

Hope House Children's Hospice





Quality Report

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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	Good	
Are services safe?	Good	
Are services effective?	Good	
Are services caring?	Good	
Are services responsive?	Good	
Are services well-led?	Good	

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.

Summary of findings

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

Letter from the Chief Inspector of Hospitals

Hope House Children's Hospice is operated by Hope House Children's Hospices.

The service provides care for children and young people and their families who have life limiting conditions and may only expect to live until early adult hood (up to 25 years old). We inspected services for children and young people.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced visit on 28 January 2020 and announced on the 29 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.

Services we rate

Our rating of this service improved. We rated it as **Good** overall.

The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Staff treated children, young people and their families with exceptional kindness and compassion and ensured their privacy and dignity were maintained at all times. Children, young people and their families and were fully empowered as active partners in their care, practically and emotionally, by an exceptional and distinctive service. Staff provided an exceptionally high level of emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. Feedback from people who use the service, those who are close to them and stakeholders was continually extremely positive about the way staff treated them. People thought that staff went the extra mile and their care and support exceeded their expectations.

The service planned and provided exceptional care with excellent facilities in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. Children's and young people's care and support was planned proactively in partnership with them. Staff used innovative and individual ways of involving people so that they feel consulted, empowered, listened to and valued. For people in transition, specific support groups were available and in children's hospices, links were made to antenatal services to support families where unborn babies have life-limiting conditions. Patients could immediately access the specialist palliative care service when they needed it. The service ensured children and their parents did not have to wait for end

Summary of findings

of life care and ensured they achieved their preferred place of care and death. People were actively encouraged to give their views and raise concerns or complaints. The service saw concerns and complaints as part of driving improvement. People's feedback was valued and responses to the matters people raised were dealt with in an open, transparent and honest way. Investigations were comprehensive.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Heidi Smoult

Deputy Chief Inspector of Hospitals (Central Region)

Summary of findings

Our judgements about each of the main services

Service

**Hospice
services for
children**

Rating

Good



Summary of each main service

We rated this service as good overall. We rated as safe, effective, caring, responsive and well led as good.

Summary of findings

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Good 

Hope House Children's Hospice

Services we looked at

Hospice services for children

Summary of this inspection

Background to Hope House Children's Hospice

Hope House Children's Hospice is operated by Hope House Children's Hospices. The service opened in 1995. It is a charitable and NHS funded hospice near to Oswestry in Shropshire. The hospice primarily serves the communities of Shropshire, North and Mid Wales and Cheshire but accepts patient referrals from outside this area.

Hope House Hospice provides specialist care for support for children and young adults up to 25 years with a life limiting conditions. Care is provided both at the hospice and within the community such as their own home

The service has eight in-patient beds which provides end of life care including care after death symptom control and respite stays for babies, children, young people and their families,

Facilities within the hospice include: a hydrotherapy pool, sensory room, activity room with a separate area for study (which can be separated off when required), a young person's lounge, dining room, music therapy room, separate family accommodation which include one area which can accommodate the child or young person and their family, and three additional family/ parent bedrooms.

A bereavement suite known as the Snowflake Suite includes a special, chilled bedroom for a child or young person to lie after their death.

There are extensive accessible gardens which include a sensory area with specially chosen plants, large play areas, outdoor space accessed from each patient bedroom and a separate outside area from the 'Snowflake' suite, a small lake and a specially constructed 'farm' area with metal animals.

Most of the care and support is provided in the hospice. Care and support is provided within patient's homes and in hospital.

To support care in the community Hope House, have home care support nurses and workers, children specialist palliative care nurse, sibling support worker, transition nurse, neonatal nurse. In addition to nurses and health care support workers within the hospice a local GP practice provides medical care. The service also has an activity worker, counsellors which include bereavement counsellors, social workers, physiotherapists, an occupational therapist and a music therapist who provide care and support to children, young people and their loved ones.

The hospice provides telephone advice 24 hours a day seven days a week to families and healthcare professionals who may be either in the community or in hospital.

We inspected all services provided by the service.

The hospice has had a registered manager in post since 2017.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and a specialist advisor with expertise in palliative and end of life care. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

Information about Hope House Children's Hospice

Hope House Hospice is registered to provide the following regulated activities:

- Diagnostics and screening procedures.

- Treatment of disease, disorder or injury.

Summary of this inspection

During the inspection, we visited all areas within the hospice including the inpatient unit and spoke with staff providing specialist services:

The neonatal nurse who visits, supports and offers services the hospice may provide for women who are pregnant with a baby who is unlikely to survive and parents and their families who have experienced a neonatal death or a stillbirth.

The transition nurse provided support to prepare teenagers and young adults to transfer into adult services which may also include further education, employment and independent living.

The sibling support workers provided support and includes activities for sibling of children and young people who have life limiting conditions and also bereaved siblings.

The home care team which provide care to children, young people and their families with life limiting conditions, Care provided includes end of life and respite care within the community.

At the time of our inspection there were three children/young people within the inpatient unit and staff were arranging arrangements for admission of two other children.

During our inspection we spoke with 28 staff including registered nurses, health care assistants, allied health practitioners, the lead GP, catering staff, maintenance staff and senior managers. We spoke with four parents and observed staff interaction with children and young people and reviewed four sets of patient records. We attended one home visit, one multidisciplinary meeting within a school and attended the clinical governance meeting.

Before we inspected Hope House Children's Hospice, we reviewed information we held about the service and notifications we had. A notification is information concerning significant events which the service is required to notify us of. We also asked the service to complete a provider information request (PIR) before the inspection. This is a form which asks the service to supply key information about the service. We used this information to inform our planning.

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 October 2016, which found that the hospice was meeting all standards of quality and safety it was inspected against.

Activity (December 2018 to November 2019):

- In the reporting period. There were 415 admissions to the inpatient unit and 301 children, young people and their families received support in the community. The NHS currently provides approximately 15% of funding towards care provided, the remainder 85% is provided by the charity through fundraising.
- In December 2019, 152.5 hours of care were provided to the community.

The hospice had a contract with a local GP practice which provided daily visits Monday to Friday within normal working hours. The contract with the GP practice included additional arrangements for medical end of life care which may require additional visits out of usual working hours. Outside normal working hours medical advice was sought from the NHS 111 service. If it was an emergency staff call 999. The hospice employed 29 registered nurses, three physiotherapists, one occupational therapist, one pharmacy technician, one activity therapist, two social workers, three counsellors, 21 health care support workers and other staff which includes housekeeping, catering, maintenance, fundraising, managers and administration staff as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager. In total the charity employs 241 members of staff across both hospices, fundraising and retail operations.

There have been two independent reviews of the hospice in the previous 12 months:

- A critical friend review in June 2019 and an independent infection control review in March 2019.

Track record on safety:

- Zero Never events
- There had been two serious incidents reported between January 2019 and December 2019 both were identified as no harm.
- There had been no reported cases of MRSA, MSSA, E coli or Clostridium difficile in the previous 12 months at the hospice.

Summary of this inspection

- Two complaints.

Services provided at the hospice under service level agreement:

- Clinical waste removal.
- Interpreting services.
- Pharmacy.
- Grounds Maintenance.
- Maintenance of medical equipment.
- Pathology and histology.
- GP provision.

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	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Hospice services for children

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

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 there were systems in place to make sure everyone completed it.

All staff and volunteers received a structured induction programme when they started work for the service. The induction programme included both organisational requirements and mandatory training.

Hope House Hospice required all staff to complete mandatory training in a range of topics. Topics were identified separately for clinical and non-clinical staff and included fire safety (85%), health and safety, (94%) moving and handling (93%), professional boundaries (92%), General Data Protection Regulation (GDPR) (96%) and infection prevention and control (100%). The organisations target for compliance with mandatory training was 90%. The manager told us the ambition for the service was for 100%, however they recognised some staff may be on maternity or sick leave. The 90% target reflected this and they expected staff to undertake the training within six months of returning back to work, particularly as some of the training was provided by external trainers.

There was a three year programme of mandatory training (identified in January 2019) which included both initial training and ongoing updates. The hospice had planned dates for closure in January and June for five days and

September for three days to enable all staff to undertake mandatory and statutory training. The hospice had been closed the week before our inspection for training. Staff we spoke with spoke positively about the training they had.

All staff received training in first aid. All registered clinical staff received paediatric life support training and all healthcare support workers received basic life support which included identification and management of sepsis, anaphylaxis, choking and use of the defibrillator. This training was face to face and was provided by resuscitation trainers from a local NHS trust.

All clinical staff received training to make them aware of the potential needs of children and young people which included autism, behaviour management and suicide awareness.

The hospice human resources team had a central database which recorded the dates of all staff mandatory training and identified when trained required updating. Managers received monthly updates and were aware when training was required to enable them to book the training.

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 up to date arrangements in place to protect patients from avoidable harm. Hope House Hospice had policies for safeguarding of adults at risk dated February 2018 and children's safeguarding policy dated May 2018 (for review May 2021), a revised draft policy had been to

Hospice services for children

the January 2020 clinical governance meeting and this was also shared with us. Safeguarding policies identified both safeguarding procedures for England and Wales (as the service covered both).

Staff we spoke with knew where to locate the safeguarding policies and correctly described the principles and processes they would follow if they had any concerns or if they suspected abuse.

Staff and managers, we spoke with were also able to provide examples of when they had raised a safeguarding concern and told us they felt confident in the process and the way in which concerns were managed.

Safeguarding leads for both children and adults were in place. Safeguarding leads had received level three training and received additional designated safeguarding lead training which was updated every two years. The safeguarding leads received clinical supervision and advice from the local authorities. Staff told us safeguarding concerns were discussed during team meetings, multidisciplinary meetings and case reviews to ensure best practice was identified and if any improvements were required.

Staff told us safeguarding concerns would be raised with the safeguarding leads. When required, referrals to social services or the police were managed in accordance with the Hope House Hospice policy and recorded as an incident. Staff were able to name the safeguarding leads and tell us where and how they could contact them.

The service had systems in place to check whether children or young people were subject to a child protection plan. The initial referral form to the hospice asked if a social worker was involved with the child and the family and their contact details. A social worker from the hospice attended where possible the initial care plan meeting to ascertain if there were any safeguarding concerns, any children on a child protection plan were discussed during weekly multidisciplinary meetings. The hospice social workers then liaised with the families social worker. All care records had social communication paperwork and staff recorded each visits any concerns or updates. The service maintained a secure electronic record of all children who were on a child protection plan. This information was available to senior nurses and social workers.

Hope House Children's Hospices follows the Care Quality Commission Safeguarding Children document and requirements of the intercollegiate document Safeguarding children and young people, 2019. To enable staff to effectively safeguard, protect and promote the welfare of children and young people. The competencies included a combination of skills, knowledge, attitudes and values that were required for safe and effective practice. The service policy for safeguarding training identified the following requirements:

- Level 1: All non-clinical staff working in health care settings.
- Level 2: All non-clinical and clinical staff who have any contact with children, young people and/or parents/ carers.
- Level 3: All clinical staff working with children, young people and/or their parents/ carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.

