Zoe's Place Middlesbrough

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?	**Requires improvement**	●

Overall summary

Zoe's Place Middlesbrough was operated by Zoe's Place Trust, which was a registered charity, that also operated from two other locations. The service provided palliative, respite and end of life care to babies and infants aged from birth to five years, who were suffering from life-limiting or life-threatening conditions.

Opening in 2004, Zoe's Place Middlesbrough was situated in a largely residential area occupying a converted leased building, (formerly a convent), that was wheelchair accessible and with ample off-street parking. The public reception was managed by volunteer staff with adequate seating and toilet facilities. The hospice had its own entrance which was managed by clinical staff.

The service provided respite care for the families of the babies and young children up to five years old. As part of this wrap around service, staff could offer therapy,

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bereavement support, (including use of private accommodation so the family could stay with their child for as long as they needed), plus support groups for the wider family.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 6 November 2019. Unknown to us, the service was closed on this day. We re-visited on 12 November 2019 to speak to more staff and parents/carers. To gain their feedback, we also spoke, over the phone, with parents/carers.

To get to the heart of patients' experiences of care and treatment, we asked 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 rated 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

We had previously rated this service in August 2014. At that time the service was rated outstanding overall with outstanding in the domains of effective, caring, and responsive, with safe and well-led rated as good.

At this inspection the rating went down. We rated it as **Good** overall.

We found good practice in relation to children and young people care:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect babies and children, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough staff with the right qualifications, skills, training and experience to keep babies and children safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.
- Staff kept detailed records of babies and children's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- 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 babies and children's religious, cultural and other needs.
- Staff assessed and monitored babies and children regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

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- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood babies and children's personal, cultural and religious needs.
- Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.
- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help babies and children access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care in a timely way.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where babies and children, their families and staff could raise concerns without fear.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

However, we also found the following issues that the service provider needed to improve:

- The leadership at the service had not set any key performance indicators, for example, mandatory training targets, which meant it was difficult for the leadership and staff to effectively monitor performance and drive improvement.
- National recommendations, such as the inter collegiate guidance for safeguarding, required staff dealing with adults and children to be trained to a certain safeguarding level depending on the role staff had. We found clinical and volunteer staff were not trained to the appropriate level for adult safeguarding and for volunteer staff, children safeguarding.
- The environment should be free of ligature risks and risks of crushing by door hinges. However, we found examples of such risks when inspecting the environment.
- Good governance required that staff were guided by policy on how to use their risk registers, that risk registers were aligned between the local and trustee register, and that all registers reflected actual risks posed to the service. We found the local risk register and trustee risk register were not aligned and did not reflect the actual risks posed to the service. The risk management policy failed to guide staff on using the registers to record risk, its escalation, or monitoring.
- To ensure staff and users of the service knew they were following the latest guidance, notices, policies and procedures that were displayed should have had a current version control. We found version control was not displayed on notices we saw or, when it was, they were not current.

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- To assess and address risks to health, policies should set out what staff should do if faced with a deteriorating child. We found staff had no written policy to follow for the deteriorating child.
- A clinical audit programme was one way to ensure that staff were using the latest evidence-based practice. We found the service did not operate a clinical audit programme.
- To support staff in identifying parents or carers who may not have had the necessary mental capacity to consent to treatment provided to their baby or child, staff should be trained in mental capacity and consent. We found staff were not trained in mental capacity and consent.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice that affected the service. Details are at the end of the report.

Ann Ford

Deputy Chief Inspector of Hospitals (North)

Summary of findings

Our judgements about each of the main services

Service	Rating		Summary of each main service
Hospice services for children	Good	●	We rated this service as good overall because it was safe, effective, caring and responsive, although well-led requires improvement.

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Good ●

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Summary of this inspection

Background to Zoe's Place Middlesbrough

Zoe's Place Middlesbrough was operated by Zoe's Place Trust. It was a hospice that provided 'home from home' palliative, respite and end of life care to babies and children aged from birth to five years suffering from life-limiting or life-threatening conditions. It opened in Middlesbrough in 2004. The service primarily served the communities of Middlesbrough.

The service had a registered manager in post since 2004. The service was registered for the following regulated activities:

- Treatment of disease disorder or injury.

We conducted an unannounced inspection of the service on 6 November 2019 and a follow-up visit on 12 November 2019 because the service, unknown to us, was closed on 6 November 2019.

The previous CQC inspection of this service was in August 2014. At that time the service was rated outstanding overall with outstanding in the domains of effective, caring, and responsive, with safe and well-led rated as good.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and a specialist paediatric nurse. The inspection team was overseen by Sarah Dronsfield, Head of Hospital inspection.

Information about Zoe's Place Middlesbrough

The hospice was registered to provide the following regulated activities:

- Treatment of disease, disorder or injury.

During the inspection, we inspected the whole service. We spoke with 11 staff, six parents/carers of the babies/children who used the service and reviewed seven service user records. We reviewed a random selection of ten staff records in relation to the staff working at the service and three of the trustees who ran the charity.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

This was the services first inspection since August 2014, which found that the service was rated outstanding overall with outstanding in the domains of effective, caring, and responsive, with safe and well-led rated as good.

Activity – September 2018 to October 2019 (reporting period)

In the reporting period there were:

- 31 babies and children seen aged from birth to three years of age.
- Zero formal complaints.
- Zero service users seen who were aged above five years old.

The service at the location employed a full-time registered manager (who was the head of care at the location) and seven full-time registered children nurses plus two full-time learning disability nurses and care assistants.

Opening times at the location depended on service user demand.

Track record on safety

- No service user deaths or never events (never events are serious service user 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 service user harm or death but neither need have happened for an incident to be a never event).

- One serious incident in April 2019.
- One duty of candour notification (the duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify service users (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person).
- Zero safeguarding referrals.
- Zero incidences of healthcare acquired infections.
- Zero unplanned urgent transfer of a service user to another health care provider.

Services accredited by a national body:

- 'Disability confident committed' May 2019 to May 2020. This was mostly about employment practices.

