

EACH The Nook

Quality Report

Pigot Lane
Framingham Earl
Norwich
NR14 7PX
Tel: 01223800800
Website: www.each.org.uk

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

Ratings

Overall rating for this location

Outstanding 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive?

Good 

Are services well-led?

Outstanding 

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

EACH The Nook is operated by East Anglia's Children's Hospices (EACH). The service has seven inpatient beds.

The service provides a range of physical, emotional, social and spiritual support services including end of life care, symptom management, short breaks, psychological and family therapy interventions. It also provides children, young people and their families with support for emotional, physical health and wellbeing through counselling, music therapy, art therapy, specialist play, hydrotherapy, physiotherapy, occupational therapy, practical help in the family home through the 'Help at Home service', spiritual care and family information.

The Nook provides hospice care for children and young people. We inspected all services provided by the hospice.

We inspected this service using our comprehensive inspection methodology. We carried out a short-notice announced inspection on 8 January 2020.

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

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

The main service provided by this hospital was hospice care for children and young people.

Services we rate

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

We found outstanding practice in relation to hospice care for children and young people:

- Staff consistently treated patients and their families with compassion and kindness, respected their dignity and privacy, and went above and beyond expectations to meet their individual needs and

wishes. Staff were devoted to doing all they could to support the emotional needs of patients, families and carers to minimise their distress. Staff helped patients live every day to the fullest.

- Services were delivered in a way to ensure flexibility, choice and continuity of care and were tailored to meet patients' individual needs and wishes. The service planned and provided care in a way that fully met the needs of local people and the communities served. It also worked proactively with others in the wider system and local organisations to plan care and improve services.
- It was easy for people to give feedback. Concerns and complaints were taken seriously and investigated, and improvements were made in response to feedback where possible. Patients could access services when they needed them.
- Leaders ran services well using best practice information systems and supported staff to develop their skills. Staff understood the vision and values, and how to apply them in their work. Staff were motivated to provide the best care they could for their patients. There was a common focus on improving the quality and sustainability of care and people's experiences. Staff were proud to work at the service and felt respected, supported and valued.
- Leaders operated effective governance processes and staff at all levels were clear about their roles and accountabilities. The service engaged well with patients, staff and the local community.

We found areas of good practice in relation to hospice care for children and young people:

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. Staff had access to a robust training and competency programme to ensure they had the skills required to provide good quality care.

Summary of findings

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff of different kinds worked together as a team to benefit patients. Nurses and other healthcare professionals supported each other to provide good care.
- The service planned and provided services in a way that met the needs of local people. The services provided reflected the needs of the population served and they ensured flexibility, choice and continuity of care. The facilities and premises were appropriate for the services that were delivered.
- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care

Heidi Smoult

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Hospice services for children

Rating

Outstanding



Summary of each main service

Hospice services for children was the main service offered at The Nook.
We rated the service as outstanding overall, because the service was outstanding in caring and well-led, and good in safe, effective and responsive.

Summary of findings

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Outstanding



EACH The Nook

Services we looked at

Hospice services for children

Summary of this inspection

Background to EACH The Nook

EACH The Nook is operated by East Anglia's Children's Hospices (EACH). It is one of three hospices operated by EACH, along with; The Treehouse hospice in Ipswich and the Milton hospice in Cambridgeshire. EACH provides support for children and young people with life-limiting or life-threatening conditions, and their families and carers, across the counties of Norfolk, Suffolk, Cambridgeshire and Essex.

The service moved from the Quidenham hospice to a purpose-built hospice building, The Nook, in August 2019. Families started accessing the new facilities from October 2019. It has seven bedrooms for children and young people, and accommodation for their families. In addition to the bedrooms, the location includes an

outdoor play area, a music room, dedicated space for teenagers, a hydrotherapy pool, a sensory room, a faith and reflection room, a refreshment and kitchen area, dedicated indoor play areas, art and crafts room.

The service provides a range of physical, emotional, social and spiritual support services including end of life care, symptom management, short breaks, psychological and family therapy interventions. It also provides children, young people and their families with support for emotional, physical health and wellbeing through counselling, music therapy, art therapy, specialist play, hydrotherapy, physiotherapy, occupational therapy, practical help in the family home through the 'Help at Home service', spiritual care and family information.

The location has had a registered manager in post since October 2013.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, two other CQC inspectors, and a specialist advisor with expertise in children and young people's hospice care. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

Why we carried out this inspection

We carried out this inspection as part of our routine inspection programme.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out a short-notice announced inspection on 8 January 2020.

Information about EACH The Nook

The service is registered to provide the following regulated activities:

- Treatment of disease, disorder and injury.

Summary of this inspection

During the inspection, we visited the hospice and its facilities, including the care floor, bedrooms, clinic and therapy rooms, and outdoor facilities. We spoke with 14 staff, including registered nurses, healthcare assistants, therapists, support staff, and senior managers. We spoke with four trustees of the organisation and three volunteers. We spoke with four patients and relatives. During our inspection, we reviewed three sets of patient records and medication administration records.

There were no special reviews or investigations of the hospice ongoing by the CQC at any time during the 12 months before this inspection. The hospice has been inspected four times, and the most recent inspection took place in March 2016, which found that the hospice was meeting all standards of quality and safety it was inspected against.

Activity

In the reporting period from October 2018 to September 2019, the hospice provided care to 126 patients. This included:

- 31 children aged 0 to 3 years.
- 62 children aged 4 to 12 years.
- 28 young people aged 13 to 17 years.
- Five young people and adults aged 18 to 65 years.

Track record on safety

In the reporting period from October 2018 to September 2019:

- The service reported zero never events.
- The service reported zero serious incidents.
- The service reported zero incidences of healthcare associated MRSA
- The service reported zero incidences of healthcare associated Clostridium difficile (C. diff)

Track record on complaints

In the reporting period from October 2018 to September 2019:

- The service reported 30 compliments.
- The service reported five complaints.

Services provided at the hospice under service level agreement:

- Maintenance of medical equipment
- Safeguarding professional advice
- Infection prevention and control specialist advice

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.
- Staff completed and updated risk assessments for each patient and removed or minimised risks.
- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank staff a full induction.
- 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.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

However,

- Not all staff had completed the training for safeguarding vulnerable adults.

Good



Are services effective?

- The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.

Good



Summary of this inspection

- Staff gave patients enough food and drink to meet their needs. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- 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.
- Nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions.

Are services caring?

- Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and went above and beyond expectations to meet their individual needs and wishes. Children, young people and their families were truly respected and valued as individuals.
- Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs. People's emotional and social needs were seen as being as important as their physical needs.
- Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Outstanding



Are services responsive?

- The service planned and provided care in a way that met the needs of local children, young people and their families. It also worked with others in the wider system and local organisations to plan care.

Good



Summary of this inspection

- The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly.
- 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 children, young people and their families in the investigation of their complaint.

However:

- The service had a number of cancellations for planned short breaks. Between October and December 2019, there were eight instances of short break cancellations by the service. The service were in the process of a service redesign to reduce short break cancellations.

Are services well-led?

- Leaders at all levels had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were highly visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a clear vision for what it wanted to achieve and a detailed 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 and national plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of children, young people and their families receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where children, young people and their families and staff could raise concerns without fear.
- 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.

Outstanding



Summary of this inspection

- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- The service collected reliable, detailed data and analysed it to drive forward improvements. 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.
- Leaders and staff actively and openly engaged with children, young people, families, staff, equality groups, the public and local organisations to plan and manage services. They proactively collaborated with partner organisations to help improve services for children and young people.
- All staff were committed to continually learning and improving services. Staff actively shared learning throughout teams. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Detailed findings from this inspection






Overview of ratings

Our ratings for this location are:

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

Notes

Hospice services for children

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

Information about the service

EACH The Nook is operated by East Anglia’s Children’s Hospices (EACH). The service has seven inpatient beds.

The service provides a range of physical, emotional, social and spiritual support services including end of life care, symptom management, short breaks, psychological and family therapy interventions. It also provides children, young people and their families with support for emotional, physical health and wellbeing through counselling, music therapy, art therapy, specialist play, hydrotherapy, physiotherapy, occupational therapy, practical help in the family home through the ‘Help at Home service’, spiritual care and family information.

The Nook provides hospice care for children and young people. We inspected all services provided by the hospice.

We inspected this service using our comprehensive inspection methodology. We carried out a short-notice announced inspection on 8 January 2020.

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

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

The main service provided by this hospital was hospice care for children and young people.

Summary of findings

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

We found outstanding practice in relation to hospice care for children and young people:

- Staff consistently treated patients and their families with compassion and kindness, respected their dignity and privacy, and went above and beyond expectations to meet their individual needs and wishes. Staff were devoted to doing all they could to support the emotional needs of patients, families and carers to minimise their distress. Staff helped patients live every day to the fullest.
- Services were delivered in a way to ensure flexibility, choice and continuity of care and were tailored to meet patients’ individual needs and wishes. The service planned and provided care in a way that fully met the needs of local people and the communities served. It also worked proactively with others in the wider system and local organisations to plan care and improve services.
- It was easy for people to give feedback. Concerns and complaints were taken seriously and investigated, and improvements were made in response to feedback where possible. Patients could access services when they needed them.
- Leaders ran services well using best practice information systems and supported staff to develop their skills. Staff understood the vision and values, and how to apply them in their work. Staff were



Hospice services for children

motivated to provide the best care they could for their patients. There was a common focus on improving the quality and sustainability of care and people's experiences. Staff were proud to work at the service and felt respected, supported and valued.