Information provided showed 100% of staff had received required safeguarding training (either level 1, 2 or 3 dependant in their role). Information we received identified hospitality staff were only required to receive level 1 safeguarding adults and children but as part of the training session undertaken had joined clinical staff for this training and 78% of hospitality staff had subsequently received safeguarding adults and children level 3. Safeguarding training included modern slavery, child sexual exploitation, gang culture, honour-based violence, forced marriage, female genital mutilation and domestic abuse

There had been no serious safeguarding child reviews about children or young people associated with Hope House Hospice. The safeguarding leads attended child death reviews which reviewed every child death with the local authority and identified learning which was shared with staff within the hospice when needed. Hope House Hospice had three monthly safeguarding steering group meetings which were chaired by a trustee who had extensive experience of children's service. The steering group reviewed all children's safeguarding referrals and children who were subject to a child protection plans. In addition, we observed safeguarding incidents were discussed during the clinical governance meeting.

Hospice services for children

Staff received training in the Prevent strategy which raised staff awareness of radicalisation and had commenced at the time of the inspection, 93% of staff had undertaken this training. Hope House Hospice selected staff and volunteers through a robust recruitment process. All staff and volunteers had a Disclosure and Barring (DBS) check and required checks to ensure appropriate people were employed. People who were not directly employed by the hospice were supervised at all time. The hospice had requested a record of the disclosure and barring check for all contractors. Nurses professional registration was confirmed and ongoing checks of renewal of registration was undertaken with the regulatory body (Nursing and Midwifery Council).

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 service performed well for cleanliness. Housekeeping staff kept the premises clean and there were schedules and checking systems in place to ensure all areas were cleaned as indicated in the schedule. There were facilities to support good infection prevention control in all patient rooms, communal rooms and in the corridors and clinic rooms. The hospice was visibly clean.

Furniture, furnishing and equipment were easily cleanable. We saw 'I am clean stickers' which confirmed equipment had been cleaned before patient use. Patient rooms were deep cleaned between patients, which included equipment, furniture and the room. Clinical and domestic staff confirmed when cleaning had completed.

Hand gel dispensers were available throughout patient areas and in the reception area where visitors and staff signed in. Information was available which highlighted the need to use hand gels and hand washing. In the community staff used hand gels. The organisation identified a need for all staff to receive annual hand hygiene training which included a hand hygiene assessment. Staff hand washing checks were undertaken annually, 55 out of 59 staff (93%) had been assessed.

All clinical staff were observed to be bare below the elbows as outlined in the infection prevention control policy. All staff were observed using appropriate protective equipment such as gloves and aprons to carry out procedures and personal care activities.

The service had an annual external infection control audit. Data provided for the latest audit, undertaken in March 2019, demonstrated 91% compliance. The report identified areas of immediate risk which required to be addressed with immediate effect, high risk which should be addressed within one month and medium risk which required to be addressed within three months. An action plan to address areas of non-compliance was implemented. For example, there was an action to ensure cluttered storage cupboards were tidied and equipment boxes were stored off the floor and baths were dried after use to ensure puddles of water did not remain. The audit findings were presented to the board, with three monthly updates to the Clinical Governance Committee. We saw one outcome of the audit was a need to ensure staff received ongoing checks of their vaccination status.

Hope House Hospice had two infection control link nurses who had both attended additional infection control training. The infection control link nurses each had one allocated day each month to undertake infection control tasks. Their tasks included infection control audits such as personal protection equipment (PPE) boxes which were used outside the hospice, checks of cleanliness of the service vehicles and hand washing assessments. We saw when audits had been completed they identified actions which had been shared with staff and addressed. The hospitality manager had also completed the same training as the link nurses. Infection control link staff attended health and safety meetings. There was a service level agreement in place with an external infection control expert who provided training, completed annual audits, provided telephone and email advice. They had ratified the hospice infection control policy and ensured the service were up to date with any changes in infection control and prevention practice. The infection control links also attending the 'Together for Short Lives' infection control group for children's hospices. The service had a plan to have infection control meetings with the first meeting arranged for March 2020.

Hospice services for children

The service had recently had an outbreak of norovirus. They sought advice from public health who advised them of actions to take and provided them with a 'tool kit' to help them. The service had no other infection outbreaks.

There had been no reported cases of MRSA, MSSA, E coli or Clostridium difficile in the previous 12 months at the hospice.

The service had a legionella certificate (dated July 2019) and appropriate arrangements in place to check water temperatures to identify further potential legionella risk.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff had appropriate training to use the equipment. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. Staff call bells were available throughout patient areas and when they were rung by children, young adults or their loved ones they were quickly answered by staff. The design of the environment followed national guidance. The hospice has been built 27 years ago and was designed around the needs of children and young adults. The building was secure and was well maintained by dedicated maintenance staff.

Staff carried out daily safety checks of specialist equipment. The service had a housekeeping and maintenance team responsible for the building and grounds. We saw staff carried out daily checks of specialist equipment such as hoist, hoist batteries, and pressure relieving mattresses. The hydrotherapy pool water for the appropriate amount of chemicals to keep it clean was checked twice daily by staff. There was a programme of both routine and responsive maintenance. Any day to day maintenance requirements were identified within a maintenance book which was checked daily by maintenance staff. A record was made of any actions undertaken including if contractors had been booked when the fault had been addressed.

The service had suitable facilities to meet the needs of patients' families. The hospice environment was safe for the children, young adults and their siblings. All patient

bedrooms were on the ground floor with a patio door opening onto secure, and accessible gardens. Toys and equipment were regularly checked for damage that may represent a potential choking hazard.

The service had its own vehicles which could be used by staff to transport children and families. All vehicles had a log which identified which staff member had used it and recorded it was checked before and after use. Regular maintenance and servicing records were maintained.

The environment had been planned to ensure it was suitable for children and young people with sensory, behavioural and mental health needs. Communal rooms and corridors were spacious which provided suitable wheelchair access and were well lit with both natural and artificial light.

Following refurbishment (which included removal of carpets) the dining room had been identified

as noisy which was a distraction and a challenge for some children with autism and neurological problems. As a result, special boards had been added to reduce noise. There was a special sensory room which provided relaxing light and sounds which provided relaxation for children and young adults when required.

Resuscitation equipment which included defibrillators, suction equipment, oxygen, breathing tubes and masks were provided for all age ranges. We saw staff fully checked resuscitation equipment weekly (if it had not been used) and then tagged the equipment to confirm it had been checked and recorded the tag number. Staff checked the tag was intact daily and who it had been checked by this ensured equipment was available and fit for purpose.

The service had enough suitable equipment to help them to safely care for patients. Hope House Hospice used regular and approved contractors for identified equipment for example, the fire alarm, system, fire extinguishers, the boiler, electronic doors and air conditioning system. The health and safety manager confirmed they requested proof of liability insurance from contractors and contractors were supervised at all times.

Hospice services for children

There were suitable arrangements to promote the security of patients and staff. The building was secure, and access was restricted with the use of staff (and some younger adults when risk assessed) electronic keys. All visitors signed in at main reception.

Clinical waste disposal arrangements were in place throughout the hospice. People could access waste bins which were clearly labelled, for example, clinical waste only or domestic waste only. Bins were lidded and operated with a foot-pedal to prevent hand contamination. We looked at sharps bins and saw that staff observed good practice while disposing of sharps.

Assessing and responding to patient risk

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

Information about children and young people care needs and identified risks and actions to reduce risks was requested and available before their first and then subsequent stays at the hospice.

Staff carried out a holistic assessment which included physical and psychological needs and risk assessments on admission for each child or young person. Each child and young person then received a full daily review. Identification of increased risks (including concerns about the child's or young person health).

The service had a detailed plan of care which identified each child or young persons 'normal' baseline observations and actions which should be undertaken if they were unwell or had a relapse of their condition such as an epileptic fit or increased breathing difficulties. The plan of care also identified behaviour that may challenge, and we saw strategies were identified to manage and reduce this behaviour.

Children and young people's care plan identified children who were at increased risk. We saw risk assessments were in place for (such as bedrail risk assessments, moving and handling risk assessments, travel in the minibus, pressure ulcers and aqua therapy and were comprehensively completed and when needed reviewed.

There were systems in place to identify and highlight infection and when children and young people were unwell. We saw staff escalated concerns to ensure the child or young people received timely treatment to reduce the risk of further complications. The service had purchased a machine to effectively identify the early presence of inflammation which demonstrated when an infection was present and when antibiotics were required. We saw this used during the inspection.

There was information displayed in the staff office raising staff awareness of sepsis. The Head of Care told us the service monitored all children and young people for signs of sepsis and were currently developing a sepsis tool which could be used for children in hospices. The service had 85% of staff who have received training in sepsis.

Staff managed emergencies in line with policy and procedures. Any concerns about their health were escalated to the GP for the hospice during the working week, the 111 service out of hours or as a 999 emergency. A multi-professional review of children and young people's risks and needs was undertaken weekly. We saw care records prominently identified key safety issues for individual patients such as allergies, choking and breathing risk. This meant accessible information was available for staff to keep each patient safe. On every occasion, an incident report was completed and was documented in the patient notes. Between 1 January 2019 and 31 December 2019, five children or young people were transferred from the inpatient unit to the local NHS hospital for assessment of acute symptoms.

Children and young people who were in the last days of life were reviewed by a doctor at least once daily. We spoke to the GP who had the role as medical officer. They told us they visited end of life patients seven days a week, if they were not available for example on annual leave another GP from the same practice would visit. Arrangements were also in place for a doctor from the 111 service to visit if required. Children and young people deaths were always certified by a doctor, although registered nurses had also received training to certify death.

Shift changes and handovers included all necessary key information to keep patients safe. There were twice daily handovers. We observed the day to night handover we observed handover information sheets were used by the team leader to ensure all information was handed over.

Hospice services for children

We found the handover was structured, detailed and identified key information such as current health needs and treatment, whether they required active resuscitation and identified allergies. We observed the handover included not only the children and young people who were in patient but also updated staff about potential patients who were not in the hospice. This meant staff could be prepared and aware if parents rang them in distress if their child condition had changed and required advice or reassurance.

Staffing

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

The service had enough staff and support staff to keep patients safe. Information provided by the service identified at the time of our inspection there were: 29 registered nurses, 21 health care support workers, three physiotherapists, one occupational therapist, one pharmacy technician, one activities coordinator, two social workers, 11 hospitality staff, two maintenance staff and three administration staff in post. Registered nurses included a clinical nurse specialist, neonatal nurse, transitions nurse, coordinators of care and clinical practice educator.

The service did not employ any doctors but had a service level agreement in place with a local GP practice to provide daily routine weekday visits to review children and a symptom management clinic one day a week.

Staffing levels were determined following an assessment of each individual child or young person's needs. The head of care and care co-ordinators accurately calculated and reviewed the number and grade of nurses and healthcare support workers needed for each shift in accordance with national guidance. During this the inspection we saw this had been actioned when a child's needs had changed, and they required additional support of a second nurse.

The minimum staffing levels were two registered nurses and five healthcare workers on each day shift when all seven beds were occupied and two registered nurses and

one healthcare support worker on night shifts. There was a registered sick children's nurse on every shift. Rotas were planned and staffing numbers were sufficient to meet patients' needs

The service provided both inpatient and community care to children young people. Staff 'flexed' between the inpatient unit and community to responded to children and young people children's increasing dependency and complexity of needs and where the service was required. The service had identified 'a pyramid of care' which identified priorities for treatment with highest priority being end of life care and safety of the child or young person and lesser priority routine respite care. The pyramid of care prioritises end of life care and crisis care due to a deterioration in a child's condition. We saw the numbers on duty accurately reflected requirements.

The service identified that workforce planning was continually evolving as they developed and enhanced service provision. Each year a formal budget plan considered staffing levels in terms of patient safety, capability and capacity, location, service requirements which included annual leave, some sickness short and long term, time for training and development and organisational development initiatives. Line managers were involved in developing the budget process which was then assessed by the director of care, leadership team and the trustees as the financial budget was agreed and signed off. The head of care and director of care reviewed staffing requirements monthly and when required additional staffing was made available.