Services provided at the hospital under service level agreement:

- Fire risk assessment
- GP cover
- Clinical and domestic waste

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good ●

Our rating of safe stayed the same. We rated it as Good because:

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- **Staff understood how to protect babies and children 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.**
- **The service controlled infection risk well. Staff used equipment and control measures to protect babies and children, themselves and others from infection. They kept equipment and the premises visibly clean.**
- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**
- **The service had enough staff with the right qualifications, skills, training and experience to keep babies and children safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.**
- **Staff kept detailed records of babies and children's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.**
- **The service managed baby and children safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

Are services effective?

Good ●

Our rating of effective went down. We rated it as Good because:

- **The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of babies and children in their care.**

- **Staff gave babies and children 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 babies and children's religious, cultural and other needs.**
- **Staff assessed and monitored babies and children regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**
- **The service monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for babies and children.**
- **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**
- **All those responsible for delivering care worked together as a team to benefit babies and children. They supported each other to provide good care and communicated effectively with other agencies.**

However:

- **While staff supported parents or carers of babies and children to make informed decisions about their care and treatment, we were not assured they knew how to support parents or carers who lacked capacity to make their own decisions or were experiencing mental ill health, because staff were not trained in consent and Mental Capacity Act.**

Are services caring?

Good ●

Our rating of caring went down. We rated it as Good because:

- **Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- **Staff provided emotional support to babies and children, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**
- **Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.**

Summary of this inspection

Are services responsive?

Good ●

Our rating of responsive went down. We rated it as Good because:

- **The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**
- **The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help babies and children access services. They coordinated care with other services and providers.**
- **People could access the service when they needed it and received the right care in a timely way.**
- **It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included parents or carers in the investigation of their complaint.**

Are services well-led?

Requires improvement ●

Our rating of well-led went down. We rated it as Requires improvement because:

- **We were not assured the leaders had the information they needed to understand and manage the priorities and issues the service faced.**
- **While the service had a vision for what it wanted to achieve the strategy to turn it into action was a list of expectations. It did not appear to have been developed with all relevant stakeholders, or be aligned to local plans within the wider health economy. Without specific, measurable, achievable, realistic, timed (SMART) expectations (or something similar), while leaders and staff understood it, it was difficult to see how they could objectively monitor progress.**
- **We were not assured 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.**
- **We were not assured leaders and teams used systems to manage performance effectively. The local risk register did not reflect the risks we found and that register was not aligned to the trustee risk register which appeared to**

focus on ‘potential’ as opposed to ‘live’ risks escalated from the local risk register. Actions to reduce their impact were not always SMART (or something similar). The service had plans to cope with unexpected events.
- **While the service did collect reliable data, we were not assured it was being analysed. We were not assured leaders had the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.**

However:

- **Staff felt respected, supported and valued. They were focused on the needs of babies and children receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where families and staff could raise concerns without fear.**
- **Leaders and staff actively and openly engaged with parents or carers, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for babies and children.**
- **All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation but did not participate in research.**

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good ●

Hospice services for children

Safe	Good ●
Effective	Good ●
Caring	Good ●
Responsive	Good ●
Well-led	Requires improvement ●

Are hospice services for children safe?

Good ●

Mandatory training

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

We saw from the random sample of ten staff files we reviewed that, on starting employment, each staff member had received an induction.

To ensure staff completed their mandatory training, staff told us the hospice closed for a full day to train staff. Mandatory modules included (with percentage staff compliance in brackets): fire induction (96%); fire marshal (45%); mentor update (100%); basic life support (100%); child safeguarding level three (89%); child safeguarding level three update (78%); manual handling practical (93%); infection control update (93%) food hygiene (82%) ventilation training (82%); and sepsis (71%).

Compliance with annual completion of mandatory modules was overseen by the clinical educator and head of care. We saw a spreadsheet was kept for these purposes.

However, there was no target set by the trustees or leaders for staff compliance with mandatory training.

Safeguarding

Staff understood how to protect babies and children 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. However, staff had no policy or mandatory training in vulnerable adults.

The hospice had a lead for children safeguarding who was the head of care. The lead was trained to level three safeguarding but had access to a level four trained supervisor at a local hospital trust.

Any children that were subject to any protection plans or orders could be flagged on the service’s electronic patient record system. Each child had an individual care plan and any specific safeguarding needs were also noted on this.

Adults seeking access to children had to enter the hospice through a separate door that had closed circuit television monitoring. A staff member would answer the doorbell in person and escort the adult(s) into the premises.

The service displayed up to date photos of the whole team so that those using the service could see who a staff member was.

We saw that staff could refer to a safeguarding policy for children that had been developed with support from a local trust. Also, staff could refer to an information board on display in their staff room, and the local children safeguarding board (LCSB) online resources.

Staff attended multi-disciplinary team (MDT) meetings for children in their care, where necessary.

All staff attended a two-day recommended LCSB course which was refreshed annually in addition to undertaking e-learning safeguarding modules. This included training on PREVENT and female genital mutilation (FGM) and child sexual exploitation (CSE).

The hospice told us that 26 out of 28 staff were currently trained to level three children safeguarding; the two staff not yet trained were booked to receive such training.

We saw that checks prior to employment starting included, disclosure and barring checks (DBS), which were updated every three years.

Staff we spoke with could give us examples of when they had reported safeguarding concerns. For example, when staff spotted bruising on a child.

Supervision of staff on safeguarding took place with the level four trained lead in the local hospital four times a year.

The service did not have a policy for vulnerable adults because it cared for children up to five years old. However, staff could access e-learning on safeguarding adults. We flagged with staff our concern that staff were not trained and had no policy in place for vulnerable adults considering the children they looked after were looked after themselves by adults who may be vulnerable. Staff said they would review this.

Staff also agreed to review safeguarding training for their volunteers at the recommended level. Presently, while volunteers had an enhanced DBS check, they did not undertake any safeguarding training.

Cleanliness, infection control and hygiene

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

With the exception of the two vehicles used to transport babies, children and staff, we found all equipment staff used and the environment to be free of clutter and visibly clean.

