospital.

Seven-day services

Key services were available seven days a week to support timely patient care.

Hospice at home services were available seven days per week, 24 hours per day.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support. 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, virtual support groups and mindfulness therapies. Mindfulness is an ancient Buddhist practice, which means paying attention in a non-judgmental and focused way to help increase awareness, clarity and acceptance of our present moment reality.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. The hospice's consent policy which was last reviewed in February 2021 set out processes to ensure suitable procedures were in place for obtaining consent in relation to treatment provided to patients. When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Four patient files we reviewed had a current and complete care plan that set out their advanced care preference and had a current advanced decision in place.

We saw where Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were in place this had been discussed with patients, their families and relevant healthcare professionals. A DNACPR is an advanced decision not to attempt cardiopulmonary resuscitation in the event of cardiac arrest. This meant the service involved and enabled people and their families to fully contribute to advance decisions about their end of life care through sensitive, respectful discussions.

Good

Community end of life care

Staff received and kept up to date with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards. Staff received training and they understood and followed the principles of the MCA.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Awareness of the requirements of the acts was included in the clinical core skills mandatory training for staff.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. All policies were stored electronically and staff had access to them.

Are Community end of life care caring?

Good

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. This was evidenced in the home visit we observed.

Patients said staff treated them well and with kindness. We spoke with a family member who told us all staff were “extremely respectful” and “supportive”.

During the inspection, it was clear a culture of compassion and delivering individual needs and wants to palliative and end of life care patients was truly embedded and ingrained in the hospice.

The feedback received from people using the service, relatives and healthcare professionals was positive. This was evidenced in the hospice evaluation from April 2020 to April 2021 and also corroborated by the clinical commissioning group.

The service had a person-centred culture, which was achieved by negotiating care needs with people using the service. Preferences and needs were central to how care was delivered.

Volunteers took sympathy cards to relatives whose loved ones had passed away. Staff sent out evaluation cards a month after the date of death to relatives.

We saw the hospice at home service evaluation results showed a response rate of 10 out of 38. Responses received showed phone calls to and from the hospice at home coordination team was dealt with sensitively. All respondents felt the hospice staff took time to listen to their concerns and 60% of respondents did not feel they would have managed without hospice at home care.

Staff followed policy to keep patient care and treatment confidential. We saw staff were discreet when caring for patients.

Good

Community end of life care

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. The counselling team set up a dedicated mental health and well-being page on the hospice's website and provided information around meditations, soothing music, sleep exercises and stories in the wake of the first lockdown.

Children and young people's counsellors offered bereavement play therapy sessions to children. A parent who attended a face-to-face session with her children said; "To other parents or carers of children who may need support, the first thing I would say is contact Blythe House in a heartbeat. It's an outstanding, invaluable local service and I feel so grateful and lucky that it's on our doorstep".

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

We reviewed the hospice at home evaluation and one of the respondents commented "The service you provided during the night enabled me to get some sleep. This allowed me to better cope during the day. Thank you to the whole team for their support".

Staff who attended our focus groups said they created time to provide holistic care to sit and listen to patients and their family members. They used their skills to help people live better.

Emotional and social needs were just as important as physical needs. Spiritual care team and community volunteers supported the hospice at home function.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Volunteers staff were passionate about meeting patients' needs.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service had a compliments log in place and had recorded eight significant compliments in December 2020.

Hospice at home staff collected routine feedback from patients and their relatives. Feedback received was positive and gave some insight into the service. There were 23 responses, which was a 31% response rate and main points included:

- 100% of people felt they received enough care, they were listened to and were happy with the care their family member received.
- 91% of respondents said their anxiety was relieved to some degree by having the service in place.
- 70% of people felt they would have had to use the GP more if the team were not there to help them.
- 65% felt they would not have been able to manage their relative at home without hospice at home support.

Good

Community end of life care

Staff including carers supported patients to make advanced decisions about their care. Advanced care planning was embedded in the service, and it was clear all areas of the hospice had influence in this. For example, the social programmes of care played a part in helping patients to understand and express what was important to them.

Staff supported patients to make informed decisions about their care. We saw evidence in the records we reviewed of discussions between end of life care staff and patients, and their families, including discussions around do not attempt cardiopulmonary resuscitation decisions, and decisions about patients' preferred places of care.

