Butterwick Limited

Butterwick House

Inspection report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inspected but not rated
Are services responsive to people's needs?	Inspected but not rated
Are services well-led?	Inadequate

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as inadequate because improvements made since our last inspection did not yet justify a higher rating:

- Staff did not always receive the correct level of training on how to recognise and report abuse but they knew how to apply it. Staff did not always complete and update risk assessments for each patient and remove or minimise risks.
- Staff did not always identify and quickly act upon patients at risk of deterioration. Staff did not always keep detailed records of patients' care and treatment. Records were not always clear, up to date, stored securely and easily available to all staff providing care.
- The service did not always use systems and processes to safely prescribe, administer, record and store medicines.
- Staff did not monitor the effectiveness of care and treatment. They did not use the findings to make improvements and achieved good outcomes for patients.
- The provider was undergoing a significant process of change, made up of many different programmes of work. There was a lack of any robust oversight or management of this. Leaders did not run services well using reliable information systems and did not support staff to develop their skills. The governance structure was new and not embedded. The leadership team had gaps in its skills.
- Staff did not always understand the service's vision and values, and how to apply them in their work. Staff did not always feel respected, supported and valued. Staff were not always clear about their roles and accountabilities. The service did not always engage well with the community to plan and manage services.

However:

- The service had enough staff to care for patients and keep them safe.
- The service controlled infection risk well. The design, maintenance and use of facilities, premises and equipment kept people safe.

Following our inspection, we raised significant concerns with the provider by issuing a warning notice relating to breaches of Regulation 12 and 17. In addition, we issued the provider with requirement notices and told the provider that it must take prompt action to comply with the regulations.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for children	Inadequate	

Summary of findings

Contents

Summary of this inspection

Background to Butterwick House

Butterwick House is operated by Butterwick Limited. The service provides hospice services for children and young people from Stockton, Middlesbrough and surrounding areas. It is registered as a charitable trust and receives funding from the NHS. The hospice has six inpatient beds for the provision of respite care. Butterwick House is registered to provide diagnostic and screening procedures and treatment of disease, disorder or injury. At the time of our inspection there was an application in progress for a registered manager.

We previously inspected Butterwick House in October 2020 as we had concerns about the quality of services. We inspected medicines practices and processes at Butterwick House, the medicines management training provided to staff, and how their knowledge was checked, and how they reported and investigated incidents. We also looked at the wider oversight and management of incident management and risk across the organisation. We did not rerate the service at this inspection, and the provider remained in special measures. In light of the findings from the October 2020 inspection, the provider was issued with a Notice of Decision which placed conditions on their registration. The provider subsequently submitted an application and supporting evidence to the Care Quality Commission to remove these conditions in March 2021 which was approved.

We carried out a focused inspection on 4th, 5th and 6th of May 2021 in response to concern regarding the quality of service and to follow up on improvements made by the hospice to address concerns raised as part of our previous inspection in October 2020. At the time of the inspection the hospice was only admitting children and young people already known to the service for short-break respite care. It was not taking new referrals or end of life children or young people at this time.

How we carried out this inspection

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Our team consisted of an inspection manager, inspectors, a pharmacist specialist, and a specialist adviser with relevant experience in hospice care.

We spoke with eight staff, including: trustees; the chief executive officer; the director of patient care; the clinical lead for children; a clinical sister; registered nursing staff and healthcare assistants. We reviewed 10 staff files (including trustee and leadership staff files) and seven patient records.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

We told the service that it must act to bring services into line with three legal requirements. This action related to treatment of disease, disorder, or injury services.