On entering the premises through the public entrance there was nothing to encourage visitors to wash their hands and no gels or sink nearby where visitors could do so. In contrast, if entering through the door used by adults visiting their children, there were notices up and hand gel on the wall. However, some parents we spoke with said staff did not encourage them to wash their hands. We raised this with staff and they said they would look into this.

On inspection of the two vehicles used to transport staff and children we found them to be visibly unclean. One van, (fitted with a tail lift used for wheelchairs) had a ‘used’ tissue in the cabin and strewn across the floor in the back, were rolls of tissue. The floor of the vehicle had recesses in the floor and these had, stuck in them, leaves and debris brought in from outside. The other van had non-detachable seats and these had crumbs on them. On our follow-up visit, we noted both vans were visibly clean.

All staff seen were bare below the elbow and made use of personal protective equipment (PPE), such as aprons and gloves, when providing care. Staff had access to ample supplies of PPE. Above each sink in each room where babies and children slept there were posters about handwashing technique.

The hospice had an infection control lead who was the head of care. In the period October 2018 to October 2019 there were no reported healthcare associated infections. We saw logs of regular tap flushing to address the risk of legionella.

Infection prevention control audits were conducted monthly and, at team meetings, the results and any actions were discussed with staff. We saw monthly audits covering sharps, mattresses, and hand hygiene with actions noted. Staff told us no key performance indicators had been set for any of these audits. The audits used a tick system against a met, partially met, not met, criteria. No one had converted the ticks into an overall percentage score.

If a baby or child needed to be isolated because of an infection the hospice had two isolation rooms and could barrier nurse that child to prevent the risk of the spread of infection.

Infection prevention and control was a standing agenda item at the clinical governance meetings.

The hospice benefited from a dedicated housekeeper. Deep cleaning of the four rooms used by babies or children took place according to a routine maintenance schedule. All substances hazardous to health were securely locked away.

Each year a local trust conducted an external infection prevention control audit. We saw a completed audit for July 2019 which covered the ward environment and showed compliance at 90%.

Environment and equipment

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

The service was based in a converted former convent, with ample parking, and wheelchair accessible premises.

The layout was in two parts.

On entering through the public entrance, on the left of the building was the reception and offices (including sitting room and conference room), and on the right was the hospice used for babies and children. Access to the hospice was controlled through volunteers who staffed the public reception and by keypad locks on the doors joining the two sides of the building.

For adults visiting their babies or children there was a separate entrance that led straight into the hospice.

Downstairs the hospice consisted of an office for the head of care and their deputy, a sensory room, a large open space used for activities, and (off of the activity space) two single patient rooms and two multi-bedded bays plus one room that allowed family to stay nearby or in the room. The rooms had large wooden cots in with beds that could be lowered to the floor. Staff could affix padding to the inside of the cots, where necessary. There was also a corridor leading to stores, a locked medicines room, laundry, and kitchen, access to which was controlled by a keypad lock.

Upstairs (which could be accessed using a lift off of the activity room) there was a chapel (that was set up as a fully functioning but un-used Christian church) and a bereavement suite. The suite included a kitchen, sensory room, sitting room, medicines room, viewing room (which could be cooled) and rooms for the child and family, with en-suite facilities. Outside there was a garden, (including a bereavement garden), a play area, and a summer house.

The head of care and nominated health and safety link staff member carried out monthly, a health and safety walkabout.

We saw health and safety audits that covered the physical environment inside and outside the hospice. It did not include the vehicles used by the service. Oversight of the outstanding recommendations took place at the health and safety meetings.

We saw a range of equipment used for activity with children such as magic carpets, toys, and ball pits. Staff told us balls in the ball pit used in the sensory rooms were cleaned after each use and toys were cleaned on a 'used by' basis by night staff. All toys and balls seen were visibly clean.

All portable equipment seen had an up to date portable appliance testing. Equipment used by staff, such as hoists, (ceiling and floor), and weighing scales were in date for their maintenance checks. All sharps bins seen were assembled properly, off of the floor, not over full, and signed and dated.

Parent/carers of children brought the equipment their children needed into the hospice (including a spare) because the hospice did not stock or keep any such equipment on the premises. However, the hospice could provide padded wheelchairs and child seats for the vans.

We saw staff used a maintenance spreadsheet, for premises and equipment, to monitor what needed doing and by when.

When we walked around we noted in two of the children rooms there was a ligature risk posed by the red emergency pull cord, which went from the ceiling almost to the floor. While some cords had a transparent plastic tubing on the lower half of the cord, which mitigated the risk to some extent, not all of them did. Also, in the activity space, ligature risks were posed by the handles on cloth bags hanging on the wall. It did not appear that ligature risks were covered in the health and safety audit, but staff told us they were noted on the child's individual management plan. Further, some doors, such as the door into the sensory room, did not have finger guards in place to prevent a crushing injury to fingers or hands. We pointed out these matters to staff and were told they would be dealt with.

Storage did pose a challenge for staff. For example, within one of the baby/children's rooms, we saw a door leading to a cupboard sized space. Inside, on all three walls, there was shelving almost from the ceiling to the floor. The floor was also occupied by items stacked one on top of the other. We pointed out to staff that the bending, twisting, and reaching above the head, together with the lack of space to move around, posed a health and safety risk to staff. This was not on the local risk register.

The service did not benefit from a backup generator in the event that power was lost to the premises. However, to mitigate this, we saw an emergency plan addressed what staff should do in this eventuality. Staff told us this had not been practised as a routine in the last year.

All fire exit signage was clear and we followed the fire evacuation route and found all three fire exits were free of obstruction, inside and out. All fire extinguishers seen were in date for their review, including those in the vans. The fire system was tested one day a week.

It was noted that notices in the baby/children rooms were affixed to a white board using magnets which were brightly coloured and in sizes that resembled a sweet. We were concerned, should the magnet fall to the floor for any reason, it could present a choking hazard. Staff said they would address this.