Information provided before our inspection identified between January 2019 and December 2019, 14 staff had started working for Hope House Children's Hospice and 20 staff had left the service's employment. The registered manager told us they had difficulties recruiting new staff and particularly registered sick children's nurses. As a result of this they had reduced the overall bed capacity (this was for both the inpatient unit and community care).

The service had low sickness rates: 3% sickness rate for registered nurses and allied health professionals and a 2% sickness rate for healthcare support workers.

Gaps in duty rotas were mostly filled by substantive staff working additional hours with some bank staff, the service did not use agency staff.

Hospice services for children

Managers made sure all bank staff had a full induction and understood the service. Hope House Children's Hospice operated its own bank and had a bank worker policy which set out staff requirements. All bank workers received an orientation to the service and were also required to complete statutory and mandatory e-learning modules, moving and handling training and attend the service induction.

There were over 600 volunteers who worked throughout Hope House Children's Hospice within retail outlets, hospitality, the inpatient unit and fund raising. Five volunteers were trained to provide caring support. Volunteers were supported in being competent in their role and received training appropriate to their role. A new head of human resources and volunteering had been employed, following the retirement of their predecessor in 2019, to oversee arrangements for volunteers.

Records

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

At the last inspection we found patient records were not always sufficiently detailed or fully reviewed to reflect the individual needs of children and young people. During this inspection we found children and young people's care records were child or young person centred and were comprehensive and could be easily navigated. Care records were fully reviewed against each area of the child or young person's need at least twice a day. The service used paper patient records. We reviewed four sets of patient records and each contained all the appropriate information.

Records were securely stored and could only be accessed by those who had authority to do so.

Before the child or young person's admission (both initial and subsequent admissions) information was requested from their doctor, consultants and other health professionals such as dietitians and speech and language therapists involved in their care. This meant they had up to date information about the child or young person and their needs and treatment requirements. When patients transferred to a new team, there were no delays in staff accessing their records.

On discharge from the service (either as an inpatient of from community services), all patients were provided with a discharge summary for their GP. Copies of the discharge summary were also sent to other key clinicians for example their oncologist.

Ten patient records were audited monthly. The audit included a review of all care records such as; medicines records, care records, risk assessments and if they included the patient's name and date of birth on each page. Any omissions were discussed with staff and then any lessons were shared across the team.

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.

Medicines and medicines related stationery were managed well. 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 were safe, secure and appropriate storage arrangements for medicines including intravenous fluids and medicines which needed to be stored at identified temperatures. Access to rooms, cupboards and the fridge where medicines were stored was restricted with key pad access to both the medicines room and cupboards where medicines were stored with only appropriate staff having the keypad code.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We checked patient records and prescription charts for six patients. We saw appropriate arrangements were in place to prescribe and record administration of patient medicines including a reason if medicines were not administered. The child or young person weight was recorded and was checked at each admission and reviewed at least weekly. This ensured staff were aware of safe dose of the medicine to be administered.

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All allergies were recorded on the main care plan and prescription charts for all patients. We saw some children had numerous medicine and other allergies. We saw staff highlighted information about medicine and other allergies during staff handovers.

A pharmacist technician was employed 30 hours per week and there was a service level agreement in place with a local NHS trust to provide a weekly visit and review patients medicines and medicine arrangements.

There were appropriate processes for medicines reconciliation when patients were admitted. The pharmacy technician requested up to date information about children's and young people's medicines which were currently prescribed from their GP and consultant before they were admitted. Nursing staff checked and recorded all medicines received against the information provided about the child or young person's medicines. The accuracy and dosage were also checked by the pharmacy technician. The reconciliation was then further checked by the pharmacist at their next visit.

The pharmacy technician shared medicine alerts throughout the service to ensure staff were aware of any updated safety and other information

At the time of the inspection the service did not have any non-medical prescribers. However, the clinical nurse specialist was undertaken a prescribing course with support from the local GP practice.

Staff dispensing medicines undertook competencies in medicines' management which included the safe administration of medicines and included medicine calculations, route of administration and observation of administration of medicines and arrangements for destruction of medicines including nebulisers and syringe drivers. Assessment processes were robust and demonstrated their competence and knowledge.

There was a controlled drugs accountable officer for the service to ensure safe management. Controlled drugs are medicines which require additional arrangements for their storage and administration under the Misuse of Drugs legislation (and subsequent amendments). We observed robust controlled drugs checks were in place, with checks undertaken and recorded at each staff handover. This meant there was a system in place to keep people safe.

There were appropriate systems were in place for ensuring that patients and other healthcare professionals who would be looking after them, had suitable information about their medicines on discharge from the inpatient unit to support their ongoing care.

There was a medicines management committee in place which met every three months and discussed medicines arrangements, medicines incidents and any required changes in practice and any necessary actions identified. The pharmacist and pharmacy technician attended the internal monthly medicines management group meeting. Information from the medicines management meeting was shared with the clinical governance committee.

The service had 43 medicine incidents reported between January 2019 and December 2019. Forty one incidents were identified as low harm, two incidents were moderate harm. We saw there were appropriate action put in place and shared with the team following these incidents. Senior managers reviewed the numbers and trends of incidents. We saw all medicines' incidents were reviewed by managers and the clinical governance committee meetings.

The service had systems to ensure staff were made aware about safety alerts and incidents, so patients received their medicines safely. Any alerts relating to medicine incidents, themes and trends were circulated across all service leads to ensure safe practice

The Accountable Officer for controlled drugs (CDs) completed quarterly CD audits, along with CD incidents these were discussed internally at the medicines management group and were also reported to the local controlled drug local intelligence network (CDLiN).

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.

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Staff knew what incidents to report and how to report them. Staff reported all incidents they should report. We were not aware of any incidents which were not reported when they should have been.

The service used a paper based incident reporting system. The incident would be investigated by an appropriate senior manager. Staff we spoke with were confident about the process and said they received feedback about incidents reported.

Staff reported serious incidents in line with policy. There had been two serious incidents reported between January 2019 and December 2019 both were identified as no harm. The incidents related to a hoist for the hydrotherapy pool and an oxygen delivery device which had been incorrectly set up. We reviewed the incidents and found appropriate actions had been undertaken to reduce the risk of subsequent similar incidents.

During the same period no deaths were referred to the coroner. All child deaths throughout the region were reviewed by the child death panel which Hope House attended. If there were any suspicious circumstances any child or young person death would then be referred to the coroner if required.

There had not been any never events from January 2019 to December 2019. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

The duty of candour is a statutory (legal) duty to be honest with patients or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. There was an operational duty of candour policy to support and guide managers in decision making regarding the implementation of duty of candour.

Staff were required to be open and honest and had received training about duty of candour policy. Staff understood the duty of candour. Families were informed and kept up to date of any incidents or accidents that had occurred including medicine management. The service was open and transparent and gave families a full explanation when things went wrong. All incidents, accidents and complaints were reviewed at clinical

governance and the procedures and outcomes reviewed including duty of candour. From January 2019 to December 2019 the duty of candour had been applied in relation to 55 incidents.

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. Policies and procedures were readily available for all staff on the intranet and could be accessed easily. Policies appropriately referenced current good practice and national guidelines from organisations such as the National Institute for Health and Care Excellence (NICE) and Royal Colleges.

The hospice had a clinical policies panel which met a minimum of four times a year to review and update policies. The director of care had overall responsibility for ensuring the policies and procedures were kept up to date and in line with national guidance. All policies were in date and version controlled so that staff were assured that they were using the most up to date version.

The service had an annual audit schedule in place that included records, medicines use, review of transfer arrangements for children who had been sent to hospital in an emergency, oral care assessments, non-invasive ventilation use and infection prevention control. The audit schedule was updated to implement follow up audits where needed or for new audits which were implemented when required such as the completion and availability of records when a child was transferred to hospital in an emergency.

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The results of audits and reviews were reported within six monthly reports which were shared with local Clinical commissioning group and the clinical governance committee. Audit results were shared with staff by email and at team meetings. All on-going work, recommendations from the audits and updates were incorporated into any action plans and monitored by the clinical governance committee.

Families were supported in developing advanced care plans for children and young people with life limiting conditions. Children, young people and their families could communicate their health care wishes so that these could be followed when a child or young person's condition deteriorated. A framework was provided for discussing and documenting the agreed wishes of a child or young person and their parents when the child or young person developed potentially life-threatening complications of their condition. The service used the Recommended summary Plan for Emergency Care and Treatment (ReSPECT), which included decisions concerning resuscitation. Staff worked collaboratively with other professionals to ensure that the holistic and clinical needs of the child or young person and their family were met. Records we reviewed demonstrated that advanced care plans contained information about a child or young person's wishes. During our inspection we saw that young people's views were clearly considered and acted upon.

The service had participated in an audit of all advanced care plans of children who had received end of life care completed in conjunction with the palliative steering group in Shropshire (the results of the audit were not available at the time of the inspection).

The service worked with other children's hospice as part of West Midlands Paediatric Care Network to highlight good practice and develop bench marking and patient outcome tools which may be used to identify further developments in care within children's hospices.

The service were members of Hospice UK and received weekly communication and updates, related to best practice.

Staff protected the rights of children and young people subject to the Mental Health Act and followed the Code of Practice. Children's mental health, physical and social

needs were holistically assessed. Support was delivered in accordance with legislation, standards and evidence-based guidance, including NICE and other expert professional bodies.

When children or young people were accepted to the service the child and family's holistic needs were assessed to ensure services were tailored to meet their individual needs. If it was identified the child needed clinical care provided either in the inpatient unit or through community services. A care plan was completed with the family prior to care being delivered. We saw care plans were reviewed regularly and were updated to reflect changes in condition.

At handover meetings, staff routinely referred to the psychological and emotional needs of children, young people and their families. We saw the psychological and emotional needs were also discussed thoroughly at multidisciplinary meetings.

Nutrition and hydration

Staff gave patients 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 and young people's religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

The hospice had a fully equipped onsite kitchen with appropriately qualified catering staff who provided a choice of home cooked nutritious food to meet all individual needs which included cultural and religious in addition to likes and dislikes and specialised diets of children and young people. Three cooked meals a day were available and hot and cold drinks offered at regular intervals and on request.

Each child and young person had a detailed care plan with specific details on dietary feeding and hydration requirements. Allergies were recorded in the child or young person's care plan and communicated to the kitchen staff by the nursing staff and added to the daily menu request. There was a list of allergens displayed at mealtimes which enabled staff, family members and visitors to avoid foods if indicated. We saw menus were

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displayed a week in advance. Nutritional menus met individual dietary needs and was identified by the dietary needs group. The group comprised of care and hospitality staff and was led by the hospitality manager.

Jugs with a choice of cold drinks and hot drinks were available. We observed staff asked children what they would like to drink, and drinks were kept close by to them at all times. We saw the children's drinks were regularly refreshed. A choice of cups, mugs, glasses, beakers, bottles and straws were available to suit individual needs and preferences.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Fluid balance and/or renal function was monitored when required. The hydration status of children and young people nearing end of life was assessed daily.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Before children or young people were admitted to the service staff requested a review by a dietitian and speech and language therapist. The review requested details about the child or young person's dietary intake needs any specialist dietary needs including total parenteral nutrition or gastrostomy feeding regimes (a feeding tube directly into their stomach following a surgical incision in their abdomen). Staff monitored the child or young person's nutritional intake against the identified guidelines. If staff had any concerns about nutritional intake they would seek further advice from a doctor and or dietitian.