The provider MUST ensure the following;

Summary of this inspection

- The service must ensure that staff fully and properly assess the risks to the health and safety of service users of receiving the care or treatment and do all that is reasonably practicable to mitigate any such risks **(Regulation 12 (2)(b).**
- The service must ensure that all staff receive safeguarding training for adults and children, as necessary, to evidence that systems and processes are operated effectively to prevent abuse of service users **(Regulation 12 (2)(c).**
- The service must ensure the proper and safe management of medicines (**Regulation 12 (2)(g).**
- The service must assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity and include the experiences of service users within this **(Regulation 17(2)(a).**
- The service must assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity **(Regulation 17 (2)(b).**
- The service must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided **(Regulation 17 (2)(c).**
- The service must ensure that there is a robust process in place that maintains accurate and up-to-date oversight of the mandatory training of staff working within the service **(Regulation 17 (2)(d).**

We told the provider that it should take action because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

The provider SHOULD ensure the following;

- The service should ensure that staff follow protocols and procedures regarding personal protective equipment to mitigate against COVID-19 **(Regulation 12 (2)(g).**
- The service should ensure that documents have a clear version control, pages are numbered throughout, and identifiable info is included on all pages **(Regulation 17 (2)(c).**
- The service should ensure that all documentation is signed and dated as required **(Regulation 17 (2)(c).**
- The service should ensure that there is a clear process for the storage of all appraisal and supervision documentation **(Regulation 18 (2)(a).**
- The service should ensure that the vision and strategy for the service is underpinned by clear development and improvement plans **(Regulation 17 (2)(e).**
- The service should ensure that the priorities set out in its published strategy 2019-24 are specific, measurable, achievable, realistic, and timed **(Regulation 17 (2)(f).**
- The service should consider there is a robust investigation process that is applied consistently to feedback provided by patients, families and carers.
- The service should consider giving leaders within the service a clear, defined roles and responsibilities that support delivery of the service.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hospice services for children	Inadequate	Inspected but not rated	Not inspected	Inspected but not rated	Inadequate	Inadequate
Overall	Inadequate	Inspected but not rated	Not inspected	Inspected but not rated	Inadequate	Inadequate

Inadequate

Hospice services for children

Safe	Inadequate
Effective	Inspected but not rated
Responsive	Inspected but not rated
Well-led	Inadequate

Are Hospice services for children safe?

Inadequate

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

Mandatory training

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

Staff received and kept up to date with their mandatory training. The mandatory training was comprehensive and met the needs of children, young people and staff.
However, managers did not always monitor mandatory training and alert staff when they needed to update their training. We reviewed a training matrix spreadsheet that senior leaders used to maintain oversight of staff training. There were discrepancies between the spreadsheet entries for theory and observational competence.

We raised this with senior leaders who confirmed that the spreadsheet was manually updated and that the discrepancies had arisen due to human error and oversight. We reviewed the training certificates of staff members which confirmed the entries in the observational competence section of the spreadsheet were accurate. There was no documented target within the matrix that set out when staff should be compliant with their mandatory training. We were not assured that the service had a robust process in place to maintain accurate oversight of mandatory training for staff.

Safeguarding

Staff did not always receive the correct level of training on how to recognise and report abuse. Although, staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

The hospice had a safeguarding children policy for staff to refer to which was in date and ratified by trustees. However, the policy was not in accord with published inter-collegiate guidance on safeguarding children (first edition: August 2018) and it was not being followed.

Staff did not always receive training specific for their role on how to recognise and report abuse. The provider's policy stated that the clinical lead who was named in the policy as the lead for children's safeguarding, should be trained to level three adult safeguarding. The inter-collegiate guidance stated that the named specialist in an organisation, such as the lead for safeguarding, should be trained to level four. The training matrix reviewed did not demonstrate the

children's safeguarding lead had received the appropriate level of safeguarding training.

The providers policy stated that all staff and volunteers were to complete safeguarding training relevant to their role. Trustees were not recently trained in children's safeguarding, and only two of the 430 volunteers that were registered with the service had received the appropriate safeguarding training. We raised this as a concern as that had been identified as part of the previous inspection and the provider was unable to demonstrate how they had taken action to address this.

We reviewed the HR files of four staff members and saw evidence that the appropriate disclosure and barring service checks (DBS) were not always in place. In one trustee file no DBS check had been completed and on another trustee file the DBS check was in progress. There was no corresponding risk assessment in relation to the absence of the DBS. This was not in line with the providers policy.

However, staff said that safeguarding was discussed as part of their regular supervision, and staff were aware that the service had a named safeguarding lead in place.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. We saw evidence of the services' involvement and contribution towards local safeguarding children conferences. Staff knew how to make a safeguarding referral, how to contact local authority safeguarding teams, and who to inform if they had concerns.