With the exception of one notice in the bathroom (which itself had a review date of 2014), notices seen for use by staff, did not have a version control on them. It was impossible to tell whether the advice in the notice was current or not. One notice told staff to weigh children but staff told us this no longer happened as a matter of routine because, for example, staff used the weight in the most recent clinic letter. Other notices (such as for sepsis) were copies of notices used by third party acute healthcare settings and bore no relationship to what staff at the hospice did in practice. We pointed out to staff the obvious dangers notices without version control (or out of date notices) could pose to safe care. Staff told us they would address this going forward.

In the fridge in the kitchen used to store food for children, only a couple of items in the fridge had the name of the child on and the date the item was opened. We pointed this out to staff who told us they would raise this with staff.

We saw that oxygen and emergency equipment (such as the resuscitation trolley) were checked daily by night staff.

We checked the emergency resuscitation trolley and saw that this had been checked daily by night staff. It was stocked with age appropriate masks and other equipment to be used in resuscitation.

We saw that staff separated domestic and clinical waste in colour coded bins. We saw that the bins used to store clinical waste outside the building were locked pending collection by a third-party clinical waste collection service.

Assessing and responding to patient risk

Staff had no written policy to follow to support them in identifying and quickly acting upon babies or children at risk of deterioration. But staff completed and updated risk assessments for each baby or child and removed or minimised risks.

We were concerned that frontline staff caring for children, including overnight care, did not have a written policy telling them what to do in the event of a deteriorating baby or child.

While staff had been trained in sepsis recognition and recognition of the sick child, the training on sepsis covered signs and symptoms only, and did not tell staff what to do in the hospice. Staff told us the hospice's clinical educator was in the process of developing training about sepsis that was fit for purpose for a hospice providing a 'home from home' service.

After the inspection we raised our concerns with the service and asked them to address them forthwith. The service responded by creating a flow chart for staff to follow, based on national guidance, using a traffic light system. The service also committed to introducing a written policy within a specified timeframe. At the follow-up inspection staff reported that the interim system was working well.

Notwithstanding the above, the hospice did have a thorough process in place for accepting a baby or child into the service.

Prior to accepting a baby or child into the care of the hospice staff visited the home of the baby or child to ascertain whether the hospice could provide care. Staff had a detailed acceptance criterion to follow. This was followed by a 'stay and play' session and a 'getting to know you' day. If both parties remained satisfied, the hospice would then offer an overnight stay.

Each baby or child in the care of the hospice had a named nurse. It was the responsibility of the named nurse to develop and keep under review a care plan and complete and update risk assessments, as appropriate. The care plans were developed in partnership with the family prior to a first visit. The plans were reviewed on admission and monthly. For instance, if the medication for a baby or child had changed, this would be picked up on admission. The care plan addressed expected events, bearing in mind the complex conditions the baby or children had.

Prior to admission, a phone call was made to discuss any changes to the medication and this was verified, where possible, prior to administering any medication. If verification was not possible staff completed a risk assessment prior to administering medication.

Staff told us, if for any reason staff considered there were not enough staff available to safely care for babies or children at the hospice, a decision would be made to suspend further admissions or close the hospice.

We saw an up to date resuscitation policy. This detailed the steps staff should take if a baby or child had breathing problems. This involved calling 999 and providing basic resuscitation life support pending arrival of the paramedics. All staff files seen showed staff had completed training in basic life support.

While no baby or child presently had a do not resuscitate form in place, staff explained when this applied, the parent would bring the original form with them, and the care plan would be noted.

Staffing

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

The hospice provided care to a maximum of six babies or children at any one time. Staffing consisted of four team leaders, who led a team of seven registered children nurses and two disability children nurses, senior care assistants and care assistants. Each shift was led by a nurse in charge.

During the day, children at the hospice received one to one care. A play leader was not included in the staffing numbers and attended each day to develop and deliver targeted play sessions for the children.

The rota for staffing was compiled in light of bookings and subject to regular review by the head of care or their deputy. This ensured during the day babies or children had one to one care from a registered children nurse and in the evenings, there was one registered children nurse on duty with three care assistants.

A GP visited the hospice at least once a week and was contactable if any of the babies or children required a consultation. Staff could also contact a consultant based at a nearby hospital trust.

As at October 2019 there were seven full time registered children nurses and two disability children nurses, 11 care assistants and three non-qualified staff.

The service had two vacancies for registered nurses and one vacancy for a care assistant and had low levels (below 1%) of staff sickness.

Bank staff (who were staff that had worked regularly at the hospice and had been trained to the same level as permanent staff) were used at times of unexpected leave or annual leave. Bank staff attended an induction day within one month of commencement of their contract.

A registered children's nurse was on-call at weekends and the head of care and their deputy were also contactable 24/7.

Quality of Records

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

We looked at seven sets of baby or children records and found them all to be legible, detailed, and accurate.

When not in use, the paper part of the records was locked away. Staff (including bank staff) accessed the electronic part of the record using a password. Staff told us they had three laptops for use in accessing the electronic part of the record system. Staff told us this was an adequate number for them to access and update the electronic part of the record.

We noted that allergies were recorded.

The electronic part of the record alerted staff if there were any safeguarding issues with the baby or child, such as a care protection plan.

The electronic care plan went into detail about the any mental health needs, learning disability needs, behavioural needs, and any autism needs, as applicable.

Using a secure email network, staff at the hospice could share details about babies or children with relevant hospital trusts.

When we inspected on 6 November 2019 the policy for records had a review date of March 2019, so was past its review date. By the time of our follow-up inspection on 12 November 2019 the updated policy was in place.

To ensure information was up to date and relevant, each month, staff conducted a records audit, which looked, in detail, whether the records met a series of standards. However, there was no over-arching key performance indicator set for each standard and so it was not possible to see whether the monthly audit was a pass or a fail.

Moving from paper records to a mixture of paper and electronic records was a significant change. However, staff could not show us a risk assessment that had been completed prior to making such a significant change in record keeping practice.

Medicines

The service only administered medicines brought in by the parents and stored them pending collection by the parent at the end of their baby's or child's stay.

Staff at the hospice explained that, apart from medicines that could be purchased over the counter, the hospice did not keep a stock of any medication, such as controlled drugs, (which because of their potential for misuse, were subject to strict legislative controls).