Mealtimes were identified as social occasions and staff had their meals with children and young people in the dining room. Relatives were also encouraged to eat in the dining room with their children and could order food and had access to free beverages.

Pain relief

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

Staff discussed pain and how children and young people (if they were unable to communicate verbally) may show signs of pain with their parents and carers this

information was included within their plan of care. Children and young people's pain was assessed and managed using recognised pain assessment tools. We saw pain levels were regularly assessed using a pain assessment tool which was in picture format and consisted of five faces representing different stages of comfort and happiness. This tool was also suitable for patients with a learning disability. Other recognised tools were used to help identify distress cues in children and young people who because of age, cognitive impairment, or physical illness, had limited communication.

Staff followed the (NICE) Quality Standard NG61. This quality standard defines clinical best practice for end of life care which includes the prescribing of strong opioids for pain in palliative care for infants, children and young people with life-limiting conditions up to and including the age of 17 years.

Children and young people had been prescribed pain relief medication as and when required (PRN) so that breakthrough pain could be managed. The service used different routes to administer pain relief dependent on the child or young person's needs such as orally or via feeding tubes, pain relieving patches applied to the skin. Staff confirmed syringe pumps were accessible if a patient was receiving end of life care and required subcutaneous medication for pain relief. Breakthrough pain can occur in between regular, planned pain relief.

Staff prescribed, administered and recorded pain relief accurately. The service had processes in place to ensure the accurate prescription, administration and recording of pain relief. Nursing staff double checked medicines and controlled drugs to ensure safe and accurate administration.

The hospice had weekly symptom control clinics with a doctor and clinical nurse specialist when the child or young person's pain relief would also be reviewed.

Patient outcomes

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

There was a clear approach to monitoring, auditing and benchmarking the quality of the services and outcomes for children and young people receiving care and

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treatment. The service participated in clinical audits. The hospice had an annual audit plan which included national audits for West Midlands Paediatric Palliative Care Committee (WMPPC) and Shropshire area steering group. Any changes from the audit plan were reported to be due to operational issues, workload and staffing issues.

There were no national audits which related specifically to specialist paediatric palliative care. The service was working with other children's hospices within the West Midlands to identify possible audits and how benchmarking could be undertaken

Managers and staff carried out a programme of repeated audits to check improvement over time. The audit schedule included hand washing audits, oral care assessments, medicines management, documentation, transfer of children in an emergency and application of national guidance. The audit plan was updated to implement follow up audits where needed or to review new processes. Managers used information from the audits to improve care and treatment. Improvement was checked and monitored. Action plans were in place and were monitored through clinical governance meetings. Medication audits were undertaken every quarter by an independent pharmacist and included storage, administration and management of controlled drugs.

Managers shared and made sure staff understood information from the audits. Staff told us about audits that were undertaken and action plans that were in place. For example, action plans were in place to improve the completion of the transfer document. Feedback was shared with staff at team meetings, through newsletters and emails. Audit results were also discussed at clinical governance and senior management team meetings. Minutes of meetings confirmed this.

Outcomes for children and young people were positive, consistent and met expectations, such as national standards. All children and young people had an individualised care plan in place, that set out their advance care preferences. It covered activities of daily living, family and carer support, infection control, mental capacity, tissue viability, advance care planning and symptom management. There was provision for recording preferred place of care and death within records. The records were regularly reviewed and audited.

Senior managers told us they were not required to provide quality patient outcomes measures to commissioning groups. A report was provided to the clinical commissioning groups about the number of children who had received care and were either new referrals or ongoing patients, age and gender, the total number of hours of care provided and the number of cancellations and number who had received end of life care four times a year. Initial data indicated that 85% of referrals had achieved positive outcomes for the four key areas. No information was provided about any delays to admissions due to late referrals.

Competent staff

The service made sure staff were competent for their roles. The continuing development of the staff's skills, competence and knowledge was recognised as being integral to ensuring high-quality care. Staff were proactively supported and encouraged to acquire new skills and share best practice. Volunteers were supported in their role.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families. Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families. A registered children's nurse was always on duty along with registered nurses with end of life and palliative care experience. We reviewed five staff files and found they contained relevant information to demonstrate staff suitability and competence for their roles and included references, full employment history, evidence of qualifications and professional registration, where applicable.

Each role had a six-month probation period, so performance could be assessed during this time.

Managers gave all new staff a full induction tailored to their role before they started work. Upon commencing employment staff attended a company induction and departmental inductions aligned to skills and competency assessments and all required mandatory and statutory training. Completion rates are regularly monitored, and data is shared with line managers.

Managers checked qualified staff had professional registration and we saw 100% of eligible staff had

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completed revalidation with their professional body. All new staff received a period of preceptorship the duration of which varied depending upon their previous experience.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. The service had:

- Four paediatric nurses who had completed palliative care degree modules.
- One nurse had completed a neonatal palliative care module.
- The service had three nurses with a BSc in palliative care.
- Two capacity assessors (one nurse and one social worker).
- One nurse clinical nursing studies palliative care.
- Three nurses key studies on end of life care.
- Principles in end of life care one nurse five health care support workers.
- Ten nurses had palliative care training.

Managers actively encouraged staff to maintain their continued professional development through attendance at internal and external study days, Staff were encouraged to attend regional and national conferences and feedback learning to teams. A monthly journal club was held to discuss research and best practice and held spotlight sessions which were focused update sessions.

A clinical practice educator supported the learning and development needs of health care support workers. The clinical nurse specialist supported training and development of qualified nurses. The clinical educators worked with staff individually and in groups to support and develop practice. supported the learning and development needs of staff. In addition, short clinical training sessions were available with the clinical nurse specialist.

The service was in the process of advertising for trainee nursing associates (TNA) who were to be integrated into the workforce once their training was complete.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff received annual performance appraisals as a formal way of managing skills, competencies and their development for the future. Objectives were set and reviewed twice

annually through the appraisal programme. Any staff skill gaps were identified through appraisals with training and supervision offered to ensure that staff can effectively meet the patient's' needs.

Appraisal compliance was 100% with delivery of staff appraisals ongoing. We saw the service had a data base which identified when appraisals were due and when applicable the reasons if they had not such as maternity leave.

Managers supported staff to develop through regular, constructive clinical supervision of their work. Staff received regular supervision from team leaders plus opportunities for formal clinical supervision and support as required. Clinical supervision is a formal process of professional support and learning that addresses practitioners' developmental needs in a non-judgemental way. Its aim is to help them increase both their competence and confidence through exchanges with experienced professionals and the use of reflective skills. Staff were offered regular debriefs (group or one to one) following incidents, safeguarding concerns and deaths. Staff told us that they received monthly clinical supervision. Peer supervision sessions also took place during team meetings and to review individual cases. Staff also had open access to staff support counsellors both face to face and over the telephone, and regular safeguarding supervision.

Staff competencies were in place and staff were assessed against these competencies. Health care support workers followed a competency training plan using national online modules and in house training to ensure they had appropriate skills, knowledge and understanding to meet children and young people's needs. Health care support workers were assessed as competent by the clinical practice educator.

The service had introduced self-assessments for nurses to identify their perceived level of competency. Nurses were then supported and then assessed to ensure they met the required level of competency. Staff had training which included both online training modules and face to face training and a review of identified competencies annually. We saw competencies had been developed to cover a broad range of clinical areas including enteral feeding through a gastrostomy tube (a tube inserted

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through the abdomen that delivers nutrition directly to the stomach), medicines management including the use of nebulisers, oral suction, tracheostomy care and non-invasive ventilation.

Staff told us they were supported and received additional training if they hadn't cared for a patient condition such as a tracheostomy for some time. This ensured they maintained appropriate competencies to ensure they could safely care for patients. All staff were colour coded into red, amber and green depending on their level of competence to ensure they received support and required training to meet the needs of the children and young people.

Managers made sure staff received any specialist training for their role. The service had an annual learning and development budget for individuals to access role specific learning and development. This was based on organisational, professional and individual requirements and learning needs were agreed through discussions with staff at appraisals and one to ones. Every member of staff we spoke with told us their training was supported by the organisation. Staff said as long as they could demonstrate how the training course or conference would benefit children young people or their families it would be funded. Information provided by the service identified between 1 January 2019 and December 2019 training that had been fully funded (course fees and time away from the service) by Hope House Children's Hospice included:

Physiotherapists

- One physiotherapist funded for a post graduate diploma in palliative care, two physiotherapists completed manual handling train the trainer course and had also completed neuro-disability foundation course.

Occupational Therapists

- One occupational therapist had completed the Special Education Needs and Disabilities course and a course in management in behaviour that challenged,

Nurses

- One nurse had undertaken a mental health first aid course
- Six nurses had attended end of life and palliative care courses.
- Two nurses had attended children and grief - 2.

- End of life /palliative care - 6.
- Two nurses had attended infection prevention (plus hospitality manager).
- The neonatal nurse had attended a neonatal update for neonatal champion and the neonatal link nurse had undertaken pregnancy and loss.
- The practice educator had undertaken an 'Educator' module.
- Three nurses had undertaken a MSc Palliative care and symptom management module.
- The clinical nurse specialist had undertaken the Nurse prescribing course.
- Four nurses had undertaken the RESPECT training.
- One nurse had undertaken palliative care degree module.
- Difficult conversations - two staff.
- End of life and palliative care three staff - 3.
- Challenging behaviour - two staff.
- Makaton (trainer level) - one staff member.

In addition, the following training was booked for staff to attend:

- Six nurses to attend palliative care training.
- One nurse an oncology update.
- The activities lead Makaton training.

Managers identified poor staff performance promptly and supported staff to improve. The service had a performance management policy and processes were used when any under performance was identified. Support was then given to the staff member, to meet the required standards, using an improvement plan.

The service recruited, trained and supported volunteers to support patients in the service. As with clinical staff, each volunteer underwent a formal induction and received training required to undertake the role they had volunteered to undertake.

Training on specialist equipment was provided through both on-line training programmes and relevant experts. Individualised training also provided for individual care needs for example the new machine to check for inflammation and the need for antibiotics, specialist beds, pulmonary dialysis.

Staff attended peer group meetings with other children's hospices within the West Midlands Paediatric Palliative

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Care Network, this ensured staff were kept up to date with developments within children and young people's hospices and children and young people's end of life care..

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. Staff held two weekly panel meetings which included the director of care, head of care, head of community care, the medical officer, sibling support coordinator and family team workers. Referrals to the service, case presentations, support plans and engagement with other agencies were discussed. Meetings were robust and detailed with clear objectives and outcomes. Safeguarding issues were discussed as well as ongoing family support. Staff also attended palliative care and case review meetings within all the geographical areas where the hospice provided services.

There were weekly internal multidisciplinary meetings to identify needs of children, young person and families. Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families. We saw evidence of community working and engagement with other agencies. For example, community and hospital nursing and medical teams, educational and social care teams. Staff provided feedback from the multidisciplinary meetings they attended.

All children and young people had a multidisciplinary annual review undertaken by the referral panel. The annual review included: a request for up to date information from the child or young person's consultant, a review of their plan of care including their advanced care plan and any do not resuscitate directives, medicines and suitability of equipment and whether they continued to meet the criteria for hospice care (life expectancy to 25 years or early adult hood).