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.

We saw staff adhering to processes designed to control the risk of spreading COVID-19. Visitors were required to wear masks, record their temperature and complete a COVID-19 questionnaire before being allowed to move further into the premises. Staff and visitors could wash their hands using hand gel provided, and there were clinical wipes on hand to wipe down surfaces or equipment used.

Areas throughout the unit were kept clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The provider's hand hygiene audit showed consistent high compliance.

However, staff did not always follow infection control principles including the use of personal protective equipment (PPE). We saw staff were not always wearing their mask correctly whilst present on the unit.

Environment and equipment

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

The design of the environment followed national guidance. Staff carried out daily safety checks of specialist equipment. Equipment checklists had been completed and that manufacture servicing details were present and in date. Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and removed or minimised risks. Staff did not always identify and quickly act upon patients at risk of deterioration.
Staff completed risk assessments for each child and young person on admission using a recognised tool, but staff did not review this regularly. In all of the records we reviewed, we found risk assessments that had not been updated since 2019. This was not in line with the provider's procedure for key workers and continuous care planning, which states that it is the responsibility of the key worker to complete an annual review of the documentation of the child/young person to ensure it is in line with current need. Risk assessments were not stored within the care plan folders for children and young people, and it was unclear how staff would access these in a timely manner when required.

In all risk assessments reviewed the names of children and any identifying information had not been recorded. There were gaps in risk assessments regarding the completion and approval signatures. It was unclear as to if these risk assessments had been approved for use.

Staff knew about specific risk issues regarding the children in their care, however, plans in place to address and respond to risk were not always clear. We reviewed six sets of care plans. In two of the records we reviewed, we found conflicting information in relation to the emergency medication to be administered in relation to the Emergency Healthcare Plan (EHCP).

In one of the records we reviewed, the EHCP stipulates that diazepam should be used as first line medication, but that staff would be required to make a 999 call as this medication should not be administered without the supervision of a paramedic. The emergency medication had not been transcribed onto the medication administration record (MAR) chart, and within the chart there was a note for staff to "See Clinic Letter". It was not indicated which letter or the date of letter that staff should refer to. A set of un-labelled clinic letters were included at the end of the care plan file, in which there was a letter that stipulates there is no longer a requirement for an ambulance to be called and that this medication can be administered by staff.

We raised these concerns with the senior who confirmed that the procedure would for be to staff to follow the EHCP exactly as outlined in the plan. Senior leaders explained that there would be a further entry in the care plan that would outline to the staff the process to followed. We asked for senior leaders to highlight this entry, which upon review the emergency medication listed was incorrect and this had been discontinued as first line medication in December 2020. We raised this as a concern as this care plan had been reviewed with the patient's family and signed as part of their March 2021 and April 2021 admission, but this error had not been identified.

Shift changes and handovers did not always include all necessary key information to keep children and young people safe. We discussed with senior leader how staff would be aware of the changes to first line medication. Senior leaders outlined that this would be discussed with staff as part of their handover and this would be documented within the handover sheet. Senior leaders provided us with a copy of the relevant handover sheet in which it was documented on the sheet the change to the diazepam as first line emergency medication – but care plans had not been updated to reflect this.

The handover sheet for a further admission included no information around the change to first line emergency medication and the care plan had not been updated. On the handover sheet, the wrong information was included for the patient as the information for a patient with the same initials had been entered in the overview columns and medication columns.

Inadequate

Hospice services for children

Staffing

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

Senior leaders planned nurse staffing levels in advance against planned admissions. Senior leaders reviewed the clinical needs of all patients and planned staffing levels in accordance with this to ensure staff had the required clinical competencies to deliver care and treatment. The service had enough medical staff to keep patients safe. The provider had a service level agreement in place with a local NHS trust for advice and support from the paediatric team 24/7, including access to the paediatric admission unit if deemed necessary by the on call consultant. Out of hours there was medical cover provided by phone.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not always clear, up to date, stored securely and easily available to all staff providing care.
Patient notes were not always comprehensive. In all records we reviewed there were gaps present in patient records. Not all signatures and dates had been completed and there was no indication as to if these areas had not been completed as they were not applicable. In one of the records we reviewed, the incorrect name had been used throughout the care plan and had been manually scribbled out. The wrong gender pronouns were also used throughout the patient's record and this had not been amended.