Patients gave positive feedback about the service. The services 'Here to help you at home' booklet included advice and guidance around caring for someone at home; support when someone was believed to be in the last days of life; and what to do after someone had died.

Peoples' feelings at the time of dying/death was a priority. This positively influenced bereavement by making memories the family could use to know they had done the right thing at the right time and had facilitated their loved one's wishes.

Are Community end of life care responsive?

Good

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

Service delivery to meet the needs of local people

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

In March 2020, the service was nominated for the Macmillan Cancer Support Service team of the year award and received a Community Volunteer Team Recognition for passionate and determined teams supporting people affected by cancer. The awards panel selected Blythe House Hospice as the Midlands Regional winner.

The service was nominated to receive a Derbyshire Beacon of Hope Award in June 2021. The award looks to identify and thank individuals and organisations who have worked tirelessly to keep communities safe during the COVID 19 pandemic.

Managers planned and organised services so they met the changing needs of the local population. The hospice at home service was available 24 hours, seven days a week and received referrals through the rapid discharge for end of life care.

The hospice at home team delivered twice as much care during the pandemic. This reduced reliance on the acute sector and enabled people to die at home with their loved ones during lockdown and restrictions. The hospice was the only provider willing and capable of doing this as many care agencies had furloughed their staff and did not see patients living with COVID 19.

Local and regional health care systems relied heavily on Blythe House Hospice, and the service was outstanding in their response and reliability.

Good

Community end of life care

The service launched a bereavement support group in March 2020 and the sessions were open to local people suffering from the effects of bereavement. The group offered a chance for people using the service to share their experiences, feelings and discuss coping strategies with other service users.

The Blythe House Hospice community volunteer programme set up a seven day a week telephone helpline for the local community to call for support. The service embarked on a 'Here to Help' approach during the COVID-19 pandemic. There had been 2,000 episodes of volunteer activity since March 2020. Volunteers went 'above and beyond' to visit people who lived alone to help with shopping, pet walking, took prescriptions to the pharmacy and friendly telephone check-ins.

The service employed a community engagement nurse who went into the community and spoke with healthcare professionals to raise awareness of Blythe House Hospice services and pathways. They also visited schools including a local school for pupils living with learning difficulties to talk about services such as children's counselling services available at the hospice.

The hospice at home team had one band 5 nurse who worked four days a week and a band 7 nurse who worked five days a week to meet the needs of the local population. The service had recently recruited a band 5 nurse who was due to start in August 2021.

Facilities and premises were appropriate for the services being delivered. The hospice building underwent a major transformation with updates to the reception, bathroom, therapy rooms and treatment areas to ensure accessibility for all visitors. This refurbishment was managed and co-funded by a national charity.

The service had systems to help care for patients in need of additional support or specialist intervention. Care navigators contacted the appropriate clinician with the referral and the details they had obtained. This worked particularly well for patients requiring counselling sessions where annual leave could lead to delays in contacting the patients.

The service had a carers support group which provided bereavement support to family members and carers of patients living with breast and prostate cancer. This was led by a band 7 nurse who had worked for the service for eight years.

The service had a community hub (formerly known as the Living Well Service) which provided specialist palliative care and support to patients and carers throughout the pandemic. The service had invested in new technologies to switch from face-to-face contacts to telephone support to enable staff to continue to keep patients safe.

The community hub offered hub groups every Wednesday by video calls and this was facilitated by trained and experienced nurses and support workers. They also provided carers support and education sessions through telephone, online or COVID-19 secure face-to-face meetings by appointment only.

We reviewed the care records of a patient living with multi-neurone disease and found comprehensive support had been given to the patient, relative and other members of the family.

Managers ensured patients who did not attend appointments were contacted. The hospice had a process in place to contact any patient that did not attend for an appointment. This included the ability to check if patients had been admitted to hospital.

Children's and young persons counselling had continued on a face-to-face basis. Adult counselling had also continued through a mixture of video calls and face to face appointments.

The counselling and bereavement team offered counselling and psychotherapy services for hospice patients and carers who were experiencing emotional distress as a result of their own life-limiting illness or the illness of someone significant to them.

The Prostate Cancer Support Group was open to anyone affected by prostate cancer including patients, partners, carers and friends and took place once a month through an online platform due to COVID-19.