Staff worked with colleagues in other services to deliver effective care, treatment and support. For example, speech and language therapists, dietitians and pharmacists. Staff worked collaboratively with families, education, adult services and a local trust if adolescents

were transitioning from children to adult healthcare services. Adolescents and their families were supported by transition nurse and social workers. Each young person had a plan for continuing health and medical support, to assist in the transition from child to adult healthcare services. The hospice worked closely with the learning disability services and other relevant professionals.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health or depression. Mental health support was accessed through referrals to the GP. Staff had access to emergency mental health teams if necessary. Psychological support was available for children, young people and their families through supportive groups run through the hospice.

Seven-day services

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

The service was available 24 hours a day seven days a week except for one week in January, one week in July and three days in September when the service was closed for staff training. However, if end of life care was required during this time arrangements would be made either within Hope House or within their sister hospice in Wales. Home visits including community home care and sibling support sessions were arranged seven days a week to meet the needs of children, young people and their families. The hospice had a contract in place for a GP to visit each weekday. We spoke with the GP who said they would also visit at weekends for children and young people who required end of life care. Staff could call for support from doctors and other disciplines, including mental health services 24 hours a day, seven days a week. There was always a manager who was on call to provide advice and support. Maintenance staff were available seven days a week.

Health promotion

Staff gave children and young people practical support to help them have healthier lives and live well until they died.

Staff assessed each child and young person's health when they were admitted and provided support to meet any individual needs to live a healthier lifestyle. The

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patient records we reviewed and observations we made confirmed this. Emotional, spiritual, psychological and practical support was routinely provided. The service had relevant information promoting healthy lifestyles and support. 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. This included notice boards containing information about good oral hygiene and healthy eating. The medical officer and the clinical nurse specialist had weekly symptom control clinics. They were working with patients, their families and external agencies including paediatric consultants and an adult hospice to develop symptom control within Hope House. The overall aim was to improve the children/young people's quality of life. Staff worked closely with other health professionals such as doctors, health visitors and school nurses and families of infants and young children to ensure they received immunisations and other routine checks.

Consent and Mental Capacity Act

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 made sure children, young people and their families consented to treatment based on all the information available. Staff always had access to up-to-date, accurate and comprehensive information on children and young people's care and treatment. Staff ensured they liaised with all multidisciplinary teams to ensure they had the most up to date information available. For example, with consent, staff shared knowledge of the child and documents such as care plans with other agencies. The service used information from documents such as the Education Health Care Plans (EHCP).

Staff were aware of the appropriate procedures in obtaining consent. They talked to children and explained procedures to them in a way they could understand. We saw examples of how staff would seek a child's consent before undertaking any activity.

Staff clearly recorded consent in the children and young people's records. Staff gained consent from children, young people or their families for their care and

treatment in line with legislation and guidance. Staff did not provide any care without first asking their permission. In the four patient records we looked at, we saw copies of signed consent forms and observed that consent to treatment was obtained appropriately.

When children, young people and their families could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Gillick competence is a term used in medical law to decide whether a child (under 16 years of age) was able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Fraser guidelines relate to contraception and sexual health and addresses the specific issue of giving contraceptive advice and treatment to those under 16 without parental consent.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff involved in care received mandatory training on the Mental Capacity Act every three years. The service considered the requirements of the Deprivation of Liberty Standards and ensured the needs of children and young people was reflected in care plans and health needs assessments.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

We saw that' Deprivation of Liberty Safeguards (DoLS) applications were completed when appropriate. The service had two staff members who were trained as capacity assessors to ensure young people's capacity was appropriately assessed. One of the safeguarding leads had a lead role in DoLS. The DoLS lead monitored the use

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of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Information we received following our inspection identified there were eight young people with a DoLS in place.

The service had an up to date consent policy. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Up to date policies were available on the intranet, staff told us that they knew how to access policies. Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Are hospice services for children caring?

Good 

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

Compassionate care

Staff provided exceptional care and compassion and ensured patients privacy and dignity were maintained at all times. Children, young people and their families were truly respected and valued as individuals and were empowered as active partners in their care, practically and emotionally, by an exceptional and distinctive service.

People received outstanding care from exceptional staff who were compassionate, kind, understanding, enabling and had distinctive skills in this aspect of care. Staff also cared for and supported the people that matter to the person who was dying with empathy and understanding. Throughout our inspection and without exception we observed children, young people and their families were at the centre of everything Hope House staff did. Staff responded compassionately when children, young people or their relatives and loved ones needed help or were distressed. Support was given by exceptionally caring staff to meet the needs of the children, young people and their families. Feedback from people who used the service was continually positive about the way staff treated them. We saw staff genuinely cared about their patients and families. We saw staff were genuinely concerned about the delay (not due to Hope House Children's Hospice) admitting two children whose care was time critical and staff were going above beyond to

support the families. We saw staff in the community went above and beyond provide to support families to enable them to care for their children who had multiple and complex challenges. We saw staff compassionately discussed changes to care and treatment with families.

Parents valued their relationships with the staff team and felt that they often went 'the extra mile' for them, when providing care and support. We saw parents trusted staff to care for their children to ensure consistent care and routine for them. As a result, they felt really cared for and that they mattered. Staff were exceptional in enabling people to remain independent and had an in-depth appreciation of people's individual needs around privacy and dignity. The service also focused on people's well-being and developed innovative ways to support and help them, both psychologically and practically. We saw staff communicated both verbally and used sign language to ensure children understood. Staff told us they ensured they followed parents instructions for care and this was included in their plan of care. Family support was also seen as key to people's well-being and the needs of their families were also supported.

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. We observed staff interact and treat children, young people and their families in a warm, caring and compassionate manner. It was evident and we saw that staff built strong and trusted relationships with children and young people and their families. There was a strong, visible child and young person-centred culture. Staff were highly motivated and inspired to provide care that was compassionate, kind and promoted dignity and told us that they wanted to ensure that children, young people and their families received really good care. We saw one example in the community when staff provided support at short notice to maintain the well-being of the family. We saw children and especially very young children and toddlers were happy and content to remain in the excellent care of Hope House staff. Staff told us this was because they had built up trust with the children and their families. One mother told us "X (The child name) won't go to anyone but me but they love the Hope House staff".

Parents without exception told us staff were exceptionally caring and compassionate. Every parent we spoke with

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told us staff were very caring and treated them well. This was also reflected in the comments the service received within the 2018 Service User Experience Review report. It identified:

- “Parents had no concerns about leaving their children at Hope House and felt they were in safe hands”.

Parents told us:

- “What a huge difference you made to X (child’s name) life”.
- “Love, care, affection and professionalism”.
- “Treated with care, consideration and respect from all staff. Treated as an individual not just another case history”.
- “Incredible people”.
- “Understanding and compassionate. Non-judgmental. It’s good to have someone to talk to. I don’t know what I would do without them”.

The local clinical commissioning group visited in March 2018 identified: “The service and its staff had a strong patient-centred culture. Staff were motivated and inspired to offer care for patients with kindness and compassion”.

Staff respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff were empathetic to patients living with a learning disability and patients with mental health needs and we saw this during our inspection.

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. The service respected the diverse nature of each individual and were responsive to the needs of the multi-cultural nature of their patient population. The service was careful to ensure dignity and privacy in the way they delivered physical care. At every opportunity, curtains were drawn, and blinds were closed on bedroom doors by staff when intimate care was being provided to the child or young person.

Staff supported children, young people and their families to experience their last wishes and displayed determination and creativity to overcome obstacles to delivering care. Children and young people’s individual preferences and needs were reflected in how care was

delivered. Children, young people and their families were supported in accessing things of value that gave them comfort. There were lots of examples and included; ‘pool’ parties, pamper weekends and movie nights for the teenagers and young adults, visits from animals and arrangements for photograph shoots for families.

Staff told us about the opportunities they gave to support bereaved parents who had babies who were still born or were born elsewhere and had subsequently died. They told us parents said they had missed the opportunity to bath their baby or take it for a walk in a pram. Staff had arranged this, providing those parents with memories they would otherwise not have had with their baby.

Staff made foot and handprints of their child which were made into cards or jewellery if parents wished it to remember their baby or child.

Staff followed policy to keep patient care and treatment confidential. The service had an information governance policy and staff were compliant with it. Conversations between staff and patients were kept private and sensitive information was never shared in the presence of those not authorised to hear it.

Emotional support

Staff provided a high level of emotional support to patients, families and carers to minimise their distress. They fully understood and supported patients’ personal, cultural and religious needs.

Feedback from people who use the service, those who were close to them and stakeholders was continually positive about the way staff treated people. People thought that staff went the extra mile and their care and support exceeded their expectations. Relationships between people who use the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders.

Staff gave children, young people and their families help, emotional support and advice when they needed it. We saw and parents we spoke with said they were active partners in their care. Staff were fully committed to working in partnership with children, young people and their families. We observed the approach staff took when interacting with children, young people and their families which was supportive and put them at ease.

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The service offered or helped families to access a range of services to support children, young people and families with complex psychosocial needs.

Staff gave children, young people and their families emotional support and advice when they needed it. The service provided pre and post bereavement support and counselling for children, young people and their families.

We saw staff supported patients who became distressed and helped them maintain their privacy and dignity. Staff told us families who had a child who died could access the 'Snowflake' suite without going through the main hospice if they wished to ease their distress. There were rooms available which could be used for difficult conversations and for people to take time to reflect when required.

Staff demonstrated empathy when having difficult conversations and opening conversations about an individual's emotional and social needs.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their well-being and on those close to them. Family and visitors were able to share mealtimes with inpatients by ordering meals from the kitchen.

Understanding and involvement of patients and those close to them

Staff fully 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 at all times.

The service had a strong, visible person-centred culture and was exceptional at helping people to express their views, so they understood things from their points of view. Staff and management were fully committed to this approach and found innovative ways to make it a reality for each person using the service. They used creative ways to make sure that people had accessible, tailored and inclusive methods of communication.

Staff made sure children, young people, their families and those close to them understood their care and treatment. We observed staff discussing care with patients clearly. Parents told us they understood what was happening and what treatment/care their children would receive. We

saw parents and their families were contacted and updated to let them know how their child was. We observed parents' wishes about how care should be given was supported by staff, such as bedtime regime, management of behaviour and toileting regime.

Staff talked with children, young people and their families in a way they could understand, using communication aids and sign language where necessary.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. Survey were undertaken of patients and loved ones thoughts of the service and people could also put any comments into a feedback post box which enabled patients, families and carers to provide feedback on the care received.

Staff supported children and young people to make advanced decisions about their care alongside their families. Staff were proactive with advance care planning, documenting in the patient record their future wishes around treatment escalation and place of care. This helped staff to know they were always acting in line with what the child, young person or their family wanted even when they lost the capacity to make decisions about their own care.

Staff supported children and young people (when possible) to make informed decisions about their care. Staff encouraged patients to identify their physical symptoms and they were addressed using the skills of the whole multidisciplinary team.

We saw the service user review survey identified 100% of people who completed the survey said they would recommend Hope House Children's Hospice to their friends and family.

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

Good 

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

Hospice services for children

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

Managers proactively planned and organised services, so they met the changing needs of the local population. The hospice provided inpatient care, day care, bereavement support and counselling and a home care service for children and young people from birth to 25 years who had a life limiting illness. Care and support were provided not only to the child or young person but included their entire family including parents, siblings and grandparents and others whom cared for them. Support included both practical and financial help such as assisting with hospital appointments, care at home, respite care, accessing specialist equipment and activities and trips out for their siblings.

The hospice had reduced to six (from eight) inpatient beds at the time of the inspection. Various changes had been made as a result of surveys and children's opinions for example change in how the number of beds were allocated to six, four of which were booked beds and two beds were 'Crisis beds' which could be used by families at short notice.