In all records we reviewed, clinic letters had been stored within the care plans of children/young people in an unlabelled section. There were references to clinic letters within the records of children and young people, but references did not specify where they were stored and which letter specifically staff should refer to.

In all the records reviewed, patient identifiable information was not included in all areas of the patient's care plan. The service had access to an electronic record system but did not document routinely within the care plan of patients their unique ID number. It was unclear how staff would be able to identify the information contained within patient records belonged to the correct child.

In all records we reviewed there was an absence of details relating to version control, page numbers and dates. It was unclear how staff would identify missing areas of care plan documentation – and how staff were assured information within the record was the most up to date version. Staff handover sheets also lacked corresponding page numbers and dates on all pages. It was unclear how staff would identify potential missing information from the handover documentation.

Staff could access patient records easily. We found that patients records were stored both electronically and in paper records. Records were stored securely in a locked area within the office on the unit. Staff could gain access to electronic records by using computers located within the central lounge area and main office.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines. We found errors within two of the care plans reviewed, where discrepancies regarding medication were listed, for example, glycopyrrolate still being listed as when required medication and ibuprofen still being included on this list. These discrepancies had not been identified within the provider's medication audit, care plan audit or audit undertaken by external pharmacy input.

In one of the care plans reviewed there was no person-centred information included on the patient's when required medication chart despite space being allocated for this information. The supporting care plan included narrative around paracetamol and ibuprofen, however only paracetamol had been recorded within the medication as required chart. Medication used to promote sleep had not been included in the corresponding sleep care plan. This was not in line with the provider's policy for medicines management.

However, staff reviewed children and young people's medicines regularly as part of the admission process. At the time of this inspection, the service had a controlled drugs officer in place. The unit was also attended by an external registered community pharmacist.

Medicine reconciliation was completed on the unit and we saw evidence of dose changes present within the medication records.

Incidents

The service did not always manage patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented.

We requested a copy of the service's incident log for review, but this was not provided. We were unable to establish if the provider had maintained an accurate record of incidents that had occurred within the service. The provider had a up to date incident policy and staff we spoke with were aware of this policy and told us they knew how to report incidents. The provider also had a system in place to receive and act on any national patient safety alerts.

Senior leaders and staff told us learning from incidents was shared at safety huddles and in written form. The service had a display board that included incident details from all areas of the organisation that had relevant learning for the unit.

Staff were aware of the duty of candour. The service had displayed throughout the unit information explaining duty of candour to families and carers.

Senior leaders told us that they met to discuss incidents and look at improvements to children and young people's care. We saw evidence of changes made as a result of feedback from families and carers, such as changes to the pre-admission checklist to ensure emergency healthcare plans were discussed with families prior to each child's admission to the unit.

However, we reviewed a copy of an incident investigation that had been completed in relation to feedback provided from a family member. Not all parts of the incident investigation documentation had been provided. Part 1e was absent

from the documentation provided and we were unable to review how the provider had identified lessons learned from this incident. Within the incident action plan there had been no recording of any actions taken to address the concerns raised. There was no recording of the ownership of actions and timescales for completion. This was not in line with the provider's incident management policy.

Are Hospice services for children effective?

Inspected but not rated

Patient outcomes

Staff did not monitor the effectiveness of care and treatment. They did not use the findings to make improvements and achieved good outcomes for patients. The service had been not been accredited under relevant clinical accreditation schemes.

The service did not participate in relevant national clinical audits. The service did not have oversight of the outcomes for children and young people were positive, consistent and met expectations such as national standards. Senior leaders and staff were unable to improve children and young people's outcomes due to the absence of outcoming monitoring. Managers and staff carried out a limited programme of repeated internal audits to check improvement over time.

Competent staff

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

The service utilised external clinical educators to support the learning and development needs of staff. Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families. Clinical competency certificates for all staff working within the unit were present and in date.