The Breast Friends Breast Cancer Support Group took place once a month and provided a relaxed and informal atmosphere for friendship, advice and support.

We held focus groups with staff who said patients were comfortable to attend sessions through video calls and found it quite positive. Most who had been unable to attend pre-pandemic due to life limiting conditions were able to attend the video call sessions.

Meeting people's individual needs

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

Care plans and risk assessments for patients were person-centred and consistently tailored to each individual patient's needs. Each person's care plan was devised in discussions with the patient about what was important to them. The care plans were regularly reviewed and updated, and referrals were made to members of the multidisciplinary team according to each patient's needs.

Staff used innovative approaches to meet complex needs of people using the service. The hospice at home service purchased a respirator, hoods and connection tubing to ensure care for a patient living with motor neurone disease could be continued during the COVID 19 pandemic. The service was flexible to the patient's choice to continue care from the same provider.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The hospice at home team provided night sits to patients receiving end of life care from 10pm till 7am and personal care from 7am to 10pm. The service had 18 patients receiving care in their own homes at the time of our inspection.

We reviewed notes and saw a grandchild had been receiving counselling support to help them cope. The counselling service was extended to family members affected by a relative's diagnosis or family members of people who had suddenly passed away.

Staff supported patients living with lung cancer and other related forms of cancer by providing fatigue, breathlessness and anxiety clinics. The fatigue, breathlessness and anxiety course was offered over eight weeks and provided symptom management strategies to patients. Patients found the service very useful as it gave them a better quality of life.

Good

Community end of life care

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. With patients being unable to attend the service during the pandemic, the clinical counselling staff responded by putting in virtual consultations and support to their patients.

Access and flow

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

From June 2020 to May 2021, the hospice received 491 referrals with 146 referrals to the community hub and 345 referrals to the hospice at home team.

The hospice at home team carried out 4,928 visits delivering 18,933 hours of care to patients in their own homes. Carer respite was the main reason for referrals followed by crisis avoidance and rapid response to avoid crisis admissions. Carer respite helped carers to manage and reduce anxiety. Staff delivered care at a negotiated time to carers' needs. Senior staff carried out daily reviews to ensure concerns escalated by carers were dealt with in a timely manner.

Services were flexed, increased or altered daily to support changing circumstances which often occurred in the final phase of life. Concerns and changes to services were discussed and clearly documented by relevant professionals involved.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The service employed two care navigators who became a single point of access for all referrals and enquiries. This gave the service a quick response time to all referrals (within one working day).

When patients had their appointments cancelled, managers made sure they were rearranged as soon as possible and within national targets and guidance. No appointments had been cancelled in the past year.

Staff monitored referrals and the nursing team discussed new referrals with care coordinators. Staff told us the communication between care navigators, care coordinators and nursing staff was good.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. The service received 33 compliments from patients and their relatives and no complaints from June 2020 to May 2021.

Patients and visitors were encouraged to raise any concerns directly with staff when they arose, and it was the hospice's policy to address informal concerns before they escalated to formal complaints.

Staff understood the policy on complaints and knew how to handle them. Complaints were acknowledged within five working days of receipt and responded to within 30 working days.

Good

Community end of life care

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The Chief Executive Officer or nominated senior manager investigated, responded to complaints and identified themes. The complaints policy which was last reviewed in February 2019 with the next review date February 2022 set out processes to ensure there was a clear system in place for identifying, receiving, handling and responding appropriately to complaints and comments made by service users, their families and carers.

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from complaints was shared in staff meetings as relevant, and with other agencies if appropriate.

Are Community end of life care well-led?

Good

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

Leadership

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

The hospice's senior management team (SMT) reported directly to the hospice's trustees. The SMT team consisted of a chief executive officer (CEO), human resources manager, clinical services manager, business development manager and a community volunteer programme manager. The CEO had been with the hospice for a significant number of years.

Volunteers and all staff we spoke with felt supported in their role and spoke very positive about the SMT.

The service had recently merged with Helen's Trust. This partnership meant more patients had the opportunity to receive good end of life care in their own homes supported by Blythe House Hospice team.

Staff we spoke with during our inspection and focus groups following our inspection confirmed the SMT and senior managers were visible, approachable and had an 'open door' policy. One of the staff who had recently joined the hospice said; "the senior management have been welcoming and reassuring and I feel I could go to them with any concerns I had".