None of the staff prescribed medication but instead administered medication (which could include controlled drugs) brought in by the parents/carers.

If medication needed to be stored in a fridge, the locked room, used for storing medication, had a fridge. In addition to logging the room temperature, we saw that staff kept a log of maximum and minimum fridge temperatures.

Within the locked room there was a locked metal cabinet to store controlled drugs. The nurse in charge kept the keys for this room and the controlled drugs cabinet. Controlled drugs brought in by parents were signed in and out in a controlled drugs book. We saw this and all balances were correct.

To ensure correct medicine dosage was given, it was necessary to weigh a child. However, staff told us they stopped weighing the children because it was causing confusion where a child had recently been weighed in a different clinical setting. Instead staff used a recent measurement provided by the parent/carer or one provided in the clinical records. However, if staff thought it necessary, they had calibrated weighing scales they could use to weigh a baby or child.

For each baby or child, there was an electronic medical administration chart that staff kept up to date. We reviewed seven of these. We found them to be accurate and up to date. This included allergy information.

The service conducted detailed monthly audits of medicine with results fed back to staff. For example, the August audit of medications showed all controlled drugs were not double signed. The September 2019 medicine audit showed ongoing issues with controlled drug book checking medications in and out. Also, items were being crossed out on medication charts but not being signed.

The audit had an action plan. Some actions were blank. Other actions were to discuss at the next nurses meeting. However, there was no follow-up (apart from the next monthly audit) to check whether the action led to a safe result. No individual owner was assigned for the action. The issues were not on the local risk register.

Checks we made of the controlled drugs log book showed stock was balanced and the log book completed accurately so it appeared the issues noted in the audit were historical.

The head of care was the controlled drugs accountable officer and attended local intelligence network meetings. We saw a quarterly report to the local intelligence network. The head of care kept a spreadsheet of any medication issues. Any drug alerts were handled by the head of care.

The hospice had a service level agreement with a third party that ensured a pharmacist carried out twice yearly medicine audits and reviewed and updated medication policies, and provided training and advice relating to medicines. The pharmacist was available Monday to Friday.

Incidents

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

Incidents were reported according to the hospice’s adverse incident reporting system that was in place. We saw the service had a up to date incident reporting policy. Incidents were reported using a non-electronic system but details were transferred to a spreadsheet. Incidents were discussed at the quarterly clinical governance meetings and lessons learned cascaded back to staff at local meetings. Incidents reported were investigated by the head of care or their deputy using a root cause analysis method. Any such analysis was shared at the governance meeting to ensure learning was embedded across other locations.

In the period October 2018 to October 2019 there was one death reported to CQC that was followed by involvement of the coroner. This did not result in an inquest; there were no never events; one serious incident that was reported in April 2019 involving a deteriorating patient. We saw the investigation report which was detailed with an action plan in place. We saw all actions had been performed; and there was one duty of candour notification regarding the April 2019 incident.

Management also attended the Palliative Care Network, Long-term Ventilation Forum and controlled drug meetings regularly for shared learning.

The head of care received any national patient safety alerts.

Are hospice services for children effective?

(for example, treatment is effective)

Good ●

Our rating of effective went down. We rated it as Good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of babies and children in their care.

According to the clinical governance policy supplied by the service, the responsibility for ensuring practices and policies complied with National Institute for Health and Clinical Excellence (NICE) guidelines, remained with the head of care. However, staff told us, in reality, it was the director of care that kept an overview of when policies needed to be reviewed and assigned the review to the nominated head of care.

We were supplied with a clinical governance plan for 2016. This was in the form of a poster. It did not appear this had been updated since 2016. We saw an audit timetable that specified a monthly audit of medication; documentation; cleaning; infection control; and health and safety. Additional audits were to be done as agreed by the head of care. We could not see any clinical audit programme, for instance, to check that a particular NICE guideline was being followed.

As part of the process of review, policies were reviewed at quarterly governance meetings that were attended by the heads of care and director of care. At this meeting policies were reviewed to ensure that they were up to date and followed guidance published by NICE and then approved.

Staff could access polices electronically on the hospice’s computer system.

Nutrition and hydration

Staff gave babies and children 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 babies and children's religious, cultural and other needs.

Staff provided nutrition and hydration to babies or children in the care of the hospice according to plans agreed with the dietetics service and which was recorded in the nutritional care plan. Information was verified with that service and staff attended regular multi-disciplinary team (MDT) meetings about the baby or child at which a dietitian was present. Fluid balance charts were used, where appropriate, to record fluids.

Each time a baby or child came into the service the diet and medicine chart was clarified with the parent to pick up any changes and to ensure staff were working off of the most up to date information.

Staff did not prepare food but instead blended food brought in by the parent/carer. However, some food we found in the fridge was not marked up in accord with the hospice's policy.

Nutrition plans took account of NICE guidelines for 'End of life care for infants, children and young people with life-limiting conditions: planning and management'.

Pain relief

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

Staff had a range of tools, including the individualised care plan discussed and agreed with the parent/carer, to recognise when a baby or child was in pain. The GP or consultant could prescribe pain killing medication that staff would administer.

Pain plans took account of NICE guidelines for 'End of life care for infants, children and young people with life-limiting conditions: planning and management'.

Patient outcomes

The service monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for babies or children.

Staff described the only way they currently monitored outcomes consisted of an annual parent/carer satisfaction survey plus review of any monthly feedback forms that family could complete after their baby or child had stayed with the hospice. The head of care analysed the survey and parent/carer feedback and this was discussed at head of care meetings and with staff and families.

While staff described seeing improvement based on a physiotherapy plan developed for a child, this was not measured in any objective way.

Staff explained that a lot of their outcomes were seen in the support they supplied to families.

We did not see any evidence of other ways of objectively monitoring patient outcomes such as pain audits, treatment plans, or attainment of goals.

Competent staff

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

Staff working at the hospice were employed having supplied two satisfactory references and a clear DBS check, the latter being re-checked every three years. Professional registration of nurses was checked on a yearly basis and monthly checks showed the revalidation date was near. We saw evidence of this in the staff files we reviewed.