- Leaders operated effective governance processes and staff at all levels were clear about their roles and accountabilities. The service engaged well with patients, staff and the local community.

We found areas of good practice in relation to hospice care for children and young people:

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. Staff had access to a robust training and competency programme to ensure they had the skills required to provide good quality care.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff of different kinds worked together as a team to benefit patients. Nurses and other healthcare professionals supported each other to provide good care.
- The service planned and provided services in a way that met the needs of local people. The services provided reflected the needs of the population served and they ensured flexibility, choice and continuity of care. The facilities and premises were appropriate for the services that were delivered.
- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care

Are hospice services for children 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.

The mandatory training was comprehensive and met the needs of patients and staff. Training was delivered both electronically and face to face.

The mandatory training included infection prevention and control, data security and protection, fire safety, moving and handling, oxygen management, safeguarding vulnerable adults level 1 and 2, safeguarding children level 1, 2 and 3, resuscitation and anaphylaxis, and food hygiene.

The service set a target of 90% for the completion of all mandatory training modules. Data from December 2019 showed that the targets were met for three out of the eight mandatory training modules. These were moving and handling (90%), data security and protection (100%) and food hygiene (100%). Compliance rates for all the other modules was between 50% and 72%. Senior managers told us that the non-compliance figures were due to a delay in commencing the training programme for 2019/20 to allow time for the move to the new building in September 2019. In addition, there were a number of staff who were on maternity leave, sickness and annual leave.

Managers monitored mandatory training and alerted staff when they needed to update their training. In addition, all staff received e-mail reminders from the education department and were given time by their managers to complete training.

Senior managers we spoke with were aware of individual staff members who were required to complete mandatory training and told us time would be allocated for completion on return from sick or leave. They told us that staff were on target to meet the 90% compliance rate by March 2020 and this was being achieved by providing more training sessions.



Hospice services for children

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.

There were clear safeguarding processes and procedures in place for safeguarding vulnerable adults and children. The policy set out responsibilities of staff and contact details of local authority referral. The policy also covered child sexual exploitation (CSE) and female genital mutilation (FGM).

Staff received safeguarding training specific for their role on how to recognise and report abuse. As part of the induction programme, all new staff and volunteers are made aware of the adult and children safeguarding policy and were told who to contact and how to contact them if they have a safeguarding concern.

Following induction staff received safeguarding training appropriate to their role as set out in the intercollegiate document for children and young people (2019) and adult Safeguarding (2018): Roles and Competencies for Health Care Staff.

The service set a target of 90% for completion of safeguarding training. At the time of our inspection the data submitted showed the compliance across each role was as follows

Nursing staff:

- Safeguarding children level 3: 67% (12 out of 18 staff)
- Preventing radicalisation level 3: 56% (10 out of 18 staff)
- Adult safeguarding level 2: 50% (9 out of 18 staff)

Care assistant staff:

- Safeguarding children level 3: 88% (7 out of 9 staff)
- Preventing radicalisation level 3: 38% (3 out of 8 staff)
- Adult safeguarding level 2: 0% (0 out of 8 staff)

Other staff (which includes well-being staff, occupational therapists and physiotherapists)

- Safeguarding children level 3: 62% (8 out of 13 staff)
- Preventing radicalisation level 3: 69% (9 out of 13 staff)

- Adult safeguarding level 2: 31% (4 out of 13 staff)

Volunteers:

- Safeguarding children level 2: 92% (10 out of 11 volunteers)

Managers told us that the low compliance rate for safeguarding training was due to a delay in commencing the training programme for 2019/20 to allow time for the move to the new building in September. However, managers provided evidence that all members of staff have been booked to complete their safeguarding training by March 2020.

The service reviewed and approved their safeguarding adults policy in August 2019 in response to the Intercollegiate Document: Adult Safeguarding: Roles and Competencies for Health Care Staff August 2018. At the time of our inspection all staff we spoke with were aware of the new policy however they had not received their role specific adult safeguarding training. The senior leadership team told us that there was training programme in place to ensure all care staff will have completed their safeguarding adults Level 2 training by end of March 2020.

The service had a service level agreement (SLA) with a local community NHS trust to provide professional safeguarding advice and training.

Staff we spoke with knew how to make a safeguarding referral and who to inform if they had concerns. The names and contact details of the safeguarding team were displayed on the notice boards and staff confirmed that the safeguarding team were responsive and provided support when needed.

Staff we spoke with knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. A staff member described a particular safeguarding incident to us and how it had been managed. Information was shared amongst the wider team through staff briefing, email and newsletter.

Staff followed safe procedures for children visiting the hospice or who were in patients. All members of care staff had level 3 children safeguarding training. In addition, the service provided level 1 and level 2 children's safeguarding training to all non-clinical staff and volunteers.



Hospice services for children

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The care area environment, including the bedrooms, treatment room and all the facilities in the hospice that we visited were visibly clean and had suitable furnishings which were clean and well-maintained.

Each area had a daily, weekly and monthly cleaning schedule. The schedules had signatures against the cleaning performed.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff used 'I am clean' stickers to indicate that equipment and rooms had been cleaned.

We saw staff clean all toys immediately after use to minimise any risk of infection. If they could not do this immediately, staff placed all used toys in a dedicated box for cleaning.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff were bare below the elbows and used gloves and aprons where indicated and washed their hands between patient contacts. The treatment rooms and the inpatient bedrooms had disposable aprons, gloves in various sizes, hand washing facilities including filled soap dispensers and paper towels.

Infection prevention and control was monitored by senior staff and the audit results reported quarterly. We viewed the hand hygiene audit reports from November to December 2019 and saw that the staff were mostly compliant with the audit. For example, all staff demonstrated correct procedure for hand washing, and were seen to wash their hands when necessary in accordance with the World Health Organisation (WHO) Five Moments for Hand Hygiene guidance. However, the audit also picked up noncompliance where one member staff was wearing nail varnish, this was escalated immediately, and action taken to ensure compliance. As a result of the audit, two recommendations were

implemented, which included an order of additional hand washing posters and actions for local infection control leads to observe and comment on good and bad practices.

An infection prevention and control audit was completed prior to moving to the new location to ensure that the building, facilities and equipment were compliant with current infection prevention and control regulation. An action plan was developed following the audit and we saw that any infection risk and/or noncompliance to the regulation that was identified by the audit was rectified or a mitigation put in place to reduce the risk.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

The service had suitable facilities to meet the needs of patient's and their families. The Nook moved to their new purpose-built two storey building located near Norwich in September 2019. The service is accessed by a single front entrance which leads to a reception and waiting area. There were toilets and access to the rest of the building from the reception area.

The care area and the inpatient unit was through double doors, with restricted access. Each inpatient bed was equipped with suitable equipment and had access to an ensuite bathroom.

Children and young people were supported in the safest way possible, for example 'safe-space' cots and beds had been provided so that children who were at risk of harm during the night if they slept in a regular bed or cot were protected. The service also provided beds that could be brought right down to the floor level or mattresses could be placed at floor level if that was safer for a particular child. There was suitable hoisting equipment available for children and young people who required assistance to transfer, for example from their chair to their bed or bathroom.

The service had enough suitable equipment to help them to safely care for patients. We saw that equipment was stored appropriately and neatly. Consumable items, for example, dressings were stored in cupboards and



Hospice services for children

drawers. We randomly checked several consumable items which were within date. We checked a number of electrical equipment and all had evidence of electrical safety testing and maintenance testing.

There were processes in place to ensure that equipment was maintained and serviced. Equipment servicing, and repairs were undertaken by an NHS trust's clinical engineering department through a service level agreement (SLA). Staff could contact the department to highlight concerns about any items of equipment and told us that they were responsive. We saw that equipment was checked regularly and maintained to ensure it was in a safe condition.

During our inspection we checked resuscitation equipment. Emergency grab bags were easily accessible and locked with anti-tamper tags. We checked three grab bags and during our check one grab bag contained single use masks that were opened for training and were not replaced. We highlighted this to a team leader and the items were replaced.

We reviewed resuscitation trolley records and saw that weekly and monthly checks were completed from November 2019 to January 2020. This showed a consistent and regular approach to safety checks.

Staff disposed of clinical waste safely. The service had a waste segregation system in place and we found separate bins and bags in place throughout the hospice. Staff disposed waste correctly and followed the policy that was in place. Sharps bins were correctly assembled, dated and labelled and not overfilled.

Staff stored control of substances hazardous to health (COSHH) materials correctly in locked cupboards which ensured patients and the public could not access substance.