Facilities and premises were excellent and appropriate for the services being delivered. The hospice was purpose built to resemble a domestic residence, free private parking spaces for families, visitors and staff was available. All patient areas were on the ground floor. Doorways were wide and suitable for wheelchair and buggy access and had sensors to trigger opening. Sensors were carried by all staff and the older children and younger adults who been assessed as having suitable capacity also had the door opening sensors

There was a large activity room with a study area which could be partitioned off for a quiet area. There was a large dining room with a range of wipeable tables, chairs and highchairs. There was a separate teenager/ young adults lounge with comfortable seating, music systems, computer equipment and a large wall mounted television, a sensory room with a range of sensory equipment including specialist lighting, bubble machine and soft music, a music therapy room and a large

hydrotherapy pool with disabled changing facilities including available. Bedrooms were all individual with direct access through patio doors to the enclosed gardens.

The hospice had large and extensive gardens with level access pathways to enable wheelchair access. There was a large outdoor area with soft flooring and a range of play equipment, a small lake and a specially constructed 'farm' area with metal animals which children could visit and collect the rubber eggs, there was a large pool in the gardens and sensory planted raised flower beds

Parents and carers had access to a private flat which had three separate bedrooms (one bedroom was being used as a training room at the time of the inspection, but use could be returned to a bedroom if required), lounge, kitchen area and bathroom on the first floor. The flat could be used by one family including siblings or more than one set of parents sharing the lounge and kitchen facility. In addition, there was the 'Lyra' suite which was accommodated on the ground floor. Lyra suite was frequently used for end of life care for children and young adults and their families or children with mobility difficulties and could not use the stairs. There was a large bedroom for the child, separate bedroom for the parents or other loved ones, a lounge with comfortable chairs and a bed settee, kitchen area.

A bereavement suite known as the Snowflake Suite included a bedroom and a lounge / bedroom which could be chilled for a child or young person to lie after their death in peaceful surroundings. Snowflake unit had a separate entrance for those families who did not wish to come through the hospice and its own separate and enclosed garden. Snowflake suite could be used for any baby, child or young person who had died whether or not they were previously known to the hospice. There was also opportunity for the use of a cooling cot or quilt to enable families to have their child cared for at home or in a family bedroom.

Support was offered to families following bereavement, providing emotional and practical support to family members to find their own best way to cope with their loss. The service had systems to help care for children and young people in need of additional support or specialist intervention and planning for transition to adult services. All children's areas were adapted to meet the complex needs of the children who accessed the

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service. This included recognition of children's and young people's communication and sensory needs. Staff were trained and understood the complex nature and impact of sensory difficulties. The neonatal nurse provided support to pregnant woman whom it was identified whose baby would not survive and families who had a stillbirth or neonatal death. The neonatal nurses visited local maternity units and delivery suite and hospitals to raise staff awareness of the support that could be made available to parents and families should they experience a still birth or neonatal death.

The transitions nurse and other staff worked collaboratively with families and members of the multidisciplinary team when adolescents were transitioning to adult services. The service offered an initial 12 overnight stays each year. Additional overnight stays were available for end of life care, palliative care and crisis care. If the beds were not full then 'bonus' nights were offered to families. The service used a pyramid of care which identified priorities for care. Families were told that respite care may need to be cancelled at the last minute to prioritise care in accordance with the agreed priorities of care. These visits included day care and overnight stay visits for children, young people and their families.

Meeting people's individual needs

People's care and support was planned proactively in partnership with them. Staff used innovative and individual ways of involving people so that they feel consulted, empowered, listened to and valued. For people in transition, specific support groups were available and in children's hospices, links were made to antenatal services to support families where unborn babies have life-limiting conditions.

Managers planned and organised services, so they met the changing needs of the local population. The organisation provided holistic care and its services reflected the needs of the population it served.

The service provided care and support from babies to young adults (up to 25 years). Information provided by the service (see table below) identified the age range of the children and young adults. All of the children and young people have one to one care and can be cared for in different areas of the hospice if the service had a mix of ages in or taken on separate outings which were age

appropriate. Many of the young adults had lower cognitive ages. The Young Adult weekends were arranged just for younger adults only (unless the service had an end of life child who required hospice care).

Age Range Hope House placements

0-4	32
5-10	40
11-15	52
16-18	14
19-25	13
Total	151

The above table shows the age ranges of children and young people Hope House Children's Hospice provided care and support to between January 2019 and December 2019.

The service used personalised child friendly care plans and goal setting and included both patient and their families in the assessment and care planning process. Patients were actively encouraged to maintain their interests both on the inpatient unit and within the community.

Staff organised carer assessments as necessary and coordinated and signposted financial support and benefits to patients and carers. We saw examples of this during our inspection which provided enormous support to patients and their families who were worried about finances.

The home care team visited patients within the community and in hospital and made arrangements for children and young people to be assessed for suitable equipment through the local NHS community nursing service, or the local authority.

The home care team worked alongside other Hope House Children's Hospice specialist such as the neonatal nurse, transition nurse and the sibling coordinator to provide care both the patient and their family.

The service used the local advance care planning documents and also a "wishes" document and supported

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patients to complete them. End of life care discussions with patients and families and their preferences were embedded and reviewed frequently as preferences could change during progression of their condition.

There were facilities for patients and their families to enable them to remain within the hospice (see in the section above Service delivery to meet the needs of local people).

To support care and the holistic needs for every child and young person the service had a range of staff with different skills and roles to meet their needs. The service had home care support nurses and workers, children's specialist palliative care nurses, sibling support worker, a transition nurse, neonatal nurse. . In addition to nurses and health care support workers within the hospice a local GP practice provides medical care. The service also had an activity worker, counsellors which included bereavement counsellors, social workers, physiotherapists, an occupational therapist and a music therapist who provided care and support to children, young people and their loved ones.

There were multiple quiet rooms which were used for sensitive and confidential conversations and meetings.

Facilities were designed to meet the needs of children, young people and their families. All children's areas were adapted to meet the complex needs of the children who access the services. Children and young people had individual bedrooms to ensure their privacy and dignity at all times. Ceiling hoists were available in all patient bedrooms and toilets and bathrooms and portable hoists were also available. The service had specialist equipment including specialist beds and cots for children and young people. The sensory room was used to provide a relaxing environment for children who had visual and neurological challenges and had sensory lighting, bubbles, and soft play equipment and bean bags to sit on.

Staff supported children and young people living with complex health care needs by using 'All about me' care plans which were completed in conjunction with the family/child/young person that reflected their individual needs, choices, likes /dislikes and what they were able to do. The care plans were reviewed at each period of care or when changes occurred.

Staff used transition plans to support young people moving on to adult services. Staff considered the needs of adolescents and young people transitioning to adult services. Staff told us how they attended multidisciplinary meetings with families and ensured the views of the young person were heard and considered. Staff told us how they supported parents who were also adjusting to their child transitioning and increasingly making their own decisions about their care and treatment.

Staff understood and applied the policy on meeting the information and communication needs of children and young people with a disability or sensory loss. Staff used a range of communication aids to support communication with children and young people. Staff used a range of tools including signing and Makaton to communicate with children and young people as necessary. For example, pain assessment tools were pictorial, so children could point to a happy or sad face to indicate their need for pain relief. The service did not have a hearing loop but had been trialing individual 'amplifier' for children and young adults with hearing deficit.

Staff had access to communication aids to help children, young people and their families become partners in their care and treatment. The service used technology and equipment such as tablets to enhance the delivery of care and support independence.

The service had a hydrotherapy pool where children had therapeutic support from physiotherapists. The hydrotherapy pool could also be used by families under supervision of staff..

Staff supported children and young people living with complex health care needs by using 'All About Me' documents to support their independence and decision making and took their needs and preferences into account. Children and young people's rights were supported through maximising independence, maintaining the least restrictive options, empowering, involving and maintaining respect and dignity. Families were supported to attend appointments if desired so that they had contemporaneous knowledge of the child or young person's condition and could advise families on any changes and support them appropriately.

The service provided a range of activities and support groups both at the hospice and in the community to

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meet the needs of parents and carers, siblings and grandparents. For example, the service ran bereavement groups, grand-parents' groups, coffee mornings, siblings' groups, picnics and arranged events in community locations for those who could not access the hospice easily.

Additional support included the provision of day care for children and families. Facilities at the hospice were bookable for a day visit. Planned short breaks were available to enable families to a period of respite and be reassured their child would be well cared for in the hospice. Families told us how they valued the planned breaks for all the family. Emergency short break care was available for medical and social needs.

Home care workers supported children, young people and their families at home visits. During these visits they provided emotional and practical help and support. This included supporting families to access financial and practical help, for example applying for specific health related benefits or for support with alterations to the home to enable wheelchair access and equipment such as a lift.

Staff maintained a weekly activities board. Activities included art and craft therapy and music, hydrotherapy and indoor games. All children, young people and their families were able to participate in these activities.

Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed. As part of the assessment process the need for an interpreter would be identified. Families who required an interpreter could use the interpreting services available to the hospice, so they had a clear understanding of their child's health needs and were involved in the plans for their care. The head of care said leaflets were available in welsh (the second most common language spoken locally). However, if written information was required this would be translated and made available on an individual basis to ensure accurate information was available. The service was not available 24 hours a day.

Staff endeavoured to provide care that was not limited in terms of diversity, ethnicity, culture or aimed at any particular community group. They demonstrated a holistic, patient-centred approach to care planning and delivery of care. Children, young people and their families

spiritual, religious, psychological, emotional and social needs were taken into account. This was evident from the records we reviewed and observations we made during the inspection.

The service had close links to local religious groups and had facilitated visits to religious centres such as the local mosque and temples.

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 on-site catering team able to cater for all dietary needs including vegan, vegetarian, halal, kosher and African Caribbean food. Food and drinks were available 24 hours a day for children, young people and their families.

The service had an up to date equality and diversity inclusion and human rights policy which included the privacy and dignity expectations of staff, for example encouraging practices that took into account the rights of individuals to be treated with dignity and respect.

All feedback was collated and reported back to families through the 'You said, we did' display boards in the hospice. We saw this included the additional boards to reduce the noise in the dining room and the request by the young adults to have sensors so they could open the doors.

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

Access and flow

Patients could immediately access the specialist palliative care service when they needed it. The service ensured children and their parents did not have to wait for end of life care and ensured they achieved their preferred place of care and death.

Managers monitored waiting times and made sure patients could access services in a timely way. Referrals for hospice care (which included in patient or community home care) were received over the telephone, in person or electronically. If a referral was made over the phone or in person the staff member would complete the referral form and ask the person to check its content. The child or young person's information was reviewed by the hospice

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admissions panel to ensure they met the hospice criteria of a life limiting condition and that they would most probably not reach early adult hood (25 years). The admissions panel met at least every two weeks. For acceptance of hospice service agreement was required by at least three panel members who were senior managers and clinicians. The admissions panel also reviewed all children and young people to ensure they continued to meet the hospice criteria every twelve months. Between January 2019 and December 2019, 151 children and young people with a life limiting illness were receiving the service. Within this time frame there had been 415 admissions to the service, of these 408 were for respite care. There had been 301 children and young people who had received care and support within the community.