We reviewed the provider's current induction programme and observed the induction of a new staff member who was present on the unit during the time of inspection. We saw that staff had not signed and dated appropriately the induction checklist to be completed. It was unclear from the signatures present if staff members had completed both theory and practical elements of their induction prior to this being signed off, as only one signature was present.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always gain consent from children, young people or their families for their care and treatment in line with legislation and guidance. Staff did not always clearly recorded consent in the children and young people's records. In one of the records we reviewed, the decision in relation to consent to share information had not been recorded, dated or signed. It was unclear as to why this had not been completed.

Senior leaders did not monitor how well the service followed the Mental Capacity Act and made changes to practice when necessary. Senior leaders told us that Mental Capacity Act documentation and Deprivation of Liberty Safeguards documentation would be audited as part of the care plan audit completed by the service. The current audit schedule

outlines this is to be completed on a quarterly basis, but senior leaders told us that they had increased this to a monthly frequency whilst new documentation becomes embedded. We requested to review a copy of the care plan audit and results, however senior leaders were unable to produce this and told us that the care plan audit had not been completed. We were not assured that the service had oversight of their compliance against the MCA and DOLS.

However, staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care.

Staff made sure children, young people and their families consented to treatment based on all the information available. When children, young people or their families could not give consent, staff made decisions in their best interest, taking into account their wishes, culture and traditions.

Staff understood 'Gillick Competence and Fraser Guidelines'. Staff received and kept up to date with training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS).

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, MCA and the Children Acts 1989 and 2004 and knew who to contact for advice. Staff could describe and knew how to access the provider policy and get accurate advice on MCA and DOLS.

Are Hospice services for children responsive?

Inspected but not rated

Learning from complaints and concerns

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

Children, young people and their families knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. We saw that the provider had displayed information for patients, families and carers on how to contact the Care Quality Commission with any concerns. We requested a copy of the service's complaints log to review, however senior leaders informed us that there had been no formal complaints raised within the past six months. Staff were unable to give examples of how they used patient feedback to improve daily practice as they were not aware of any formal complaints that had been made in relation to the service.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes, however we found inconsistencies in how feedback was captured and investigated. Senior leaders told us the service often received informal feedback from families and carers, and that often families and carers did not wish to raise these as formal complaints. Senior leaders gave examples on how the service had acted on informal

feedback, however there was an absence of a formal process for capturing and documenting this. We saw inconsistencies in the way that senior leaders disseminated informal feedback to staff, as well as inconsistencies in the levels of investigation. We were not assured that the provider took a systematic approach to investigating all feedback provided.

Are Hospice services for children well-led?

Inadequate

Leadership

Leaders did not have the skills and abilities to run the service. They did not understand and manage the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff. They did not always support staff to develop their skills and take on more senior roles.

The provider was led by a board of trustees who delegated day to day leadership to a chief executive who receive reports from a director of patient care, human resources manager, an operational manager, but no clinical governance lead.

The trustees were not formally allocated any specific portfolio to oversee and manage but some trustees, staff told us, depending on their background, did take an interest in certain areas.
The service had recently appointed a number of senior leaders, but we found that there were gaps in the skill mix of the senior leadership team in relation to the identification and management of governance issues. Senior leaders we spoke with discussed the importance of establishing a clinical governance lead within the organisation. We saw that the provider did not currently have an appointed clinical governance lead and that the responsibilities that would be fulfilled by this role had been distributed across various other senior leaders. It was unclear as to how the provider was ensured that these additional responsibilities were being fulfilled.

We were not assured the leadership team had good oversight on the quality of care being provided. We saw a lack of data available to the trustees and wider leadership team. We found an absence of any benchmarking, patient outcome monitoring or clinical audit programme.

The new leadership team demonstrated a desire to make things better, but all the leaders we spoke with shared with us the scale of the task that faced them. At present the leadership team were not able to offer support to other healthcare providers. The team told us they were focussed internally on building the workforce, improving governance, stabilising finances, and improving patient care.

