Francis House Family Trust

Francis House Children's Hospice

Inspection report

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

Ratings

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

Summary of findings

Overall summary

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

- The service had enough staff to care for children and young people and keep them safe. Staff had training in key skills, understood how to protect children and young people from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to children and young people, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave children and young people 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 children and young people, advised them and their families 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.
- Staff treated children and young people with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to children and young people, families and carers.
- The service planned care to meet the needs of local people, took account of children and young people's individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- 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 children and young people receiving care. Staff were clear about their roles and accountabilities. The service engaged well with children, young people and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for children	Good ●	Our rating of this service stayed the same. We rated it as good. See the summary above for details.

Summary of findings

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Background to Francis House Children's Hospice

Francis House Children's Hospice provides palliative care for children and young adults with life limiting and life-threatening conditions and support for the whole family both during the young person's life and following their death.

They also provide care and support for children and their families within the local community. Services included respite care, end of life care, bereavement support for parents, a 'shining stars' bereavement group for siblings, emotional support, day service and family support.

The hospice has 14 rooms for children and young people. The service is within one building but is separated into two areas, Francis House for children and Francis Lodge for teenagers and young adults. In addition, there are six flats for family members to stay.

At the time of the inspection the hospice cared for seven children and young people within the inpatient unit. This was the maximum number of open beds in line with the current staffing levels.

The director of care was the registered manager.

The service is registered with the CQC to provide:

Treatment of disease, disorder and injury

Diagnostic and screening procedures

How we carried out this inspection

We visited the inpatient unit and spoke with staff delivering services. We held interviews with service leads and executives. We spoke with 13 staff and volunteers including registered nurses, support staff, catering staff, housekeeping and facilities staff, reception and non-clinical staff. We also spoke with three patients and four relatives who had experienced support from hospice staff. We observed care and treatment provided in the inpatient unit, reviewed data about the service and reviewed eight patient care records.

We undertook this inspection as part of a random selection of services rated Good and Outstanding to test the reliability of our new monitoring approach.

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

Outstanding practice

We found the following outstanding practice:

Summary of this inspection

- There was a strong family centred culture where families, as well as the children and young people within the hospice's care were supported. This included support during times of difficulty such as ill health within the family. Staff were focused on the needs of the whole family and took action to address these needs in way that was flexible and person centred.
- There was a strong culture of learning and reporting, with a high number of low harm incidents reported. There was consistent evidence of staff recording personal reflections when things went wrong and a culture of learning from this.

Areas for improvement

Action the service SHOULD take to improve:

- The service should continue with plans to gather and act on anonymised feedback from children, young people and their families.
- The service should consider recording their strategy within a strategic plan format.

Our findings

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

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 made sure everyone completed it.

The mandatory training was comprehensive and met the needs of children, young people and staff. Managers scheduled regular mandatory training days as part of a rolling annual programme to ensure staff kept up to date. Examples of training completed included basic life support, infection control, manual handling, first aid, and medicines management. Additional online training was completed in subjects such as information governance, conflict resolution and health, safety and welfare.

Clinical staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism. This included regular equality, diversity and human rights training, as well as specific modules to support the care of children and young people with a variety of needs.

Managers monitored mandatory training and alerted staff when they needed to update their training. Mandatory training compliance was consistently high. Training records showed that all staff were up to date with their mandatory training, except for staff who were off work due to sickness and those who had recently commenced in post. New starters followed the hospice induction programme which included mandatory training completion. We saw that those staff who were imminently due an annual training update were booked into do this over the coming weeks.

Safeguarding

Staff understood how to protect children, young people and their families 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.

Staff received training specific for their role on how to recognise and report abuse. Care staff had completed level one and level two safeguarding training. Medical staff, registered nurses and senior care staff had completed level three child and adult safeguarding training. This was in line with the recommendations of the intercollegiate safeguarding guidance.

Staff could give examples of how to protect children, young people and their families from harassment and discrimination, including those with protected characteristics under the Equality Act. They demonstrated a good understanding and there was clear guidance available for staff within hospice policies.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Senior staff regularly attended safeguarding children meetings and contributed to the protection of children at risk through their collaborative working with other agencies.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was clear guidance on making a referral within the safeguarding policy. There was an identified safeguarding lead within the hospice and staff were clear about their responsibilities.

Staff followed safe procedures for children visiting the ward.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up to date and demonstrated that all areas were cleaned regularly. This included daily and deep cleaning schedules of communal areas and bedrooms. High touch areas such as door handles were cleaned three times a day during the pandemic and we observed staff doing this.

Environmental, cleaning and hand hygiene audits were carried out regularly. We viewed cleaning audits from May to July 2021 and saw that audits of cleaning records identified occasions where records were incomplete. As part of the audit feedback, findings were discussed at the weekly clinical governance meetings. There was also evidence of feedback to staff. An annual infection control audit showed compliance in different areas of the hospice. Results were generally above 90% and action where compliance was lower than expected included discussion at weekly staff meetings, for example, where there was light dust in some areas. We viewed the infection control audit and meeting minutes and saw that findings were routinely discussed.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff followed guidance on the use of PPE, and we observed all staff wearing face masks when in the hospice. Staff had received training in the appropriate use of PPE and there were clear donning and doffing areas. Staff and visitors were screened for signs of Covid-19 through daily lateral flow tests before accessing the hospice. Children and young people were routinely screened for infections in line with national guidance and there were protocols in place to minimise the transmission of infections. There had been no infection outbreaks in the time since the previous inspection in 2019.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

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.