Before starting unsupervised tasks, staff had a period of preceptorship, the duration of which varied depending on the staff member's experience. Staff had to complete a competency pack framework. During this probationary period, staff were not included in the staffing numbers. A mentor was appointed to support the new staff member and carry out regular reviews with them.

Each year, (or more regularly if indicated) staff had their competencies checked on relevant areas including tracheostomy care, naso-gastric care, suction, use of an oxygen concentrator, medication administration, feeding (including with pumps), and hand hygiene techniques. We saw evidence of this in the staff files we reviewed.

Staff had been trained in sepsis recognition and recognition of the sick child. Staff had been trained to administer specialist feeds using various methods including use of naso-gastric tubes and pumps.

All staff had received an annual appraisal or were booked to receive one.

Multidisciplinary working and coordinated care pathways

All those responsible for delivering care worked together as a team to benefit babies or children. They supported each other to provide good care and communicated effectively with other agencies.

We saw from records we reviewed that the frontline clinical staff worked effectively with the wider healthcare team.

Staff told us the GP visited once a week. The physiotherapy team visited three times each week. A dietitian provided advice and support about nutritional needs. An epilepsy nurse was contactable to discuss medication.

Seven-day services

Key services were sometimes available seven days a week to support timely care for children, young people and their families.

The service aimed to be open seven days a week but owing to financial pressures the trustees had recently decided to close the hospice for two nights each week.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

We saw no evidence of health promotion on display. We discussed this with staff. Staff told us they would consider using a board, used for information for parents, to include health promotion information.

Consent and Mental Capacity Act

While staff supported parents or carers of babies and children to make informed decisions about their care and treatment, we were not assured they knew how to support parents or carers who lacked capacity to make their own decisions or were experiencing mental ill health. This was because staff were not trained in consent and the Mental Capacity Act.

The hospice had a policy for consent and the Mental Capacity Act 2005 (MCA). Thirty-seven babies or children using the service were noted by the hospice as lacking capacity.

The hospice took consent for treatment from the parent or carer. However, because staff did not receive training on the MCA, we found it difficult to understand how staff could assess whether a parent or carer had sufficient mental capacity to give consent on behalf of their child. Staff said they would address this.

Are hospice services for children caring?

Good ●

Our rating of caring went down. We rated it as Good.

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Children had their own cot or bedroom space when they stayed with the hospice, which, with the exception of the two isolation rooms, was shared with another cot. Nappy changes were carried out in private in a bedroom or bathroom. The parents' questionnaire in 2019 provided positive feedback. Twenty-nine questionnaires were sent out and seven parents responded. Parents said things like "absolutely fantastic the care provided from all staff is amazing." Or "excellent care." Actions were implemented such as provision of hydrotherapy which was requested in one of the surveys.

The positive parent/carer feedback we saw in the written survey responses was confirmed by parents we spoke with both at the inspection and afterwards over the phone.

Good ●

Hospice services for children

Emotional support

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

The service ran a parents' support group which met several times a year and the hospice had a team to organise parent events. This was in addition to a sibling support group run by the play leader. Working with a third party, the hospice had developed a bereavement support group which made use of a counsellor. The plan was to extend counsellor support to all parents and families that needed it.

The bereavement suite supported parents or carers who wished to stay with their baby or child until suitable arrangements were made. This was like a self-contained flat with a kitchen, living room, sensory room and bedrooms, for all the family to stay in.

The chapel was an un-used former Christian church which had been left as the former users had left it. It felt chilly and staff explained if a parent wanted to use it they could provide portable heating. Staff said it was sometimes used for a nativity or if parents wanted a quiet place. We saw a book of remembrance.

We were concerned the space which the chapel occupied may not have felt inviting to those of no faith or a different faith from the Christian faith. We raised this with staff. Staff explained that they would try and accommodate different faiths or no faith in a different setting if this was required, working in concert with the family's choice of faith leader. Staff explained that because they leased the building it was not possible to make changes to the chapel to turn it into a multi-faith and/or no faith space.

Understanding and involvement of patients and those close to them

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

As part of the admission discussion parents and carers were asked about any cultural or religious needs.

Annually the hospice ran a parent/carer satisfaction survey. Also, there was a monthly feedback form that family could complete after a child had stayed with the hospice. We saw the one for September 2019 which showed 32 babies or children had accessed the service in that month and five feedback forms had been completed which were positive. However, it was noted that parents were reporting feedback fatigue having filled in a form the month before. A review of all monthly reports for 2019 showed that response rates were low with one month showing zero returns.

Staff told us parents wanted more information on what their baby or child were doing while at the hospice. In response the hospice was going to implement a system whereby parents could log in remotely and view videos and pictures of their baby or child.

Are hospice services for children responsive to people's needs?

(for example, to feedback?)

Good ●

Our rating of responsive went down. We rated it as Good.

Planning and delivering services which meet people's needs

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

The hospice provided services to babies or children who were admitted to the service, including respite, palliative care, end of life care, one to one care, bereavement counselling, a pick up and drop off service for children, and a range of therapy.

The hospice had framework agreements with local authorities to provide respite for children and families. This contributed towards the strategies of those bodies in terms of health and wellbeing, early help, and special needs and disability. The framework required outcomes to be reported such as feeling safe and having emotional and physical needs met.

Good ●

Hospice services for children

The hospice was working with a local trust to improve the end of life pathway should families want this.

Also, the hospice was working with a local charity to build a capability for parents to remotely access videos and photos of the stay of a child at the hospice.

Staff could access an interpreter should one be needed.

Meeting the needs of people in vulnerable circumstances

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

On the records there was a summary in the electronic care plan called ‘all about me’. This highlighted key things about the baby or child such as likes and dislikes, nutritional needs, mobility, communication and so on.

Staff worked closely with the wider healthcare team to ensure they were able to meet the needs of the baby or child, such as, by reviewing the management plan.

To meet the needs of people in vulnerable circumstances, the service also ran a parent support group, a sibling support group, a bereavement support group and conducted regular patient/carer surveys.