The SMT, and the trustees, understood the quality and sustainability challenges facing the hospice including, although not limited to, sustainability of financial streams.

Vision and Strategy

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

Blythe House Hospice's mission was to provide a high level of care and support to people affected by life-limiting illness and bereavement. The service's values were for staff to be caring, aspiring and professional.

Good

Community end of life care

Staff understood the service's vision and values, and how to apply them in their work.

The strategic goals guiding work provided by this service included; services, environment and finances.

Culture

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

Feedback received from all four focus groups held with Blythe House Hospice staff was overwhelmingly positive. Health care assistants told us they were proud to wear the hospice uniform and felt valued both within the organisation and in the community as a whole.

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 which included the remodelling of the Living Well Service.

A member of staff who attended one of our focus groups said "I am very contented here, and the wider staff team are really pleasant and easy to get along with, and the service Blythe offers is of top quality. I am very proud to work here and for the patients who use this service".

Staff and volunteers at all levels in the hospice, were committed and focussed on improving the experiences and care for all patients who used the service.

Staff said senior staff actively encouraged staff to raise concerns or issues. Staff told us a reasonable adjustment had been made to accommodate their individual need.

Staff told us their line managers had an 'open door' policy. We found there was an emphasis on support, fairness, transparency and an open culture.

Staff were able to report concerns without fear. Where staff raised concerns, they were fully investigated.

Governance

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

Governance within the hospice was overseen by the board of trustees and senior management team (SMT) through the quality and integrated governance framework. The framework, and supporting policy, provided the structure for managing and reporting on a range of auditable metrics to the SMT and to the clinical commissioning groups.

The hospice had a system for ensuring their wide range of policies and procedures were reviewed and updated regularly. The system ensured that staff had access to the most up to date policies available.

A quality framework was in place which set out how Blythe House Hospice ensured safe, effective, caring, responsive and well led services were provided.

The service received 21% of their income through the NHS clinical commissioning group and the rest of the funding was raised through events, voluntary donations and the hospice charity shops. There was a system in place to ensure people who had made donations were contacted and informed on how donated funds had been used. This showed funds raised had been put into service provision and provided reassurance to members of the public.

Blythe House Hospice had monthly governance meetings. Minutes of governance meetings from February to May 2021 showed staff held discussions around incidents, complaints, the risk register, patient safety alerts and infection control.

We saw minutes of the senior management team meetings from January to June 2021 which covered a multitude of areas including complementary therapies, hospice COVID-19 testing and vaccination, staff induction, manual handling training, equality and diversity and policies. The minutes were comprehensive and had recorded the key points with action points and completion dates.

The service had a strategic plan which detailed strategic goals from 2019-2022. It detailed the hospice care priorities which included;

- Deliver services which support all life limiting illnesses
- Maintain high professional standards and organisational cohesiveness.
- Support people and their families to die at home, if that is their wish.
- Increase community resilience and connectivity by developing volunteer workforce and clinical partnerships.
- Further develop a range of income streams.
- Build community relationships to increase financial and clinical efficiency.

Staff who attended one of our focus groups said they had been actively involved in the remodelling of the service. They felt included in the organisational changes. Although the Living Well Service (LWS) had been discontinued, patients who used to attend the LWS continued to receive support and had been fitted into the education programme, with some attending peer support groups.

The Community Hub which replaced the LWS underwent a service revamp to provide more accessible services and reach more local patients and their families. A multi-disciplinary team which included nurses, counsellors, a physiotherapist and occupational therapist provided programmes of care, education and support during the day, in the evenings and during weekends.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The executive management team were able to describe the service's main risks, and these matched the risks identified on the hospice's risk register. The senior management team regularly reviewed the risk register.

The provider's annual report 2020/2021 revealed the community hub (formerly known as the Living Well Service) had provided over 2,550 support sessions to both patients and their relatives since March 2020. Staff offered support with managing symptoms including pain, breathlessness and fatigue, provided advice around isolation, confusion, anxiety and mental well-being.

Good

Community end of life care

The 24 hours, seven days a week hospice at home service worked in partnership with Helen's Trust following the charity's successful merger in September 2020 as part of their strategy. This service was open to patients across the High Peak, Hope Valley, Derbyshire Dales and North East Derbyshire who were within the last 12 months of their life, and who wished to be cared for in their own homes. Referrals came from district nurses, community matrons, GPs, hospitals, continuing healthcare and from patients' families.