Fire extinguishers were accessible, stored appropriately, and were all up to date with servicing. There were suitable arrangements in place for fire safety, including a fire risk assessment and clear instructions for staff to follow in the event of a fire.

The service completed formal environmental risk assessments audits in areas such as, the use of the hydrotherapy pool, water quality (Legionnaire's disease) and the service performed weekly fire alarm checks.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff completed risk assessments for each patient on admission / arrival and updated them when necessary. Comprehensive risk assessments were carried out for all patients and risk management plans were developed. All patients were risk assessed for skin integrity, pressure ulcers, falls using evidence-based tools. The information was used to form management plans which were stored in patient records.

A holistic need assessment (HNA) was completed for each individual patient, and this was reviewed regularly. All patients were reviewed by a multi-disciplinary team (MDT). Staff could access patient electronic record which were completed contemporaneously and allowed for alerts to be put in place for key safety issues, for example, if a patient had any allergies.

During the inspection we reviewed three patient care records which demonstrated that all potential risks to their safety had been identified and managed appropriately. Risk assessments were completed with the aim of keeping people safe while supporting them to be as independent as possible.

The service completed a daily care planning meeting where patient safety risks were discussed in addition to bed management, referral and admissions. A weekly Multi-disciplinary team (MDT) meeting was also held to discuss risks to children and young people receiving care at home, including strategies for supporting patients with increased symptoms and their families.

Staff were trained to provide life support to patients. Paediatric resuscitation training including dealing with anaphylaxis reaction was provided as part of the mandatory training. At the time of our inspection out of the 32 staff, 23 (72%) had an up to date training. Managers told us that staff were on target to meet the 90% compliance rate by March 2020 and this was being achieved by providing more training sessions.

Staff managed emergency or unplanned transfer of patients to the hospital in line with policy and procedure by calling 999 for an emergency transfer. Most of the patients that used the service had open access



Hospice services for children

arrangements in place with the local hospital. Therefore any planned transfer would be done in consultation with the patient's consultant, the matron or clinical nurse specialist and the family.

Nurse staffing

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

The service had enough nursing staff and support staff to keep patients safe. Staffing establishments were planned based on skill mix and capacity. Managers organised staffing to ensure that end of life care was delivered as a priority. The staffing establishment was calculated to ensure there was a minimum of two nursing care staff per shift in the hospice building including a minimum of one registered nurse. There was normally one member of staff allocated per child, although more or less staff may be allocated based on assessment of the complexity of the child's care needs. The service had a minimum of one nurse and one healthcare assistant, who had enhanced competencies that included controlled drugs checking, for every shift whereby a patient was resident.

Managers could adjust staffing levels according to the needs of patients. Short term breaks were planned, staffing levels therefore were coordinated to meet the needs. Managers told us that the amount of short break care available was calculated on current staffing establishment and sometimes had to cancel short break care if the staffing levels were below the required standard. This mainly happened if there was an end of life care patient being cared for, this patient would be prioritised over providing planned short break care.

The number of nurses and healthcare assistants matched the planned numbers. We saw that the duty rota and bookings for short breaks was planned approximately four weeks in advance. The duty rota, bookings and required staffing levels were reviewed daily. Bank staff were used whenever needed for example to cover sickness absence. We also saw that staff from the other EACH hospices covered shifts when required. Support also came from the matron and clinical nurse specialist.

Staff resource issues across the three hospice localities were considered weekly at the central panel meeting and tri-site meetings were arranged to organise cover for staffing across the localities when needed.

Staffing figures from October 2018 to September 2019 showed that there were no agency staff, there were 22 whole time equivalent (WTE) nursing and allied health professionals, eight WTE health care assistants and four WTE other non-qualified.

A total of 14 members of staff had left the service during this period. This included eight nursing and allied health professional, four health care assistants and two other non-qualified. However, for the same period 22 new members staff had taken up post, including 13 nursing and allied health professional and eight health care assistants.

Sickness rates for the period July 2019 to September 2019 was 3.3% across all disciplines.

Managers made sure all bank staff had a full induction and understood the service. There was an induction programme in place for all new bank staff. Managers told us bank staff that worked in the hospice worked regular shifts and were familiar with the processes and procedures. The service did not use agency staff.

Medical staffing

There were no medical staff employed by the service.

General medical advice during office hours was provided through a service level agreement (SLA) with a local GP surgery. Out of hours this was by the 111 service.

The Nook symptom management nursing service worked closely with the child or young person's lead consultant. Therefore, expert advice during office hours was provided by the child's consultant and paediatric team, and where appropriate by a palliative care consultant within the managed clinical network.

The managed clinical network was hosted by EACH and provided access to specialist palliative care advice. The team consisted of children's palliative care trained consultant paediatricians and nurse consultants.

Records



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

Patient notes were comprehensive, and all staff could access them easily. The service used a combination of electronic and paper patient records. In the main the service used an electronic care records system and had a paper record which the service called the 'skinny files' which contained the prescription and medication administration record (MAR) charts.

Records were stored securely. Access to the electronic records system was password protected. Patient information was kept confidential and their privacy protected. Paper patient records and MAR charts were kept locked in a filing cabinet when not in use.

Care records included as much detail as possible about the young person and their family including their life histories, preferences, likes and dislikes and their hopes and goals for the future. This information was captured using the holistic needs assessment (HNA) form.

We reviewed three sets of patient records including electronic records and found that the records were legible, signed and dated.

When patients transferred to a new team, there were no delays in staff accessing their records. The electronic system the hospice used was one that was widely used across the local healthcare economy. This meant it was quick and easy to integrate and share information with other providers that were using the same system. Staff told us, if the patient's GP, the referrer or the child's lead practitioner was not using the same electronic patient record system, then the information would be sent electronically via a secure email network. Information shared included clinical updates, symptom management and advance care plans

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff in the service stored medicines securely in locked cupboards in key coded locked clinical room.

We reviewed medicines cupboards and had no concerns regarding medicines storage. We looked at 15 medicines and saw that they were within their use by date. Staff consistently recorded maximum and minimum medicines fridges temperatures and ambient room temperatures of clinical rooms where medication was stored.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. They were ordered, transported, stored, and disposed of safely and securely (including medical gases and emergency medicines and equipment). Comprehensive medicines policies and procedures were in place. There was a system in place to ensure that medicines alert or recalls were actioned appropriately.

The service did not regularly use FP10 prescriptions. In exceptional circumstances when FP10 prescriptions had to be used, the service had clear processes and procedures in place. When an FP10 was used the prescription number was recorded and reconciled appropriately. An FP10 is the green prescription that can be dispensed by a high street pharmacy.

The service did not keep a stock of prescription-only medicine. All patients would come with a supply of all their prescribed medication. The service had a system and process in place to check in and check out all the medication patients came in with. On admission staff completed a medicines reconciliation form for patients which was then checked by a second member of staff for accuracy and signed. We saw that as part of the checking process, families were asked to confirm which medicines had already been given on the day to avoid duplication. We also saw that where it was unclear how a medicine should be given, there was a process for resolving the discrepancy. Medicines, including those which need to be stored in refrigerator, were stored safely.

The service had a range of over-the-counter (homely remedies non-prescription medication available over the counter in pharmacies). An up to date homely remedy policy was in place for the administration and recording of these medicines. There was a nurse prescriber who could issue a prescription if needed. This meant that patients received the appropriate prescription without any delay.



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There were no controlled drugs (CDs) on the premises at the time of our visit, but we saw that facilities were available for secure storage and record keeping. Controlled drugs are prescription medicines that are controlled under the Misuse of Drugs legislation (and subsequent amendments). The service had a controlled drugs accountable officer and a service lead for the safe and secure handling of medicines.

Systems were in place for obtaining medicines including those required in an emergency. Appropriate processes were in place for the disposal of medicines. Staff involved in medicines administration had regular training and had undergone competency checks to ensure their knowledge and practice remained up to date.

The service stored medical gases in line with manufacturers best practice guidelines. Cylinders that were in use were stored in a ventilated room that had signage stating that the room contained oxygen. The service had piped oxygen in all the rooms, which was maintained by an external company. However, a weekly check was also completed by the service's maintenance team.

The service had an arrangement with a local pharmacy to procure prescription medicines. Specialist pharmacist advice was sought from the local community NHS trust through a service level agreement (SLA), and were available for support as part of the medicine's management group.

Medicine related incidents were recorded and monitored, lessons were learnt, and action plans were in place to ensure recurrence of errors was minimised.

A medicines management group made up of staff from all three EACH locations, met regularly. Any medicines incidents which had been reported were reviewed and monitored, so that lessons could be learnt, and improvements made if necessary. This group identified work plan activity for each year and monitored progress against the plan. All medicines information was circulated to staff via a newsletter 'Medicine Matters'.

The service had a 'controlled drug accountable officer' who was part of and reported to the local intelligence network.

Incidents

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

Staff knew what incidents to report and how to report them. Staff reported all incidents that they should report. Staff we spoke with knew what incidents to report and how to report them on the trust's electronic reporting system. They gave us examples of when they had reported incidents and were satisfied that they had a good understanding of what incidents should be reported and how to report.