We saw that there was not always a clear difference between roles and responsibilities of the clinical sister and clinical lead on the children's unit. The clinical lead could not give examples
when asked about the current priorities included on the service's risk register. We found that the clinical sister was able to provide further details in relation to this. The clinical lead on the unit did not have an established understanding of the processes in place to ensure staff had undertaken the required clinical competency training. We requested documentation in relation to the clinical competencies undertaken by staff from the clinical lead, who provided training files of staff no longer working on the unit as well as clinical competency booklets that were no longer in use.

We found that staff were not empowered to utilise their full range of skills and that tasks were not delegated effectively by senior leaders on the unit. We saw that the clinical sister on the unit was responsible for completing the audits of care plan documentation, however the clinical sister was also responsible to the completion of elements of the care plan. We raised concerns with senior leaders within the organisation around the capacity of the clinical sister on the unit, due to the excessively broad scope of their role and responsibility.

Staff gave a mixed response in relation to the presence of senior leaders on the unit. Staff we spoke with told us that the clinical sister was always present on the unit, but that other members of the senior leadership team were less so.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with some relevant stakeholders. The vision and strategy were focused on sustainability of services but were not aligned to developments in local healthcare providers. Leaders did not always understand and know how to apply this and monitor progress.

The organisation had a strategic plan currently in place to run from 2019 until 2024. We saw no evidence the written strategy had been reviewed in light of the provider being placed in special measures in November 2019. In absence of a recent review, we were not assured that the goals outlined within the strategic plan were realistic or attainable by the provider.

The providers strategic plan did not reflect how national progress towards a model of integrated health and social care had developed locally and did not include any details that referenced how this applied to the local community. There was an absence of detail how the wider community or key stakeholder such as clinical commissioning groups had been engaged in the development of the strategy.

The strategy did not contain details regarding service development or improvement plans to support the delivery of the strategic plan. The plan stated that “this strategy and the supporting plans will be driven by the board and the senior management team through action plans and regular monitoring”. We discussed with senior leaders within the organisation who told us that the focus is on establishing stability as opposed to focusing on the strategy. Senior leaders were unable to produce any documentation to reflect how the provider was maintaining progress in relation to their strategy. We were not assured that the provider had oversight of their strategic plan and what steps need to be taken to move forward.

Culture

Staff did not always feel respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

We spoke with staff regarding the culture of the unit. Staff were passionate about making the services the provider supplied work well.

Staff told us they felt the culture had improved. Nursing staff told us there was a no blame culture and told us that they felt able to report concerns quickly. The service had a whistleblowing policy which was available to all staff and

information on how to raise concerns was available within this document. We saw evidence of information placed throughout the unit that included details of how to raise concerns or make a complaint. We saw evidence of the provider introducing a "pat on the back" box, in which staff could submit positive feedback or comments about their colleagues.

However, some staff we spoke with told us that they did not always feel valued and supported. Some staff told us that they felt the provider had given the necessary support provided to staff during the COVID-19 pandemic. Staff also told us that there they had contributed above and beyond the scope of their role, this had not been recognised and often was overlooked by senior leaders. We found that the provider's strategic plan made no reference to the physical and emotional wellbeing of staff, and that there was no data being currently collected. We were not assured the trustees, or the leadership team had data on or about the culture of the service.

Governance

Leaders did not operate effective governance processes throughout the service and with partner organisations. Staff at all levels were not always clear about their roles and accountabilities and did not always have regular opportunities to meet, discuss and learn from the performance of the service.

The provider was undergoing a significant process of change, made up of many different programmes of work. There was an absence of any oversight or management of this.

We found there was a lack of clarity regarding the meeting schedule that underpinned the provider's governance structure. The integrated governance group had yet to commence and we found no reference to this group in any of the provider's policies. Many of the provider's meetings were in the process of restarting. We found an absence of action logs for a number of the provider's key meetings such as the quality, risk and safety meeting. We were not assured that the provider had mechanisms in place to establish ownership and maintain oversight of any actions agreed as part of these meetings.

We spoke with the senior leadership team to confirm the processes in place to maintain oversight of the ratification of policies. We found that a number of policies were still in development or under review. Senior leaders gave conflicting responses, with some stating that there was no log that details which stage policies were at, and other senior leaders told us that this log was in the process of being developed.