Access to the right care at the right time

People could access the service when they needed it and received the right care in a timely way.

Prior to respite starting the hospice gathered all relevant healthcare information about the baby or child. Once received and reviewed, the head of care met with the family to conduct an assessment. If the baby or child met the hospice’s acceptance criterion steps were taken to verify information received. The bay or child and their family were then invited to a ‘stay and play’ session. A named nurse was then assigned with a view to compiling an individualised care plan. The baby or child was then registered as a temporary patient with a local GP. A start date was then agreed and respite care commenced.

Bookings were arranged one month in advance. At the time of our inspection the period of time between referral and admission was six weeks. A bed was usually kept empty to accommodate an emergency admission.

If a baby or child was at end of life, with parent consent, the family could be accommodated in the hospice’s bereavement suite and had access to a bereavement counsellor.

Learning from complaints and concerns

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

We saw an up to date complaints policy. Staff were encouraged to resolve complaints at a local level. However, if this did not resolve matters families could speak with the head of care. Families had access to a guide on how to complain and there was a notice about the right to complain near the main reception area. The target to resolve complaints was 25 days. In the period October 2018 to September 2019 there were zero formal complaints.

In the period September 2018 to October 2019 the hospice received 34 compliments.

Are hospice services for children well-led?

Requires improvement ●

Our rating of well-led went down. We rated it as Requires Improvement.

Leadership

We were not assured the leaders had the information they needed to understand and manage the priorities and issues the service faced.

The governance structure consisted of a board of five trustees, one of which was an executive trustee to who a director of care reported. At location level, the registered manager was the head of care and under them was a deputy manager and then the frontline clinical and domestic team.

On speaking with the executive trustee, director of care, and head of care, we were not assured the leaders had the information they needed to understand and manage the priorities and issues the service faced. For example, the trustee body, (or the director of care, if it was delegated to them), had not set any key performance indicators, whether for mandatory training, incidents, or complaints. Further, there were no clinical audits, or audits to objectively monitor patient outcomes. We did not consider the current system used by the hospice enabled the leaders to see, quickly and clearly, the issues the service faced.

However, the head of care held a diploma in leadership and management. Staff reported that the leadership team were visible and approachable and while on inspection, we saw this was so.

From reviewing the staff files, we saw that staff were supported to develop skills such as applying to become team leaders, senior care assistants, or apply for deputy roles.

Vision and strategy

While the service had a vision for what it wanted to achieve the strategy to turn it into action was a list of expectations, and it was not clear it had been developed with all relevant stakeholders, or aligned to local plans within the wider health economy. Without specific, measurable, achievable, realistic, timed (SMART) (or something similar) expectations, while leaders and staff understood it, it was difficult to see how they could objectively monitor progress.

The hospice had a philosophy of care, ten core values and a mission statement. This was set out in a document called a business plan for 2019.

The mission statement was to reach families in need, provide compassionate palliative care to those who used the services, and promote the wellbeing of the child.

The core values, amongst others, were to put care for babies first, support families, treat children as individuals, respect and value staff and deliver effective palliative care.

While the strategy addressed clinical, financial and fundraising aspects of the service, these were statements followed by a series of expectations which did not appear to be specific, measurable, achievable, realistic, timed (SMART) (or something similar).

It was unclear how much of the strategy was developed with all relevant stakeholders or how it was aligned to local plans within the wider health economy.

While the expectation statements could be understood by staff, it was difficult to see how leaders and staff could objectively monitor progress.

Culture

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

Staff we spoke with felt respected, supported, and valued by their leaders.

When speaking with staff and through observing them it was clear that their first priority was focussing on the needs of the babies or children they cared for. Parents we spoke with confirmed this.

The service conducted a staff survey in 2019 which had a less than 50% response rate. Concerns were around job security and morale was noted as being low across all sites. Staff we spoke with told us that survey results probably reflected the way staff felt at the time because of the funding issues facing the service.

Staff reported a no bullying culture and felt they could raise anything they wanted to raise. Parents also felt they could raise anything with staff.

While the information was due to be shared with staff, the trustees did not note any action plan to address the staff survey results or (it appears from the minutes) request an action plan to do so.

Governance

We were not assured 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.

While there was a governance structure in place, detailed below, we were not assured it was well-led.

For example, notices we saw displayed around the hospice for staff to use either had no date and version control on them, or the date and version control was out of date but still in use. An example of this was the standard operating procedure displayed in the room with the bath and overhead hoist, which had a review date of 2014.

Another example concerned significant changes in practise being made without first ensuring a written policy had been created for staff to follow, with all the necessary tools, and training, plus a system to review whether the policy and training had worked. For example, the records policy had only just been updated even though staff had moved to a partial electronic records system before the policy was revised. Or the decision to stop using the paediatric early warning score and use a different system without first settling on a written policy for caring for the deteriorating child. In both these examples, no risk assessment was carried out to measure the impact of the change to decide whether it was safe to proceed.

When discussing governance with leaders it was clear that none of the trustees had a portfolio of areas that they were meant to look after in order to bring that insight back to the trustee meetings. For example, staff told us no trustee reviewed the local risk registers to check that they were being governed properly.

Head of care meetings took place weekly with the deputy head of care and monthly with the head of care and director of care. At a local level, monthly nurse meetings, and quarterly team meetings and health and safety meetings took place. Every quarter heads of care met with the director of care and a trustee and this was the clinical governance committee. Issues discussed included: risks; incidents; complaints; infection prevention control; review and approval of clinical policies and lessons learned. The trustees received a monthly report from the director of care touching on some of these issues.

To ensure staff were up to date with policies staff were required to sign to say that they had read a revised policy.

A trustee board meeting was held three monthly and the director of care (who heads of care reported to) was meant to attend that meeting. In 2019 the director of care had missed one meeting. The heads of care submitted a report to the trustee board meeting. The trustee board meeting also had sight of the governance board minutes.

We reviewed a range of minutes from nurses' meetings to governance meetings and trustee meetings. Minutes were detailed and discussed the topics noted above in addition to actions from audits.