Staff raised concerns and reported incidents and near misses in line with policy. Staff we spoke with understood their responsibility to raise concerns, to record safety incidents, concerns and near misses.

The service reported no never events from October 2018 to September 2019. A 'never event' is a serious patient safety incident that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event reported type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We reviewed three recently reported and investigated incidents which showed detailed description of incident, actions taken and recommendation for lessons learnt.

Outcomes from incidents and associated trends and themes were communicated to staff face to face by the senior leaders. The care team held daily planning meetings, where any learning from incidents was shared.

All action plans from incidents were monitored through the relevant business unit meetings and reported to the quality and risk management group.

Staff received feedback from investigation of incidents, both local and other EACH locations. Staff told us that they received feedback after reporting an incident. There were processes to share learning from incidents which



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included; staff meetings, emails and notices to ensure that action was taken to improve safety. There were also newsletters for specific types of incidents for example incident related to medicines management would be put on the 'Medicines matter' newsletter.

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. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The service had a duty of candour policy dated August 2018 which detailed the requirements of staff under the duty of candour.

Are hospice services for children effective?

(for example, treatment is 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 best 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. Staff accessed a range of guidelines through the trust intranet. Staff we spoke with said that it was easy to access the information.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

There was a rolling programme of clinical audit and monitoring in place with action plans. Outcomes were

shared with staff through email, meetings and publications. We looked at audit documentation and related reports. For example, infection prevention and control, care records and controlled drugs procedure.

The service used the holistic needs assessment (HNA) form to identify the needs and goals of the patient and their family. This helps to identify the physical and emotional needs of both the patient and the family and how the Nook team would support them. Based on the HNA a comprehensive care plan is developed which is reviewed minimum annually or as and when there was a significant change with the patient and/or family circumstance.

The service followed the National Council for Palliative care guidance in supporting patients with advanced care plans and advanced directives, to ensure they received the right treatment and care as they entered their end of life phase. These were shared with the greater multi-disciplinary team including external providers of end of life care.

EACH staff take an active role in contributing to evidence based and best practice care for children in palliative care. The service was actively engaged in several research projects and had a comprehensive research program and plan. An example was a study on delivering long term ventilation (LTV) for children and young people in a hospice. The study was looking at the LTV practice standards and as a result developing and delivering a training model project.

Another example of supporting and contributing to an evidence based research was a study in buccal opioid use for pain and dyspnoea (difficult or laboured breathing) for children with palliative care needs during end of life care. The study was assessing the effectiveness, advantage and disadvantage of buccal opioid for breakthrough pain and dyspnoea in end of life care. Buccal administration involves placing a drug between the gums and cheek, where it dissolves and is absorbed into the blood stream.

EACH ran a library and an information service, which provided and monitored any changes in national guidelines, best practice and policy. The library service supported staff to access information and keep up to date with evidence based care.

Nutrition and hydration



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

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Each patient on admission had a nutrition assessment that considered physical, psychological, spiritual and social aspects to ensure nutritional wellbeing.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. A number of the children and young people that use the service are fed through feeding tubes operated through a pump to deliver nutrition at a set rate and volume. Occasionally nutrition is delivered via naso-gastric tube. All methods of device delivery are supported by standard operating procedures. A detailed nutritional supplement plans was used prescribed by the child's dietitian and individualised care for the particular device was outlined.

Each patient had a regularly reviewed and documented individualised plan. This was shared with the catering team to ensure the patients individual needs were met. Patients and carers could access a range of information leaflets to maximise their nutrition and hydration intake.

For those children that were orally fed, the catering department prepared freshly made meals on-site. Hot and cold food options were available for each meal and patients could specify meal size. The service catered for all types of needs including vegetarian, soft, dairy and gluten free and any religious or cultural requirements.

Meals could be fortified with full fat milk or cream if required. The chef spoke with each patient on a regular basis and provided individualised menus when needed.

Food and drinks were available outside of mealtimes. Families and carers could help themselves to hot and cold drinks, they could also bring in their own food or order takeaways to be delivered to the hospice, if they wished.

Pain relief

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

Staff assessed children and young people's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff discussed pain and pain relief with children, young people and their family. This was documented in the patient's care record. Patient pain levels were then regularly reviewed using recognised tools and staff gave pain relief in line with individual needs and best practice. Staff used recognised tools to identify pain and distress in patients who were limited or unable to communicate. Staff also regularly assessed patient's ability to tolerate oral medicines with alternative administration routes prescribed if necessary, such as intravenous infusion or pain relief patches.

Nursing staff were trained on the use of syringe drivers which were used to administer a continuous subcutaneous infusion of drugs which helped to control pain and/or other symptoms.

We saw that patient's pain and other symptoms were regularly reviewed and discussed at the daily care planning meetings, handovers and during drug rounds. In addition, pain and pain management would be discussed at the weekly multidisciplinary team meeting.

Staff prescribed, administered and recorded pain relief accurately. Patient records we reviewed showed care plans included a detailed pain assessment and management plan. Anticipatory medicines with individualised indications for use, dosage and route of administration were prescribed for patients identified as being in the last days of life. These included medicines for pain, agitation, respiratory tract secretions, nausea/vomiting and dyspnoea (difficult or laboured breathing). Prescribing of anticipatory medication prevented delays and lapse in symptom control, which could cause unnecessary distress to the patient and their loved ones.

Patients received pain relief soon after requesting it. The symptom management team were part of the multidisciplinary team in the service. If a patient's level of pain or symptoms changed, the clinicians in the team



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were able to assess and review their pain medication in discussion with the child's lead consultant. This meant there was little or no delay in managing the pain or symptom.

Children and young people attending the hospice were required to bring a supply of their medications, however, staff were also able to access common pain relief medications such as paracetamol to support children and young people manage their pain. If they required a medication review or another pain relief medication, the service had a service level agreement (SLA) with a local GP surgery and a local arrangement with a pharmacy to obtain medications. In addition, the service had a nurse prescriber that was able to prescribe medication when needed urgently.

Patient outcomes

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

Managers used information from the audits to improve care and treatment. The service had a rolling programme of audits and included audits of documentation, medication management and hand hygiene. Audit outcomes were collated and associated action plans monitored and discussed at the quality and safety group meetings.

Managers and staff used the results to improve patients' outcomes. Information about the outcomes of people's care and treatment (both physical and mental where appropriate) was routinely collected and monitored. Staff used patient and family reported outcome measures using questionnaires to assess experiences and what could be done differently. The service ensures that every episode of care or intervention delivered by any member of the multidisciplinary team was individually evaluated or reviewed with the child, young person or family member, this meant the care plan for the patient would always go through a cycle of assessment, planning, delivery and review to achieve the best possible outcome for the patient and their family.

Outcomes for patients were positive, consistent and met expectations. The service conducts a six-monthly family satisfaction and experience survey. The survey was designed to capture current views about the services provided and to evaluate any changes to the service

provided. We reviewed the most recent survey from December 2019, where 100% of families who used The Nook stated that the care and support received from over the last six months as excellent, very good or good.

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 children, young people and their families. All new staff received a full role specific induction. New nurses and care assistants worked in a supernumerary capacity alongside an experienced staff member until they were competent to work alone. Staff we spoke with spoke highly of the induction programme and said it was relevant, useful and met their needs in the new workplace.

Registered nurses when they newly join the service self-assess their competence against the EACH core clinical skills and knowledge framework. Care assistants complete a comprehensive training programmes and complete an assessment in practice with the clinical educator. All new nursing care staff work with the clinical educator to identify any gaps in their skills and if needed develop an individual learning plan, overseen by their manager.

Staff attend induction training, mandatory training, clinical training, team days, management, clinical and safeguarding supervision. They had an annual appraisal and regular management supervision. The counsellors and therapists' performance was monitored via regular case management and clinical supervision. They self-assessed their competence against their respective professional standards.

All new staff were subject to a six-month probationary period, during which time they were required to meet the organisation's performance standards.

Bank staff complete the same induction and mandatory training programmes, which also included a full induction and orientation to EACH policy and standard operating procedures, local fire and safety procedures. Bank staff were encouraged and paid to attend the mandatory



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training provided by EACH but could opt out if they worked in similar positions at another provider, in which case they are asked to provide evidence of training completion.

All bank staff were offered regular shifts, on average 7.5 hours a month. This ensured that they maintained their competence and also gave the bank staff the opportunity to get to know the patients and the care they required and also support the family and the loved ones as needed.

The clinical educator supported the learning and development needs of staff. The clinical educator played an active role by providing support, educational input, development activities and internal training days for staff working in the hospice. Staff we spoke with talked highly of the team and the educational support they provided to them. The clinical educator worked clinically in the hospice to provide supernumerary support to the team.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff could attend external training courses if they added value for the individual attending and benefited the hospice. Staff we spoke with said managers were supportive if they asked to go on training courses and could give us examples of courses they had been on. Staff also told us it was an expectation of them to disseminate their learning to their colleagues when they returned from training courses, which staff were happy to do so.