We were not assured that the trustees and leaders were gathering quality data to enable them to have a clear oversight on quality management. We found that the care plan audit that was due to be completed as part of the audit programme had not been undertaken. We raised with senior leaders regarding the gaps in patient records we have found, and senior leaders told us that the current care plan audit would not have identified the omissions we had brought to their attention. We were not assured that the audits being completed by the service were fit for purpose.

The provider expressed intentions to recommence end of life and palliative care by August 2021. We saw no evidence that the provider had completed any formalised planning to facilitate this. Senior leaders acknowledge the ambitious nature of this task but were not able to provide any written plans to demonstrate how they would reach this target.

Managing risks, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identify actions to reduce their impact. They had plans to cope with unexpected events.

The organisation had a risk register in place at the time of inspection. The risk register was due to be reviewed as part of the quality, risk and safety committee (QRSC) meeting which reports to the board of trustees. We requested copies of the meeting minutes for the QRSC and we were only provided with a copy of the January 2021 meeting, however we noted this meeting was due to take place on a bi-monthly schedule. We found that whilst the QRSC meeting had taken place, no revised timescales had been included for risks where the completion date had been surpassed.

Senior leaders within the service were unable to articulate and were not aware of current risks captured within the risk register. We found that key risks to the service that had been identified within the inspection process were not included on the provider's risk register such as the vacancy in relation to the governance and quality lead. We observed that gaps in training for staff had been identified as a risk under "governance risk". This had been added to the risk register in November 2019, with corresponding actions that were listed to be reviewed in March 2020. As part of the inspection, we were unable to identify any progress that had been made with the action listed within the risk register. We also found further entries in the provider's risk register under a different tab titled "operational risk", in which a separate entry relating to volunteers training had been listed with a different set of actions and dates to be completed. It was unclear as to which entry was to be actioned and why there were differing timescales. We were not assured that the provider had oversight of the current risks that the organisation faced or the actions the provider had taken to address these.

We spoke with the leadership team regarding the approach to monitoring key performance indicators for patient outcomes. Senior leaders confirmed that plans to establish key performance indicators for patient outcome were not yet finalised and the service was not currently undertaking this. We found that the provider had previously submitted evidence in response to a previous inspection that stated "KPIs identified and agreed. Formal reporting will commence once services restart." This action had been marked as completed. It was unclear as to what the current status regarding the usage of KPI was.

Managing information

The service did not always collect reliable data and analyse it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not always integrated.

Senior leaders expressed intentions to gain access to an electronic records system that was used by healthcare providers across the locality. We were unable to see any formalised plans that outlined the actions the provider had taken to achieve this.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They did not always collaborate with partner organisations to help improve services for patients.

Senior leaders emphasised that in the absence of outcome monitoring, the service focused on collating feedback from patients, families and carers. We saw evidence that the provider had conducted patient surveys and overall, the results were positive and complimentary of the service received. Senior leaders reflected that due to low numbers of patients accessing the service in previous months, it had been difficult to gather statistically significant numbers of patient feedback.

Inadequate

Hospice services for children

Senior leaders told us that they were still in the process of developing links and forging working relationships with other children's hospice providers in the area. Senior leaders told us they attended regional meetings involving executives from local hospices, and that this forum provided a space for good communication and support. Whilst senior leaders spoke of their attendance, we were unable to observe any evidence of collaborative working or implementation of learning from other partner organisations. We did not see any evidence of how this had progressed since our last inspection.

We saw no evidence within the providers strategy of an engagement plan that contained clear milestones and targets. It was unclear as to how the provider would ensure moving forward that communication is maintained as a priority.

Learning, continuous improvement and innovation

Although staff were committed to continually learning and improving services, they did not have a good understanding of quality improvement methods and the skills to use them. Leaders did not encourage innovation or participation in research.

Staff told us that they were invested in improving the service. However, there was limited innovation or service development, no obvious knowledge or use of improvement methodologies, and minimal evidence of learning and reflective practice. Plans to share good practice were still in development. The closure of the unit due to COVID-19 had meant that there had been little focus on continuous improvement and innovation. Senior leaders spoke of plans that they had for the unit but were unable to demonstrate any tangible plans to support this.