When a referral was received for a child requiring urgent hospice agreement to the referral was made by three senior managers which included the director of care and head of care, the medical officer or other senior nurse or manager. The decision was made without waiting for the next panel meeting and would be agreed on the same day as the referral was received. Arrangements could be made quickly to ensure the family had access to the hospice in a timely manner which we observed during our inspection. A member of the hospice staff would meet the child, young person and their family before admission was arranged. We saw this was undertaken within 24 hours and if possible was arranged the same day. If the child was being transferred from hospital, it may be appropriate for hospice staff to visit the child and family at the hospital before they transferred to the hospice. This allowed the family to ask questions about the hospice and for hospice staff to get to know the family and the needs of the child.

Waiting times for hospice care were not audited (this included both inpatient and community care). We were told this was because all referrals were reviewed and when appropriate agreed at the next panel meeting which were held every two weeks. The panel meeting reviewed referrals to agree if they met the criteria, other than urgent referrals which were agreed the same day. The service kept two beds available for short notice 'crisis care'. However, should all the beds, including the 'crisis' beds be full, the service assessed priorities using a

pyramid of care. The highest priority was end of life care and patient safety. Parents were made aware that there was a risk routine respite care may need to be cancelled in identified circumstances.

Staff planned patients' discharge carefully, particularly for those with complex needs. Discharges were coordinated with third party health and social care providers to ensure patients, wanting to be cared for at home, were safe. Staff appropriately liaised with local authorities and community healthcare providers to secure appropriate care packages were in place to deliver the care which reflected patient wishes.

Staff delivered personalised responsive care at the right time to each individual. Every child or young person had a minimum of one member of nursing staff or member of the care team staff dedicated to their care each day, and in some instances two staff dependent upon their needs. The allocated staff were responsible for all aspects of the child or young person's care, which included their personal and health care needs along with their social needs, which included play and relaxation. Staff engaged with professionals to raise awareness of the services offered to ensure there was timely referral for children, young people and their families. This included community staff within the geographical areas covered by the hospice, GP's and hospital staff.

The service did not have a waiting list and children were triaged according to their clinical requirements to identify those in the greatest need. These included consideration of whether the referral was for end of life or respite care, the wishes of the child, young person and their family and capacity within the hospice to meet the individual needs. This included ensuring that there was the scope to prescribe appropriate medication for symptom management. If a child or young person's condition changed or there were any social issues managers would adapt to meet the needs of the young person and their family. Referrals were discussed at the two weekly panel meeting, considered monthly by the senior care managers and quarterly by the clinical governance committee.

Managers ensured that children and young people's moves between services were kept to a minimum and were for clinical reasons only. Staff moved children and young people only when there was a clear medical reason or in their best interest. All children and young

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people had their own rooms. Staff reported all emergency transfers as incidents. The service had an up to date transfer policy. Compliance was monitored through incident forms and feedback from the staff escort. All staff undertaking escort duty had received lone worker training.

Some children, young people, their parents, grandparents and siblings were referred for psychological, emotional and practical support. All referrals were discussed and reviewed at the two weekly panel meeting. Staff supported children, young people and their families when they were referred or transferred between services. If children and young people were transferred between services; for example, to transition to adult services, staff worked closely with them and their families. Additionally, they liaised with the multidisciplinary team to ensure that transfer of care was coordinated. If a child or young person no longer met the criteria for the hospice, staff signposted them to other services and supported the transition. The service provided care and support up to young people 25th birthday, after which they no longer met the criteria for the service. Younger children may not continue to meet the criteria if they had shown significant clinical improvement or stability in their condition. All children were reviewed annually by the panel to check they still met the criteria of the hospice. The service provided weekly symptom control clinics between January 2019 and December 2019, 17 children and young people have accessed this service.

Learning from complaints and concerns

People were actively encouraged to give their views and raise concerns or complaints. The service sees concerns and complaints as part of driving improvement. People's feedback was valued and responses to the matters people raised were dealt with in an open, transparent and honest way. Investigations were comprehensive.

Patients, relatives and carers knew how to complain or raise concerns. Patients were issued with a patient information booklet once they started to receive care from the service. A copy of this information was also available in the parents/ family accommodation and in the reception area. Families we spoke with knew how to complain or raise concerns. The service clearly displayed

information about how to raise a concern in patient areas. The service had a complaints and concerns section on their website, featuring a telephone option and an option to record information. They also received reviews on social media where people could publicly share their feedback.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint. The hospice had processes to ensure complaints were dealt with effectively, including prompt acknowledgement of the complaint, a written response to the complaint and whether changes had been made because of the complaint. Face-to-face meetings with the complainant were also offered, when indicated.

Staff understood the policy on complaints and knew how to handle them. The service had an up to date complaints policy. There were clear processes to manage complaints. Staff described the actions they would take if anyone raised a complaint. They told us where possible complaints were resolved immediately. If concerns could not be resolved informally, patients and/or those close to them were supported to make a formal complaint. Staff told us the service received very few formal complaints, which was confirmed by the number received within the inspection reporting period.

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from complaints and feedback was shared with staff through a variety of means such as meetings and noticeboards. Action was taken in response to complaints and feedback received to improve patient experience and care provision. We saw 'you said, we did' boards displayed in the hospice with examples of improvements made in response to patient feedback.

Managers investigated complaints and identified themes and any learning was shared. Complaints were discussed at the clinical governance committee and the board of trustees. Feedback regarding the impact of care was collated and reported in the three monthly quality improvement report which was shared with clinical commissioning groups, clinical governance and to staff.

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Complaints were monitored by the director of care. Managers responded to complaints within 20 working days, if there was a delay in the process managers told us that families were informed.

The service received two complaints from 1 January 2019 and 31 December. The service acknowledged all complaints within 48 hours, both verbally and in writing. The service had a 20 day target for investigating complaints. One complaint was resolved by the target date, the other complaint was not, due to the complex circumstances regarding the complaint. A senior manager told us they were responsive and sensitive to family's needs; one family had expressed a wish to be given more time.

The service had received 62 compliments and thank you letters between 1 January 2019 and 31 December 2019.

Are hospice services for children well-led?

Good 

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

Leadership

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

The service had managers at all levels with the right skills and abilities to run a service which provided high quality sustainable care. We saw compassionate, inclusive and effective leadership at all levels. The leadership team consisted of a board of trustees with a range of relevant expertise to contribute to the service. The service had managers who carried out key accountable safety roles. These included a director of care, head of care, head of community services. The senior management team met regularly with the board of trustees. The service did not have a medical director although did have medical representation on the board. The hospice had a registered manager who was also the head of care services along with the head of community services they

were responsible for the day to day running of the service. Leaders at all levels demonstrated experience, capacity and capability needed to deliver high quality and sustainable care.

The challenges to quality and sustainability were understood by the leaders and they had identified actions needed to address them. Senior managers told us the challenge was not one of staff retention, with a very low turnover of care staff, but the challenge was the recruitment of children's nurses. Actions had been identified to address the challenges. For example, the service was trialing a new model of care working in partnership with a local community nursing team to provide 24 hour a day palliative care support when required to for children and young adults within their own homes.

Leaders were visible and approachable. Staff told us all levels of leadership were visible and approachable. Staff felt they could raise concerns, issues and ideas with their line manager or escalate to senior leadership without hesitation. The relationship between senior leaders, including trustees, and operational staff was effective. We spoke with senior leaders and operational staff. All described their relationship as being effective. We were told there was an environment within the service and governance structures where challenge was welcomed and encouraged.

The board of trustee's skills and competences were assessed at the time of their appointment and reviewed annually. The service ensured the 'Fit and Proper Persons' regulations were met and ensured all required checks were undertaken when appointing trustees. The board of trustees had an equal balance of business and clinical skills.

The chair of the clinical governance committee was a trustee and one other trustee sat on the committee. Many of the other trustees had a background or expertise in health care and held roles within acute or community NHS trusts. The chair of the clinical governance committee was a trustee with a background and expertise within the acute NHS trust. Two other trustees sat on the committee both with health and social care experience.

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The service had two safeguarding leads. The deputy chair of the board of trustees was the board representative for safeguarding.

Vision and strategy

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

The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff. The service engaged with children, young people, families and the wider community to identify the vision and strategy for the service. Staff views were sought through staff surveys, workshops and meetings in the development of the vision for the service.

The service had a new care strategy that has been approved by the board in December 2019 that will be implemented over the next few years to review and improve the services offered to ensure the needs of the children and young adults were met. The strategy identified:

- The delivery of end of life care with a highly skilled specialist team wherever the child may be.
- The provision of 24 hour care and an on call service for end of life care.
- Provide symptom control in flexible locations.
- Establish a more effective and robust transition service.
- Provide all families with a named keyworker.
- Increase their partnership working with the statutory sector.
- Support children in accessing education whilst attending respite care.
- The service had a mission to provide a range of holistic, specialist, palliative care services to babies, children, young people and their families in partnership with others.:
- To ensure that children affected by conditions so serious that they're not expected to live longer than early adulthood enjoy together with their families the best possible quality of life - with access to specialist care and bereavement support, when and where they need it.

- Specialist nursing and palliative care at home, in the community and at Hope House and Tŷ Gobaith (their sister hospice in Wales).

The service strategy was aligned to local plans in the wider health and social care economy, and how services were planned to meet the needs of the population. Managers and staff worked closely with local hospitals, commissioners and other NHS partners to support families most effectively. The leadership team had worked collaboratively with staff to identify and start to implement the service plan.

Staff knew and fully understand the vision, values and strategy, and their role in achieving them. Staff and key stakeholders were involved in the development of the strategy, vision and values.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Leaders had an inspiring shared purpose to deliver and motivate staff to succeed. There were high levels of satisfaction across all staff. There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences. The culture of the service centred on the needs and experience of the children, young people and their families who used services. Staff at every level were passionate about delivering care and treatment which addressed children, young people and their families. Staff told us that they felt pride in the organisation and the work the carried out to ensure children, young people and their families received good quality care.

Staff we spoke with felt supported respected and valued. Staff told us how supportive their immediate line manager was and told us they also had support from senior leaders. Leaders ensured patients received care and treatment which was safe and of the highest quality. This was demonstrated in the care being delivered, the focus on ensuring lessons were learned when issues arose and the attitude of staff we spoke with. The culture encouraged openness and honesty at all levels within the organisation, including with people who use services and

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leaders and staff understood the importance of staff being able to raise concerns without fear of retribution. The duty of candour was understood by all staff we spoke with. Staff felt able to raise concerns and told us there were no barriers when escalating incidents or complaints. Staff said they were open with patients and their parents and loved ones when things went wrong and were encouraged to do so by leadership.

Appropriate learning and actions were taken when concerns were raised. We saw from minutes of clinical governance committee meetings there were agenda items focused on learning from incidents, complaints and feedback. We also saw recommendations and learning being highlighted in incident reports which was fed back to staff.

The service provided all staff at every level with excellent training and development opportunities,. As discussed in the competent staff section above, staff received an annual appraisal where career development would be discussed. Following which, actions would be agreed, and steps taken as an when appropriate.

There was a strong emphasis on the safety and well-being of staff. Staff often worked on their own when supporting children, young people and their families in the community. The service had a lone worker policy which was used to ensure there were processes to keep staff safe. Staff used an electronic device on their mobile phone which 'tracked them' them and they could use to summon help if needed. Staff also logged the visits they were going to undertake and the expected time they would return. During our inspection we saw staff called in to update their whereabouts when they had been delayed. Staff also had code words to identify when they felt unsafe and at risk. Staff received mental well-being training awareness. The training recognised the pressures staff may have caring for children and young people who had a short life expectancy and may die. Counselling services were available to support staff individually in group sessions or on the telephone if needed. Debrief sessions were offered to all staff regardless of the area in which they worked when a child or young person died. Staff also received ad hoc safeguarding, clinical and restorative supervision to reflect, address any clinical issues and the emotional impact these may have had on them. This ensured that staff had effective support to undertake their roles and responsibilities.