Managers supported staff to develop through regular, constructive clinical supervision of their work. This was provided on a one-to-one or group basis. Clinical supervision was a safe and confidential environment for staff to reflect on, discuss their work and their personal and professional responses to their work. The focus was on supporting staff in their personal and professional development and reflecting on their practice. Ad hoc supervision sessions were arranged to support staff following any significant events or incidents. Staff attended a minimum of two dedicated safeguarding supervision meetings per year, where they would discuss any safeguarding incidents they might have reported or any concerns or issues they had relating to safeguarding.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Weekly local multi-professionals meeting (LMPM) were held where the agenda items included safeguarding concerns, incidents, complaints or any other events affecting the service. The Nook had five care teams and one member from each of the five teams would attend to ensure all staff had an equal and regular opportunity to attend each team meeting. Meeting notes were emailed to all staff.

Managers recruited, trained and supported volunteers to support children, young people and their families in the service. Volunteers were used throughout the hospice and were trained and supported for the roles they undertook. There was a volunteer's coordinator who made sure volunteers had the required Disclosure and Barring Service (DBS) checks and mandatory training before they started volunteering at the hospice. Volunteers were also invited to attend training course offered to the permanent and bank staff. Volunteers we spoke with said if they were available and training was relevant they attended as it increased their knowledge. Volunteers who worked in more specialist areas, such as the sibling befriending service and the help at home service, had additional training to make sure they were competent for the roles they undertook. Volunteers were provided with a minimum of four supervision meetings a year.

Managers supported staff to develop through yearly, constructive appraisals of their work. As of December 2019, 100% of staff had completed an annual appraisal. At the beginning of each appraisal year, managers met with staff to agree their performance and development objectives for the coming year. These were linked to the service's strategic objectives and priorities and the standards. Staff had regular one-to-one meetings with their manager to monitor their performance. They had the opportunity to discuss training needs and were supported to develop their skills and knowledge. Staff told us they found the appraisal process useful and they were encouraged to identify any learning needs they had, and any training they wanted to undertake.

Multidisciplinary working

Nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.



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Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. Each morning the service held a daily planning meeting, where they discussed staff roles and care requirements of each child or young person in the hospice. They also discussed needs of children or family that would be attending the hospice for a day visit. During our inspection we observed a daily planning meeting, staff covered the holistic needs of the child or young person and those close to them. Clinical and non-clinical staff attended the daily planning meeting. For example, members of the maintenance team attended to ensure all necessary equipment and the facilities were working effectively and also to provide any updates on ongoing building or maintenance work.

We observed excellent multidisciplinary team (MDT) working throughout the hospice. MDT working was a fully embedded practice which helped delivered a joined-up approach to delivering care and treatment to all patients. This facilitated better communication between healthcare professionals, patients and relatives and positively impacted on the care and treatment patients received.

The hospice had good links with the local NHS trusts and local authorities, information and support was shared to offer joined up services, care and treatment for patients.

We observed positive interactions between staff and volunteers. Staff and volunteers we spoke with told us they worked together to provide the best care and support they could for patients and their families or carers. The volunteer coordinator had developed a role description, so staff and volunteers understood the role of the volunteer. This meant there were clear guidelines as to what a volunteer could and could not do. This safeguarded both the patients and volunteers.

Seven-day services

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

Staff were able to access general medical advice 24 hours a day, seven days a week. Monday to Friday during office hours this was through a service level agreement with a local GP surgery. Out of hours medical advice was accessed through the NHS 111 service.

The managed clinical network, hosted by EACH, provided access to specialist palliative care advice out of hours, during office hours this would be provided by the child or young person's lead consultant team.

The senior management team operated an on-call rota and were available seven days a week, 24 hours a day.

Health promotion

Staff gave children, young people and their families practical support to help them live well until they died.

Through the holistic needs assessment (HNA), staff assessed each child or young person and their families health and well-being. The team at the hospice worked together to give personal co-ordinated care to children, young people and their families. Services offered by the hospice supported the physical, psychological, spiritual and social needs of the patients and their family.

Staff told us that some of the needs that were identified from the NHA was family members wanting to stop smoking or developing a healthier lifestyle through exercise. Staff were able to agree and set goals with the individuals and either directed them or worked with other professionals or services.

The service offered a range of support to meet the wellbeing needs of individuals and families. Emotional and wellbeing support included social opportunities for families to come together and meet others, for example at sibling activity days, coffee mornings and male/female carers nights. The service also provided individuals and families more specific help through counsellors, music therapists, art therapists, play specialists and spiritual care advisors who provide additional support when needed.

There were health promotion materials displayed throughout the hospice; displayed on the walls, in the form of leaflets and helplines and organisations to support ongoing health promotion.

All the families we spoke with during the inspection, told us how attending the hospice had a positive impact on their health and well-being and had improved their quality of life.

Consent and Mental Capacity Act Deprivation of Liberty Safeguards



Hospice services for children

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions.

The service had up-to-date policies and procedures regarding consent and the Mental Capacity Act 2005. These included the Mental Capacity Act documentation, deprivation of liberty procedure, consent procedure and lack of capacity procedure

Staff we spoke with understood the importance of consent when delivering care and treatment to children and young people. We observed staff seeking consent from children and young people prior to examination, observations and delivery of care. In most cases this was implied consent and not documented. However, when an intervention was required, formal written consent was sought.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. When they could not give consent, staff made decisions in their best interest, considering their wishes, culture and traditions. Nurses we spoke with understood 'Gillick competence' (a term used in medical law to decide whether a child under 16 years is able to consent to their own medical treatment, without the need for parental permission or knowledge).

Staff could access guidance on Deprivation of Liberty Safeguards. There was an eLearning and policies and procedures for staff to follow should either a standard or urgent authorisation need to be made. There were no occasions in the past year where applications had been made to deprive a young person of their liberty.

Staff received Mental Capacity Act and Deprivation of Liberty Safeguards training. As part of the mandatory training staff completed modules on mental health, consent, safeguarding, best interests' decisions and deprivation of liberty. Care and nursing staff completing level three face-to-face training and senior managers completed level four training on the Mental Capacity Act and Deprivation of Liberty Safeguards. All other staff who had contact with children or young people and their families completed level two face-to-face training.

Are hospice services for children caring?

Outstanding



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

Compassionate care

Staff consistently treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and went above and beyond expectations to meet their individual needs and wishes. Children, young people and their families were truly respected and valued as individuals.

Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. Staff were passionate and committed to providing compassionate, patient centred care for children, young people and those close to them. Staff were aware of the importance of providing compassionate care and the impact their actions had on the children, young people and their families at a particular time of their lives.

Children, young people and their families said staff treated them well and with kindness. Feedback from patients consistently confirmed that staff treated them well and with kindness. Patient families and staff provided numerous examples of where staff had gone 'the extra mile' to provide care.

Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff interact and how they treated patients and their families in a friendly, warm, caring and compassionate manner. Patient-centred care was embedded in all staff working at the hospice and the community. We could see staff had built strong and trusted relationships with patients and those close to them. We observed staff displayed an understanding and non-judgmental attitude when caring for, or talking about, vulnerable patients.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs. Staff



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took their time to listen to their patients and their loved ones, and therefore they were aware of the things that mattered to them. We observed this whenever staff spoke about their patients, for example, during handovers, MDT meetings and in clinics. For example, staff told us how they organised a 'trick or treating' event in the hospice for a little girl who loved trick or treating but had never had the opportunity.

Another staff member told us of a how the chef found out the parents of child receiving end of life care were missing their traditional food. The chef researched for a recipe on the internet and surprised the family with a home cooked traditional dinner from their home town.

Staff gave us an example of the time when, they supported a young person with muscular dystrophy to attend their school residential trip. By working with the school, staff from the hospice were able to provide overnight care and school staff provided the care during the day in order for the young person to enjoy the trip with their peers.

During the inspection we observed children and young people receiving highly personalised care with their wishes being creativity fulfilled by staff. We saw a little child who wanted to pretend to be a hairdresser and the staff were acting as clients to get their hair styled.

Families told us that staff helped and encouraged them to create very tailored lasting memories of their loved ones.

The family accommodation and facilities gave families the option for overnight stay. The service manager told us that one of the family bedrooms was furnished with a double profiling bed, for families who would like to have their sick child in bed with them, as that would be the most natural thing to do.

Children and young people who had died at the service or who died in the community or local neonatal unit would continue to be cared for with dignity and respect awaiting funeral arrangements. Families could spend time with their loved ones in a private space and staff would continue to offer compassionate care.

The service offered a 'help at home' volunteer service, where families could receive help and support with a variety of tasks, including everyday household chores like shopping, cleaning, gardening, or it could just be tidying up a bedroom for decorating or help to moving home.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs. Staff went the extra mile to people's emotional and social needs and saw these as important as their physical needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it. All staff demonstrated a deep understanding of the emotional impact living with a life-limiting condition had on children, young people and their families and consistently took account of this when providing care and treatment. Through the holistic needs assessment (HNA), staff were able to provide a personalised and holistic emotional support to the patients and their family.