In May 2021, the hospice had 35 open risks on the corporate risk register, two risks related to reputation and an increase in staff stress levels due to campaigning of staff who had left the organisation, three related to the impact of COVID-19, one related to governance and the remainder related to staffing, premises, finance, legal and delivery. The service had mitigating actions to manage stress levels in place.

The provider notified the clinical commissioning group (CCG) of any business continuity issues that had impacted or was likely to impact on the delivery of services. We reviewed the CCG quality assurance dashboard for Blythe House Hospice and found the new hub started to be used for clinical activity from November 2020, and this had been in the form of one-to-one clinics and small groups of six. All infection control measures (matching those used in GP practices) and risk assessments were in place.

We reviewed the hospice governance meeting minutes of April 2021 and found clear instructions around weekly testing and recording process for COVID-19 testing had been circulated to staff.

The provider suspended plans to open more services within their building but maintained existing provision of activity throughout the national lockdown. Services within the building were consolidated into two days a week including managing the number of staff in the building each day. The building was not routinely opened on a Friday as all of the staff activity could be completed from home. The phones were diverted to the appropriate people so anyone contacting the provider would still receive a response on the same day.

The provider had fire alarms in place, and we saw these had been serviced annually. The fire alarm servicing worksheet showed the last routine maintenance occurred in November 2020.

The service had Fire Marshalls and during our inspection, the named Fire Marshall for both upstairs and downstairs had been written on a board in the reception area.

All members of staff had a risk assessment completed to identify staff who were at higher risk of complications if they caught COVID-19. Clinically vulnerable staff worked in a secure way to reduce their risk of getting COVID-19.

There was a strong emphasis on the safety and well-being of staff. Senior staff had circulated relevant contact numbers to all hospice at home carers. They rang coordinators when they arrived at the patient's home, when they left their home and were required to send a text message or ring when they arrived home.

During poor weather conditions, hospice at home staff travelled to very remote areas to provide care to patients in their own homes. Two out of 12 hospice at home staff told us they received minimal support in relation to their own safety. We raised this with senior staff who said due to the rurality of their location, they were aware of potential issues relating to staff access to and from properties during poor weather conditions. In mitigation, they liaised with a local four-by-four service who offered standby support to staff members carrying out home visits during poor weather conditions. The service had a system in place to ensure staff checked in when they arrived the patient's home and when they arrived their own homes safely.

Good

Community end of life care

Information Management

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

Information governance was included as part of mandatory training for staff. Staff understood the need to maintain patient confidentiality and understood their responsibilities under the General Data Protection Regulations (GDPR). Staff we spoke with had attended a training day for GDPR.

Everyday DOs and DON'Ts for the GDPR flyer was displayed in one of the offices. It included information such as not to leave personal information lying around.

Engagement

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

Senior staff met with the chief nurse and chief operations officer at a neighbouring hospital with a view to working more closely with them, particularly around patient discharge.

The community engagement team engaged with other services and groups and had a successful meeting with the cancer specialist nurses at a neighbouring NHS hospital. The aim was to re-establish relationships, describe new services and start to encourage referrals.

The service had all staff meetings virtually. We saw COVID-19 updates including testing procedures were discussed during the March and June 2021 meetings.

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 (CCG).

The CCG held a short form standard NHS contract with Blythe House Hospice for the delivery of services in end of life care. The CCG paid a contribution towards the end of life services delivered by Blythe House Hospice across the High Peak and North Derbyshire localities.

The service held contract and quality meetings with the local CCG on a quarterly basis. Contract activity across the services were reviewed during the meeting.

We made contact with the local CCG who said services provided by the hospice were always well evaluated and patient and carer feedback was always positive.

Learning, continuous improvement and innovation

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

Good

Community end of life care

Volunteers received regional recognition for their unwavering support during the pandemic.

The service had began a programme of change management which included a full-scale operational review of the hospice services. The benefits included maximising efficiency and focused redeployment of resources into areas most of most need.

The hospice played an important role in the wider strategic work of the CCG and were a member of the end of life board contributing to the shaping and delivery of end of life services in line with the Derbyshire End of Life Strategy.