The service recognised staff who 'had gone the extra mile' and all were recorded. Staff were thanked at team meetings and face to face. Nurses used the 'going the extra mile' acknowledgment as part of their revalidation. Staff who had long term service were recognised with extra annual leave and service awards.

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.

There were effective governance systems in place to monitor the service provided. The senior management identified a strategy to increase quality monitoring, implement electronic incident reporting and risk management to better scrutinise and analyse areas of service delivery and put plans in place to improve them. The trustee board and clinical governance committee met on a quarterly basis to review quality and safety for the service. The clinical quality committee meetings reported to the board of trustees. The service had separate committees and groups which met quarterly and fed into the clinical governance committee and leadership meetings for example, there was a medicines management, infection prevention and control, health and safety and audit and risk group (which included learning from death reports). The membership of the groups included operational and leadership staff. Meetings were summarised and presented at the clinical governance committee meetings.

Senior managers met with head of department monthly. These meetings discussed operational information about the service including staffing, risks, incidents, complaints and patient feedback. Minutes of the meetings were taken and circulated afterwards.

We reviewed clinical governance meeting minutes for October 2019, July 2019 and attended the meeting in January 2020. Each meeting had standing agenda items which included but were not limited to activity monitoring, risk management, reported incidents (including medicine incidents), complaints, safeguarding, service reviews and patient and carer feedback. An action log was taken and discussed at each meeting and we saw

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when appropriate this was followed up at the following meeting. There were quarterly trustee board meetings which reviewed the performance and development of the service, finance and funding arrangement, risks. Incidents and complaints. They were formal meetings and minutes were taken and circulated. The main trustee board received minutes from each of the trustee board governance committees. They also received hospice update papers, updates on strategic priorities, financial information and sometimes a presentation on a service area and/or an issue for debate and discussion. The senior management team were present for the whole board meeting. The leadership team attended clinical governance committee meetings and information was fed to staff at team meetings, in the form of minutes and emails.

There were effective recruitment and interview processes in place. We reviewed six staff files and found they all included criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). Nursing and Midwifery Council (NMC) checks had been completed to ensure health professionals were fit to practice. There were copies of other relevant documentation including character references, interview notes, full employment history and proof of identification.

Staff at all levels were clear about their roles and they understood what they were accountable for, and to whom. There were clear lines of accountability, with team leaders overseeing staff and helping them to achieve their objectives. This was evidenced in staffing structures and understanding of roles and responsibilities. Staff were committed to improving the quality of service provision and safeguarding high standards of care. Staff knew how to report incidents and were encouraged to do so. There were health and safety representatives across all departments and a health and safety committee met quarterly. The hospice had a medicines' management committee responsible for policy and practice within the hospice. There was evidence of regular engagement with other professionals within the health economy to improve care outcomes.

Fundraising and ensuring financial stability was prioritised to ensure the delivery of care and different models of provision were discussed and managed effectively.

Effective governance processes were established in areas we visited. The team leader in-charge of the inpatient unit checked all daily checks had been completed, such as emergency equipment and medicine storage temperatures. Arrangements were in place to manage and monitor contracts and service level agreements with partners and third-party providers. Contracts were reviewed on an annual basis, which included a review of quality indicators and feedback, where appropriate.

Managing risks, issues and performance

The service identified risk and collected reliable data to review and mitigate against risks.

There were appropriate arrangements for identifying, recording and managing risks, issues and mitigating actions. There was alignment between the recorded risks and what staff told us were concerns. The hospice had up-to-date risk management policies in place such as the complaints policy and incident and near miss policy.

The service had a risk log where there were clear mitigations and review processes. These were reported to the trustee board, reviewed regularly and acted on. There were a broad range of policies and procedures that set out the hospice's expectations and approach to safety in key areas such as recruitment, risk assessment and management, medicines management, safeguarding and Mental Capacity Act and Deprivation of Liberty Safeguards. These were accessible electronically by all staff. Policies were reviewed to ensure they were in line with best practice, new legislation, national standards or latest guidance.

The clinical governance committee played a key role and function in the management of risks within the service. This committee reviewed key information about risks within the service and ensured action was taken to mitigate them. An example of this was the regular presentation of incidents at the group including their grading and a summary of the incidents themselves. The committee would look for themes and trends and scrutinise the actions taken to reduce the risk of recurrence. The trustee board received reports regarding different streams of risk including clinical risks and operational risks. Some of the reports received included complaints, medicine errors and service reviews. This gave the committee trustees a broad and full picture of risk within the service. The service and committee board

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of trustees also took account of risks from external sources and worked to mitigate these. For example, the major risk identified was funding, with 85% of the organisation funding coming from charitable donations and 15% from public funding (clinical commissioning groups and local authorities). There was a comprehensive action plan in place to address financial risks. This showed that the service was dynamic and proactive in their approach to managing risk.

There was a programme of clinical and internal audit. This was used to monitor quality and operational processes, and results were used to identify where improvement action should be taken. Staff confirmed they received feedback from audits.

Individual risk assessments were carried out for each child and young person on admission to the service. These were reviewed regularly. When a risk was identified, we saw actions were taken to minimise any potential harm to the patient, such as skin and tissue viability, infection control and any social or safeguarding risks. 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.

Staff confirmed they received feedback on risks, incidents, issues and performance in a variety of ways, such as team meetings, noticeboards, newsletters and email.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, 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.

Performance measures and data were being collected, monitored and reviewed. Clear and robust service performance measures were reported and monitored. Staff, managers, the trustee board and commissioners had access to quality and performance data through the quarterly integrated quality and performance report. We

saw these reports were detailed and included data on a range of performance and quality indicators, such as incidents, staffing, service user feedback, complaints and audit activity. Areas of good performance were highlighted as were areas which required improvement. Reports including occupancy data, care assurance which incorporated the risks, safeguarding, incidents and controlled drugs and compliance reports were presented at the quarterly clinical governance committee meeting.

The service had information governance policies and standard operating policies. There were clear processes for reporting data breaches and recording breaches. Staff had access to up-to-date and comprehensive information regarding patients' care and treatment. Computers and laptops were encrypted, and password protected to prevent unauthorised persons from accessing confidential patient information. We saw that staff closed their computers when not using them to prevent unauthorised access. Quarterly reports were also generated for the CCG commissioned contract that was in place. Management records were well organised, and records were detailed and kept up to date. Any paper-based care records were easy to follow and kept securely as were personnel records. We saw that these were stored securely in locked cabinets.

There were effective arrangements to ensure data and statutory notifications were submitted to external bodies as required, such as local commissioners and the Care Quality Commission (CQC). There was transparency and openness with all stakeholders about performance

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Children, young people and their families' views and experiences were gathered and acted on to shape and improve the service and culture. Children, young people and their families were encouraged to share their views to help improve services. Feedback was reviewed by staff and used to inform improvements and learning, where possible. Children, young people and their families were asked about their experience of care at the hospice, such as food and food choices and their experience of using the service and accessing groups and activities. By asking

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for feedback in this way, staff hoped issues would be raised soon after they arose and meant they could be acted upon quickly. We saw evidence of this during the inspection. For example, arrangements for accessing emergency and respite care, changes to the menu and menu cards on tables which confirmed the daily food choices.

The service was heavily reliant on charitable donations and engaged with the community to raise awareness of the services it provided. The service provided ongoing media including social media updates of initiatives within the hospice. Those families who gave permission shared their stories to show the care and support the hospice had given them and their children.

Families in Wales had been invited to participate in the family voices project. Work was underway in exploring future ways of receiving feedback using technology. There were plans to fund this project for the English families in 2020.

There were over 600 volunteers who worked throughout Hope House Children's Hospice working within retail outlets, hospitality, the inpatient unit and fund raising and were central to running of the service. A new head of human resources and volunteering had been employed, following the retirement of their predecessor in 2019, to oversee arrangements for volunteers. Volunteers were supported in being competent in their role and received the same training as permanent staff. The hospice worked in partnership with other services providing care for children and young adults with life limiting conditions to ensure their individual needs were met. For example, they worked closely with local NHS trusts particularly children, maternity services and accident and emergency departments, local commissioners and local authorities to ensure the charities services were aligned with the local health and social care economy to ensure it was best meeting the needs of children, young people and their families. Staff worked in partnership with other local children's hospices

The views of staff were sought and acted upon. A staff survey was undertaken in June and July 2018 by an independent organisation on behalf of Hope House Hospice. A total of 176 Hope House staff responded (Hope House also have another hospice in Wales). The survey included 42 hospices and the results were benchmarked. The survey identified 97% of staff would be

happy for a relative to be treated at the hospice 94% said they were proud to work for Hope House. In addition, Hope House Children's Hospice staff planned to participate in the 'Staff Well being in Children's Hospices (SWiCH) study'. The SWiCH study aimed to increase understanding about the work-related stressors and rewards experienced by children's hospice staff, and identify staff support systems and organisational practices that offered the most potential to enhance staff well being at work. The study involved conducting a national survey of care team staff

From the conversations we had with staff, and observations we made during the inspection, it was evident that staff were engaged in the service. They told us they felt confident to raise concerns and were encouraged to come up with ways in which services could be improved. Information was shared with staff in a variety of ways, such as handovers, email, noticeboards, workshops during training weeks and staff events. Staff told us they had regular team meetings. Meeting minutes reviewed showed staff engagement at all levels.

Newsletters for parents and staff were produced, and available through the website. These provided information about planned events, including fundraising and photographs of children and young people engaged in activities both internal and external to the service. Photographs used were with the consent of the parent and or young person.

They collaborated with partner organisations to help improve services for patients. Staff from Hope House met regularly with eight other children's hospices to share and develop good practice. charities. The charities included in the benchmark are participants in Birdsong's Charity Pulse, Hospice and Bespoke staff surveys over the past three years

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

The service was fully committed to training and staff development. Staff told us they were encouraged and supported to complete additional training. The service had developed a competency framework with a rigorous assessment framework to ensure that all staff were competent in areas of care requiring additional knowledge and skill. New counselling hubs were being

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sought and developed with the help of local businesses who supported the hospice. The counselling team were working to forge links within the community and wider professional settings. An example was a link meeting to share good practice was organised by and held in Hope House for nine members of local organisations who

offered counselling support in a hospice setting or to bereaved families. The service had participated in the person centred care project to review and promote the use of person centred tools and how this could improve care.

Outstanding practice and areas for improvement

Outstanding practice

Children, young people and their families were truly respected and valued as individuals. They were empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service. Staff worked collaboratively with all who accessed the service with compassion. Feedback from patients and people who used the service was that staff went over and above what was expected of them. Staff consistently displayed determination and creativity to overcome obstacles to delivering care and providing people with what they requested that would make their time in the service a reflection of what they specifically wanted and needed.

Staff at all levels were recruited and developed to enhance their skills, competence and knowledge to ensure high-quality care. Staff at all levels, were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice.

The services were person centred, flexible and could be tailored to meet children, young people and their families' complex needs. There were bereavement services and a comprehensive complementary therapy provision that had been extended to those people who required it for extended periods.

A volunteer counsellor, who spent eight years counselling bereaved families at Hope House was awarded the distinguished Order of Mercy Medal at a special ceremony in London's Mansion House.

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should monitor that disclosure and barring checks have been carried for all contractors by their substantive employer
- The provider should consider monitoring and auditing waiting times for the service.