During the inspection we were told emotional support came in different forms depending what was required by the patient and those close to them. Staff worked together as a multidisciplinary team to support the emotional needs of the children, young people and their families.

The hospice had counsellors who provided targeted emotional support to patients and their loved ones. This included individual counselling sessions for parents and siblings, couple's counselling sessions, pre and post bereavement support.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their family's wellbeing. We spent time with the clinical teams in the hospice and out in the community with the long-term ventilation service and were told about and observed how patients and their loved ones were given emotional support to limit their distress. Staff listened to patient's stories and addressed their concerns.



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The service also provided tailored emotional support for siblings of patients in the hospice. This included advice and support, sibling sessions and activities such as music therapy, arts and crafts.

The hospice had a dedicated spiritual and religious room called the 'Haven'. Patients and their loved ones could access information and support from all main religions, as well as non-religious and well being information. The service had a lead chaplain that coordinated volunteer chaplains of different faiths to support patients and their families. The chaplain offered emotional, spiritual, religious or pastoral support to patients, relatives and staff of all, any or no faith.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their family's wellbeing. Patient families and staff provided numerous examples of where staff had gone 'the extra mile' to provide emotional support. For example, staff told us of a time when the staff organised to keep a tiny pug puppy in the hospice for three weeks as it was the wish of a little girl who always wanted to snuggle up to a puppy.

The service not only provided emotional support to patients and their families, there was also provision for staff support. All the staff we spoke to during the inspection told us that they had a chance for a debrief session with their managers and the well being lead, after any challenging or emotional experience.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment. Staff were fully committed to working in partnership with the children, young people and their families, involving them in decision making processes about care and treatment. During the inspection we spoke with four parents whose children received care from the service. All four, told us that staff communicated and informed them of any changes or concerns with the care and treatment plan for their child. We observed staff explaining to patients and

their family the care and treatment that was being provided. During handovers staff always had a conversation with the patients and parents and took their views into account when discussing and planning care and treatment.

Staff supported children, young people and their families to make advance care planning and advanced directives. By completing advance care plans patients were making a plan for future health and personal care if they should lose their decision-making capacity. It captured their values and wishes and enabled them to continue to influence treatment decisions even when they could no longer actively participate. The advance care plans we reviewed during the inspection were filled in comprehensively and documented discussions with the patient and their family.

Families were invited to use the communal areas, sensory room, the 'haven' and gardens. Which gave patients and their families areas away from patient's bedrooms to be together.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. We saw the service undertook a family satisfaction and experience survey in October 2019. The service invited each family who used the service in the previous six months to complete an online survey. The survey asked six questions based on their care they received from the hospice. We reviewed the results of this survey and saw seven families responded to the survey. Of these, 100% of families rated the service they received as excellent, very good or good, and 100% thought the service had listened to their needs and rated the service's response to their needs as excellent, very good or good. All respondents to the survey said they would recommend the hospice to another family and were very satisfied with the service provided.

Are hospice services for children responsive to people's needs? (for example, to feedback?)

Good



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



Hospice services for children

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local children, young people and their families. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population. The service had developed and implemented new ways of rostering to increase the capacity to deliver end of life or urgent care simultaneously with short breaks. Registered nurses delivered the more urgent care to children and young people whose conditions are unstable, deteriorating or dying. Care assistants, who had completed a training programme and competency assessments in practice, delivered planned care to children and young people with more stable care needs. This meant the service was able to reduce the number of cancellations to planned short break care and enable the service to have flexibility to change plans and be able to meet the ever-changing priorities for care at very short notice.

Where there was no demand for the hospice's services, the service occasionally operated planned closed days, whereby the service planned to close for a set period. During this time, the service operated a staff standby rota. If the condition of a child or young person deteriorates rapidly, systems and processes were in place for standby staff to attend the hospice to open, ready to receive the child or young person and their family, to provide safe care to the child or young person and support to the family.

Facilities and premises were appropriate for the services being delivered. The Nook was a newly purpose-built building. The facilities and premises were appropriate for the services that were delivered. There were seven single patient rooms, each with access to an en-suite bathroom. All bedrooms had fixed hoisting equipment that connected to the bathrooms, allowing children and young people with reduced mobility to access the bathroom facilities direct from their bedrooms.

Equipment and facilities were suitable for the different clinical conditions, age groups, and abilities of all children and siblings from birth to age 18, and their families.

The service had a purpose-built family accommodation and facilities which included three en-suite bedrooms,

available for overnight stay. There was a dining and kitchen area as well as a separate sitting room. One bedroom and bathroom in the family accommodation was fully adapted for a disabled family member. In addition, one of the family bedrooms was furnished with a double profiling bed, for families who would like to have their sick child in bed with them. The patient bedrooms were large enough to accommodate camp beds should this be required. Parent's accommodation enabled parents to stay close to their children.

The grounds were well maintained and suitable for the people who used the service. All areas of the hospice had step free access, including the outdoor areas and gardens. The children, young people and their families had access to a private seated area and gardens. People could access ample car parking and Wi-Fi.

There was designated space for young people that had game consoles, media centre, books, magazines and board games.

There was a designated bedroom with a cooling system so children were able to stay in the hospice after their death. Managers told us this service was particularly valued by bereaved families, as it allowed them to remain close to their child in a familiar environment for a period after their death.

Relatives who had difficulty with transport had potential access to a volunteer driver to support visiting. Visitors were able to make tea and coffee and they were provided with meals whether to eat with their child or in the family accommodation area.

The service had systems to care for children and young people in need of additional support or specialist intervention. For example, the services long term ventilation service (LTV) was staffed by clinical nurse specialist (CNS) that supported children, young people and their families in the community, as an outreach service. Staff in the LTV team visited children and young families at home or school to offer support and advice with the use of the ventilator. They also provided training to family members how to use the ventilator appropriately.

The service had systems and process to care for children and young people and plan for transition to adult



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services. The service worked effectively in partnership with other care providers and community organisations. Staff work closely with adult hospices to develop transition opportunities for young people.

Staff told us that they were able to outreach into the community and acute hospitals to support children, young people and their families. Staff had built a very good working relationship with the local acute hospital where they would meet the families prior to patient discharge to community or at the time of palliative diagnosis being made. This meant staff were able to plan in advance and put the support and help in place if and when the families needed it. The symptom management nursing service lead on the planning for transfer from hospital or home to the hospice and ensured this happened as soon as was safely possible.

Staff told us that they regularly worked well with other organisations to support children and young people. For example, they supported a young person with muscular dystrophy to attend their school residential trip. By working with the school, staff from the hospice were able to provide overnight care and school staff provided the care during the day in order for the young person to enjoy the trip with their peers.

The hospice was a non-religious organisation, however, it employed a lead chaplain and worked with a number of volunteer chaplains from all major faiths. The service had also developed relationships with the local multi-faith community and made contact and requested their support when needed.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

Staff made sure children and young people living with mental health problems, learning disabilities and long term conditions received the necessary care to meet all their needs. Staff told us they treated every patient as an individual. Staff endeavoured to provide care that was inclusive. Staff demonstrated a holistic, patient-centred approach to care planning and delivery of care.

Information from the holistic needs assessments (HNA) was used to develop wellbeing services to meet the families' needs. Children and young people's care plans were developed to include their individual preferences and needs. Care plans we reviewed demonstrated children and young people's spiritual, religious, psychological, emotional and social needs were taken into account.

The service had care co-ordination teams, who reviewed the families regularly and brought any changes to be discussed at the locality multi-professional meeting (LMPM) and consider how best the family can be supported. In addition, any changes to care needs are discussed at the daily care planning meetings, attendance at external multi-disciplinary meetings or discussion with other professionals involved in their care.

The hospice and all its facilities were designed to meet the needs of children, young people and their families. The hospice was equipped to meet the needs of children and young people spending time with their families. They had the opportunity and accessed numerous indoor and outdoor activities designed to support children and young people to meet their needs in a holistic manner. Activities included specialist play, art therapy, music therapy, use of the sensory room and hydrotherapy pool

The service organised various activities and events to support families including sibling activities, mums' nights, dads' activities, grandparent support groups, child support groups, teenagers and bereavement support groups.

Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed. The service had access to a face to face and telephone translation services for families whom English was not their first language. The service could also access a sign language interpreter, when needed.

The hospice had a lead chaplain who offered emotional, spiritual, religious or pastoral support to patients, relatives and staff of all, any or no faiths. There was a dedicated room called the 'haven' where patients, families and staff could use as a place for reflection. In the room was a tree statue where messages had been tied to



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its branches. This gave people a place to pay tribute to a loved one at a difficult time. The service had established links with local multi-faith community to help support families.

There were many leaflets and practical help guides available for patients and their families. Each leaflet contained details of useful contacts. The service had developed specialist easy-read versions of its information leaflets, such as a family information sheet on raising concerns and complaints, to support people living with a disabilities or communication difficulties. In addition the service's website provided information on the various services, activities and events provided.

Children, young people and their families were given a choice of food and drink to meet their cultural and religious preferences. The hospice had an onsite kitchen with a chef and dedicated staff. Staff regularly discussed with the children, young people and their families their choice for meals and would provide meals to meet their preference accordingly.