We saw an annual business plan for 2019 to 2020 which set out the decision, owing to financial constraints, to close the location for two nights each week. The rest of the plan set out steps to try and address the financial challenges.

Management of risks, issues and performance

We were not assured leaders and teams used systems to manage performance effectively. The local risk register did not reflect the risks we found and that register was not aligned to the trustee risk register which appeared to focus on 'potential' as opposed to 'live' risks, escalated from the local risk register. Actions to reduce their impact were not always SMART. The service had plans to cope with unexpected events.

We saw an up to date risk management policy. However, this did not reference the local or trustee risk register and the need to maintain, update, and monitor it or explain how risks were escalated and de-escalated between the local and trustee register. Staff told us risks with a score above 12 were escalated to the trustees but this was not written down in the policy. The policy appeared to delegate risk monitoring to the head of care with no mention of the director of care.

The leaders confirmed to us that they had not set any key performance indicators for staff to work towards. For example, in the records audit, none of the standards had a key performance indicator. This meant staff were producing management information with nothing to measure it by. This meant it was difficult for leaders to see if there was any risk associated with what staff were doing or whether the performance was acceptable.

Notwithstanding the gaps in the risk management policy, staff at a local level did maintain a risk register. This gave a date to the risk (but no number to support traceability), a short description of the risk, the immediate action taken, the risk rating, (but no score), action taken, the lead, a timescale, whether it was reported to the trustees, a residual risk rating, the outcome and the date closed. However, the only ‘live’ risk on the register concerned a sofa with a rip in it. This did not reflect the risks we found at a local level. For example, lack of a written policy for care of the deteriorating child. Further, by not having a column to place the score in, it was difficult to see how anyone could see whether the risk should be escalated.

The risk register operated by the trustees bore no resemblance, in either content, format, or layout, to the risk register maintained at a local level. It appeared to be a list of ‘potential’ risks the service may face not actual risks. We were concerned about the lack of alignment and lack of flow through between the risk register maintained at a local level and the risk register maintained at trust level. We could not understand how trustees (particularly new trustees) could clearly see what actual risks the service faced, what was being done about them, and when the risk was going to be closed. Indeed, because risks tended to be recorded across the governance minutes, just to try and gain a clear picture of what was going on, a new trustee would have had to read through all previous minutes. This was clearly not well-led.

Each baby or child cared for by the hospice had a risk assessment to try and minimise risks at an individual level.

We did not consider action plans following audits were robust. The action plans did not follow a SMART model or something equivalent. Instead, we saw that a recurring action was to ‘discuss at the nurses meeting’. This meant it was difficult to see how the leaders could satisfy themselves that such an action was successful.

Information management

While the service did collect reliable data, we were not assured it was being analysed. We were not assured leaders had the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

As noted above, staff were collecting data about records audits or infection control audits. However, no one appeared to be turning the results into a percentage score or something similar and then benchmarking the results against targets set by the leaders. As noted above leaders had not set any key performance indicators. In discussions with leaders it was confirmed that leaders did not have a dashboard of key performance indicators to help them understand performance and make decisions and improvements.

The electronic patient database staff used was password protected.

Engagement

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

We saw that the service conducted patient surveys and staff surveys by way of engagement. On an individual level parents/carer were involved in creating an individualised care plan. Staff had regular meetings. The service was working with local partners to try and create a pathway for end of life care.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation but did not participate in research.

We asked staff about learning, continuous improvement and innovation.

In response they referred us to the Vcreate system they were developing to allow parents to remotely see what their baby or child had been doing.

Staff pointed to the adoption of the care electronic patient database.

Staff referred to the setting up of the bereavement group, and the use of a counselling group.

The hospice did not take part in any research.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Ensure that there are systems and processes in place to monitor performance effectively and drive improvement **(Reg.17)**
- Ensure that all staff are trained to the appropriate level for adult safeguarding as set out in national recommendations and for volunteers in relation to children safeguarding **(Reg.17)**
- Ensure that the environment is free from all ligature risks and risks of crushing by door hinges **(Reg.17)**
- Ensure that the local risk register and trustee risk register were aligned and reflect the actual risks posed to the service and the risk management policy guided staff on using the registers to record, escalate, and monitor risk **(Reg.17)**
- Ensure that notices, policies and procedures used by staff are current and display a version control date **(Reg.17)**
- Ensure that there is a written policy for staff to follow for the deteriorating child **(Reg.17)**
- Ensure there is in place a clinical audit programme **(Reg.17)**
- Ensure that staff are trained on mental capacity and consent **(Reg.17)**

Action the provider SHOULD take to improve

- Add the vehicles used by the service to the environmental audits to ensure the vehicles are clean and safe to use
- Provide handwashing facilities and guidance for visitors using the main reception to stop the spread of infection
- Encourage parents/carers using the parent/carer entrance to wash their hands using the gel provided to stop the spread of infection
- Consider investing in a backup generator to support continuity of the service
- Consider reviewing storage arrangements to reduce to the lowest level acceptable, risks to staff from moving and handling
- Consider whether and if so how to affix notices to boards in rooms used by babies or children to avoid risks to health
- Ensure food stored in the fridge is stored in accord with the hospice’s policy
- Consider other ways to objectively measure patient outcomes apart from or in addition to parent/carer surveys
- Provide health promotion information to parents/ carers

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA (RA) Regulations Good governance** (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to- (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; **How the regulation was not being met** The above regulation was being breached because: 1. key performance indicators were not set to monitor performance effectively and drive improvement 2. all staff, including volunteer staff, were not trained to the appropriate level for adult and (for volunteer staff, children safeguarding) as set out in national recommendations

Requirement notices

3. the environment was not free from all ligature risks and risks of crushing by door hinges
4. the local risk register and trustee risk register were not aligned and did not reflect the actual risks posed to the service and the risk management policy did not adequately guide staff on risk recording, escalation, and monitoring
5. notices, policies and procedures used by staff were not current or did not display a version control date
6. there was no written policy for staff to follow for the deteriorating child
7. there was no clinical audit programme
8. staff were not trained on mental capacity and consent