Access and flow

People could access the service when they needed it and received the right care promptly.

Managers monitored waiting times and made sure children, young people and their families could access services when needed. Referrals and holistic needs assessments were prioritised according to need. Referrals came into the service from GPs, self-referral, local hospital and community health services.

Referrals were assessed at weekly central panel meeting. Any referrals requesting 'same day admission' or 'urgent' were reviewed by the hospice leadership team and would not wait for the central panel meeting. We attended the weekly central panel meeting during the inspection, and observed the process for managing referrals. Staff discussed the child or young person's need, the needs of the family and also discussed capacity in the unit and safe staffing. Once it had been decided to accept the referral, the information was taken to the locality multi-professional meeting (LMPM) to organise and prepare for completion of the holistic needs assessment (HNA).

The service reviewed each family on a yearly basis, or after a significant change in their circumstances to determine their care and support needs, which was presented at the weekly central panel meetings

Managers worked to keep the number of cancelled planned short break to a minimum. The service offered short break care to families in advance and confirmed prior to the stay. However, the service always prioritised the provision of end of life care and families are made aware that their planned short break might be cancelled. Managers told us that the service had recently completed a service review. As a result, they developed a new way of delivering care whereby children and young people with urgent care whose conditions were unstable, and deteriorating were cared for by registered nurses. However, those with stable care needs were looked after by care assistance who have undergone a full competency-based training.

The amount of planned short break care available was based on staffing levels and other demands on the service. Managers arranged additional staffing from one of the other EACH hospice locations. All staff were competent to deliver care where required at short notice. To reduce any impact to staff, managers offered staff overnight accommodation, use of pool cars and reduced working days to the affected staff.

We reviewed data on the number of unplanned closures of the hospice from October to December 2019. There was a total of two unplanned closures, one which was due to staff sickness (October 2019) and the other due to support need at another location for an end of life care patient (December 2019).

From October to December 2019 the service reported four planned closures; one in October, two in November and another one in December.

We reviewed further data on the number of planned short break cancellations for this period. The service cancelled a total of eight short breaks; four in October, three in November and one in December 2019. The service did not close the hospice when any children or young people were resident.

We discussed the number of short break cancellations with managers, who explained they had worked to minimise these. The service was in the process of establishing a more flexible staffing model, through



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which managers could allocate dedicated members of nursing staff to any of the provider's three hospices based on where the demand was greatest. Managers hoped this would minimise the number of short notice cancellations, particularly when the service received a referral for an end of life care, as these flexible staff members could provide this additional cover at short notice without the need to cancel planned care.

There was coordinated care between the services and good links with the local hospital palliative care team, GPs and the community health services. This meant everyone involved in the child or young person's care were informed of their changing health and social care needs. This benefited patient and their families by providing coordinated care, treatment and well-being at a distressing time.

Managers told us that the service did not have a waiting list for any targeted well-being interventions.

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 children, young people and their families in the investigation of their complaint.

Families we spoke with told us they knew how to make a complaint or raise concerns and felt comfortable doing so. Staff understood the system and had access to policy and procedures to guide them in managing complaints. Staff told us they always tried to resolve any issues or complaints at the time they were raised.

The service had an up to date complaints policy which included staff roles and responsibilities. The complaints policy stated that complaints would be acknowledged within three working days. There was no set timeframe for complaints to be investigated and closed by, as it depended on the nature of the complaint. Managers told us that they contacted the complainant advising them how the complaint will be investigated and how long it was expected to take. If the investigation took longer than expected, the manager would contact the complainant again, explaining why the response was delayed.

Complaints were investigated locally by the service manager and the matron. The hospice chief executive had overall responsibility for the management of complaints.

Staff understood the policy on complaints and knew how to handle them. Wherever possible staff tried to resolve concerns raised locally by being open, listening, being non-defensive and supportive. Complainants were offered an opportunity to speak with someone more senior such as the assistant director, director of care or chief executive.

At the end of a complaints investigation process, a formal letter was sent to the complainant which included how the complaint had been investigated, conclusions drawn, what action was to be taken following the complaint and next steps the complainant could take if they were not happy with the outcome.

The hospice clearly displayed information about how to raise a complaint. We saw 'How to raise a concern or make a complaint' leaflets throughout the hospice. The EACH website had a section detailing how to make a complaint. Complaints could be made in person, by telephone, and in writing by letter or email.

All complaints and investigation outcomes were discussed at the weekly locality multi-professional meeting (LMPM).

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff said learning from complaints and concerns would be communicated to them at daily care planning meetings, handovers, team meetings, emails and notice boards.

From October 2018 to September 2019 the service reported a total of five complaints, of which three were resolved through local resolution and two were managed under the formal complaints' procedure. Out of the five complaints, one was upheld. The key themes of the complaints were care delivery, access to short break provision, communication and equipment.

For the reporting period October 2018 to September 2019 the hospice had received 30 formal compliments. However, we saw many more expressions of gratitude during the inspection. These included compliments



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about how the whole family feeling cared for not just the patient, how care was focussed and individual, how caring the staff were and how patients and their families were treated with dignity and compassion.

Are hospice services for children well-led?

Outstanding



Our rating of well-led improved. We rated it as **outstanding**.

Leadership

Leaders at all levels had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were highly 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 had a clear management structure in place with defined lines of responsibility and accountability. The senior leadership team (SLT) was made up of the acting chief executive officer (CEO), acting deputy CEO and director of care, director of finance, director of income generation, director of workforce & corporate governance and head of marketing and communications. They were supported by; the assistant director of service & quality, nurse consultant, business development manager. The service also had a service level agreement for support of a medical director.

The SLT was accountable to the EACH board of trustees, who had a range of relevant expertise to contribute to the service.

At a local level, the service had an established locality leadership team (LLT) made up of the service manager, clinical lead (matron) and a well-being lead. The service manager reported to the assistant director for service & quality, with the matron reporting to the acting director of care.

Leaders had a wealth of experience and expertise developed from working in the palliative care sector and different areas of the health service.

Some members of the senior leadership team were in acting roles, such as the acting CEO and the acting director of care. We were told by the chair of the board that recruitment process was under way to fill the roles.

The senior management team and team leaders understood the issues, challenges and priorities in their service, and beyond, and proactively sought to address them. A culture of continuous improvement and service development was a common thread throughout all areas of the hospice. They worked collaboratively with partner organisations, stakeholders and other agencies to deliver high-quality, patient and family-centred palliative and end of life care services.

All staff we spoke with were positive about their leaders. They told us they were very visible, approachable and they felt well supported. We observed this during the inspection.

Vision and strategy

The service had a clear vision for what it wanted to achieve and a detailed 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 and national plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service's vision was to 'aspire daily to lead the way in providing world class care for children with life-threatening conditions' and also that 'every child deserves support, alongside their families, whenever and wherever they need it'.

The service also had a mission statement 'to improve the quality of life and wellbeing of every child and family under their care, by providing individual and comprehensive services at all times'.

Underpinning the service's vision and mission statement were four core values:

- Empathy and understanding – understanding the views and feelings of others is central to our work relationships and how we interact daily.



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- Commitment to quality – we consistently employ our best efforts and strive for the highest standards in everything that we do, always looking for ways to improve.
- Open and respectful – we operate in an honest and participative way. Welcoming constructive feedback and different views, we understand the power of words and behaviour and hold ourselves accountable for maintaining a positive and considerate work environment.
- Make it happen – we are empowered to and take responsibility for getting things done.

We observed that staff worked in a way that demonstrated they upheld the values in practice and kept exceptional patient care as the basis for all they did. The appraisal process incorporated the EACH values and staff had to evidence how they demonstrated them at work.

EACH had a five-year strategy reviewed by the Board annually. The strategy was translated into annual goals and priorities and monitored by the Care Strategic Leadership Team and Clinical Governance Committee of the Board.

The EACH vision, mission and values were reviewed and revised in 2018. Families, staff, volunteers and external stakeholders were engaged in the development work. We saw the EACH vision, mission and values were publicly displayed throughout the hospice. Most staff we spoke with could articulate the vision, mission and values.

The service had a dedicated education strategy which outlined how the organisation planned to deliver high quality supervision, learning, training and professional development opportunities for all staff. They also had a strategy and framework for emotional health and well-being, which set out the approach of how the service was going to support families with their overall wellbeing taking into consideration their social, emotional and spiritual needs and potential risk factors.

We reviewed both these strategies and they were comprehensive and referenced the provider's overarching vision and strategy.

Culture

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

Staff felt respected, supported and valued by patients and their families, their peers and their managers. Staff told us there was good team work and very good working relationships throughout the hospice. Staff were proud to work for the hospice, they were enthusiastic and passionate about the care and services they provided for patients. They enjoyed coming to work, with many staff having worked at the hospice for many years. Staff told us they were committed to providing the best possible care for children, young people and their families. One staff member told us that “it was a privilege to care for people at the most difficult time of their lives”.

During our inspection we saw pleasant, respectful and non-judgmental interactions between staff, children, young people and their families. There was an inclusive culture with an individualised and person-centred service that took into consideration the needs of the patient and their family.

There was a culture of honesty, openness and transparency. Staff were encouraged to report incidents and raise concerns or issues, so they could learn from them and improve the service they offered. The senior management team told us that they promoted an ‘open door’ culture and it was evident staff felt confident to voice any concerns or issues they had.

The service supported staff with their wellbeing by providing access to internal and external counselling services, employee assistance programmes and chaplaincy services. Debrief sessions were organised for staff after difficult or upsetting events. Staff told us clinical supervision was available to them and staff could access the chaplaincy service for support. Every member of staff we spoke with during the inspection said they felt supported and their well-being was looked after.

Staff spoke positively about development and training opportunities. Staff felt able to discuss personal



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development with their line managers and one-to-one meetings and the annual appraisals were seen as constructive and a time to identify and agree objectives as well as training needs.

Staff had regular team-building events to develop and encourage better and effective working relationships. This included four dedicated locality days each year, where all staff within the service came together. All staff had the opportunity to attend the annual summer and Christmas parties, to celebrate with the children, young people and their families.

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.

The service had robust governance structures in place at all levels of the organisation. Locally the locality leadership teams (LLT), made up of a service manager, clinical lead (matron) and locality well-being lead, were leads for governance and quality monitoring. Each locality operated within a care quality and safety framework with oversight provided by the strategic leadership team for care (director of care, medical director, nurse consultant and assistant director for service & quality).

Any issues, risks or concerns from the LLT would be escalated to the management executive (MEX) team via the strategic leadership team. The MEX was made up of the chief executive officer (CEO) along with the deputy CEO, director of care, director of finance, director of income generation and director of workforce.

The MEX reported into several committees including clinical governance board committee, finance and income generation board committee, human resources board committee, audit and compliance board committee, investment sub-committee and fundraising sub-committee. MEX and these committees reported directly to the board of trustees, led by the chair of the trustees.

Every quarter, members of the board of trustees and management executive (MEX) team led health and safety

support visits to assess the quality of the care provisions. We reviewed a recent report from these visits and noted that the visit covered four key questions; is the hospice welcoming? is the hospice safe? will the team care for me and involve me in my care? and is the hospice well organised and calm?

Following the visit, the trustee or the member of MEX gave feedback to the team, highlighting any areas for immediate concern or recommendations for improvement.

Managing risks, issues and performance

The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

There were robust arrangements for identifying, recording and managing risks, issues and mitigating actions.

There was a risk management policy which defined the framework and arrangements that EACH uses to identify and manage the risks that threaten its ability to meet the objectives and achieve its values.

There was a corporate risk register which contained a list of all current risks that affected the service. We reviewed the risk register which was updated in October 2019 and contained 12 active risks. Each risk entry was detailed and contained a risk rating, a risk owner, review date and target risk rating. A series of individual controls were developed for each risk. We saw that this controls included current progress, along with any gaps, with dated assurance comments.

Although the service did not operate a local risk register, managers told us they could suggest and raise potential risks that they felt required adding to the corporate risk register.

In addition, as the move to the Nook location was separately project managed, we saw that any local risks, for example to do with the new built, snagging issues, etc were held as part of project risk register. This risk register was regularly reviewed by the programme board and progress monitored.

The board reviewed the Board Assurance Framework (BAF) corporate risks annually. Any changes to the risks during the year were reported to the board at their



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quarterly meetings. The committees of EACH's Board of Trustees review the strategic risks relating to their responsibilities and operational risks with a score of 12 or more in between. The management executive (MEX) provides oversight and scrutiny of operational risks.

The operational risk register was managed by the clinical quality and safety groups. Risk assessments were completed for clinical risks such as novel treatments or interventions and events with risks scoring eight or more being added to the corporate risk register.

From speaking with staff and reviewing documentation we were assured the service were able to recognise, rate and monitor risk. This meant the service could identify issues that could cause harm to patients or staff and threaten the achievement of their services.

The service monitored performance against key performance indicators (KPI) through a quarterly balanced scorecard report, which included referrals, service user experience, complaints & concerns, training, staffing, staff survey results, audit results, learning from deaths and incidents, research activity, update on service redesign and financial performance.

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

Managing information

The service collected reliable, detailed data and analysed it to drive forward improvements. 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.

Staff had access to a range of policies, procedures and guidance which was available on the service's electronic system. Staff also told us IT systems were used to access the e-learning modules required for mandatory training.

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

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

There were systems in place to ensure that data and notifications were submitted to external bodies as required, such as local commissioners and the Care Quality Commission (CQC)

The service had policies and processes on Information Governance, Security and Personal Data Protection. All data controller registrations for the processing of personal data were maintained in accordance with current regulations and guidelines.

Engagement

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

The service actively encouraged children, young people and families to give feedback through evaluation forms, feedback suggestions box, annual satisfaction and experience survey, comments through the family section on the EACH website, comments slip in the Family Corner newsletter and social media.

Feedback was reviewed by staff and used to inform improvements and learning, where possible. This information was then shared staff meetings where trends and themes in feedback could be discussed, improvement of services implemented, and success celebrated.

The service actively engaged with children, young people and their families, as well as staff, stakeholders and other local organisations to shape their services. For example, managers told us how families were included via focus



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groups and surveys to contribute to the independent review of the care service during 2016-17, which resulted in a three-year service redesign programme to increase capacity in delivering end of life or urgent care simultaneously with planned short breaks, and as a result reduce the number of planned short break cancellations.

In 2018 when the vision, mission and values were reviewed and revised, families, staff, volunteers and external stakeholders were engaged in the development work.

Managers also told us that they use evaluations from events such as memory day to continually develop future events. Young people provided ideas for developing their space in the hospice and the EACH website, activities and events. We saw a recent feedback from a bereaved parent who shared their experience and how they felt when transporting their deceased baby from the hospital to the hospice. At their suggestion the service purchased a car seat specifically for this purpose to make it feel more "acceptable" to parents.

To raise public awareness and support for the hospice, the Nook held an open day for the local community where 200 people attended before its official opening.

The views of staff were sought and acted on. Staff were invited to participate in the annual staff

Locality team days were held three times a year and once a year the service held provider-wide meeting, which brought all staff from the three locations together. These meetings provided staff the forum to discuss and share ideas on how to improve the service. At the provider-wide meetings, the management executive (MEX) gave briefings to update all staff on current and long-term strategies.

Learning, continuous improvement and innovation

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

The service was committed to improve the quality of services offered to children, young people and their families. The service commissioned a university study to evaluate the well-being interventions and therapies offered by the service to support children with life-limiting or life-threatening conditions and their family. The study findings confirmed that the service had a varied workforce, who provided a range of supportive therapies that were appropriate for supporting the needs of children with life-limiting or life-threatening conditions, and their family.

We saw staff were passionate about improving the service and the quality of care they provided to the children, young people and families who used the service. For example, the service redesign improvement programme once fully implemented would increase capacity to deliver end of life or urgent care simultaneously with short breaks, and a reduced number of planned care cancellations by restructuring the provision care.

Managers ensured the service continued to meet the needs of the children, young people and families who used the service. Staff had continued to improve responsiveness and co-ordination of care for families by implementing a new care processes which included the introduction of the weekly central panel and locality multi-professional meetings (LMPM). This has also been supported by the family co-ordinator role and care coordination teams.

EACH was a key player in the regional managed clinical network. We saw staff played an active role in various children's palliative care forums nationally and international. Staff contributed to academic research into children's palliative care. For example, we saw a number of staff had published research articles on peer reviewed scientific journals and also contributed to a book on effective symptom management in neonatal palliative care in a textbook for nurses on neonatal palliative care.

Outstanding practice and areas for improvement

Outstanding practice

There was a strong commitment from all staff to provide truly a person-centred, compassionate care and support people's holistic needs. Staff were highly motivated and inspired to offer innovative ways to support children, young people and their families. Feedback from families who used the service was that staff went over and above what was expected of them.

There was an embedded and extensive team of volunteers who helped support the service to meet the needs of local people, particularly with the development of their 'Help at Home' volunteer service. Volunteers were valued members of the service who were provided with support and who felt part of the hospice team

The service was person centred and could be tailored to meet children and young people's complex needs. Staff developed a comprehensive holistic needs assessment which help identified needs of not only the child or the young person but also their family. Staff reviewed the holistic needs assessment to continually meet the needs of the child and their family.

Staff were passionate about improving the service and the quality of care they provided to the children, young people and families who used the service. For example, the service redesign improvement programme once fully implemented would increase capacity to deliver end of life or urgent care simultaneously with short breaks, and a reduced number of planned care cancellations by restructuring the provision of care.

Managers and staff ensured that the service improved and to meet the needs of the children, young people and families who used the service. Staff had continued to improve responsiveness and co-ordination of care for families by implementing a new care processes which included the introduction of the weekly central panel and locality multi-professional meetings (LMPM). This has also been supported by the family co-ordinator role and care coordination teams.

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should ensure all staff complete all mandatory adult safeguarding training.