Children, young people and their families could reach call bells and staff responded quickly when called. Call bells were available using a variety of methods to meet the needs of the children and young people. For example, through finger press, motion or voice activation. Staff were seen to respond quickly to calls for assistance.

The design of the environment followed national guidance. There were processes in place for the management of the environment, including risk assessments, maintenance checks and upkeep of the premises. There was a dedicated maintenance staff member in post. Managers had taken action to ensure the premises was suitable for caring for children and young people during the pandemic. This included identifying dedicated areas for donning personal protective equipment and for undertaking aerosol generating procedures in the event of a patient requiring this testing positive for Covid-19.

There were clear security measures at the entrance to the hospice so that visitors were greeted by staff and screened on arrival, including ensuring they had a negative lateral flow test prior to visiting. There was CCTV monitoring of the grounds and in some communal areas such as staircases and corridors. CCTV was not routinely in use in patient rooms; however, it was available in case of a requirement for closer monitoring (such as seizure monitoring) with consent from parents, or the young person if they were over 16.

Staff carried out safety checks of specialist equipment. This included monitoring emergency equipment, beds, hoists and other equipment specific to the care needs of individual patients. Clinical equipment was calibrated on an annual basis and records demonstrated this, for example, in relation to syringe pumps (used for administering medicines continuously beneath the skin). A jacuzzi was available although not in use at the time of the inspection and we saw that maintenance and water checks were carried out.

The service had suitable facilities to meet the needs of children and young people's families. There were facilities for facilities to stay at the hospice. This included sibling rooms on the unit and separate facilities for patients.

The service had enough suitable equipment to help them to safely care for children and young people.

Staff disposed of clinical waste safely. There were appropriate segregation practices and waste was stored appropriately prior to disposal.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.

Staff completed risk assessments for each child and young person on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed the records of three children or young people and saw that appropriate risk assessments had been completed. These included the risk of falls, pressure ulcers, malnutrition and risks associated with seizures.

Staff knew about and dealt with any specific risk issues. Staff had received training in recognising and dealing with sepsis. They had also received training in basic life support and managing seizures. Children and young people with specific risks had individual care plans with agreed escalation plans. In an emergency staff called 999 and the child and young person transferred to the local acute NHS trust.

Staff completed, or arranged, psychosocial assessments and risk assessments for children or young people thought to be at risk of self-harm or suicide.

Staff shared key information to keep children, young people and their families safe when handing over their care to others. They liaised closely with colleagues working within integrated local services, including acute and community children's services. There were established lines of communication and staff regularly met with staff working within other services to discuss care.

Shift changes and handovers included all necessary key information to keep children and young people safe.

Nurse staffing

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

The service had enough nursing and support staff to keep children and young people safe. This included registered nurses, children's nurses and care and support staff with relevant experience working with children and young people.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, in accordance with national guidance. At the time of the inspection the service had enough staff to care for seven children and young people. Managers calculated the staffing establishment based on the individual needs of the children and young people and enabled one to one support for all.

Managers could adjust staffing levels daily according to the needs of children and young people. Senior staff reviewed staffing daily and in advance, based on planned respite admissions and the individual needs of children and young people. The staffing levels allowed for two to one care for children and young people with complex needs. Registered nurses cared for those children and young people with extensive clinical needs.

The number of nurses and healthcare assistants matched the planned numbers. Managers reviewed the nursing establishment based on a calculation that for every child or young person admitted, seven staff were required. They were in the process of recruiting staff over time to increase capacity for admissions over the coming months.

The service had comprehensive plans to manage staff sickness. There was an on call system overnight to ensure adequate cover of registered nurses as well as the provision of senior clinical advice. The service did not use agency nurses and had a team of bank nurses who worked regularly at the hospice. Bank staff either currently worked for the hospice or were previous employees with experience.

Managers made sure all bank staff had a full induction and understood the service.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep children and young people safe. The hospice had six contracted GPs which included three with extensive experience in palliative care. The three senior GPs provided support to the other GPs through a buddy system and supported their development, as well as providing advice and guidance through a 24 hour on call and support rota. The GP's were members of the Association of Paediatric Palliative medicine and they were supported to keep up to date with best practice.

There was a GP rostered to attend the hospice daily to review all the children and young people within the hospice for respite. The GPs also provided on-call cover out of hours, during weekends and evenings.

Named consultants for each of the children and young people were accessed directly through the NHS trust in the event of paediatric specialist knowledge being required.

Records

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

Patient notes were comprehensive, and all staff could access them easily. Paper records were in use and these contained relevant and up to date information. Care plans were individualised, and records included contributions from nursing, medical and support staff.

When children and young people transferred to a new team, there were no delays in staff accessing their records. Information was shared appropriately with other teams, for example, when children and young people were transferred to community or acute services.

Do not attempt cardiopulmonary resuscitation records were completed appropriately.

Records were stored securely.

Medicines

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

Staff followed systems and processes to transcribe and administer medicines safely. Medicines were brought in by families and recorded on medicines administration records (MAR). These medicines had previously been prescribed and were checked by staff to ensure they were suitable for continued use. All transcribing and every administration of medicine was checked by two members of staff. The nursing staff had undergone training and competency assessments to allow them to do this safely. The visiting GP could prescribe any additional medicines that the child or young person required on the MAR chart. A pharmacist visited twice a week to review MAR charts and respond to medicine queries. Pharmacists were contactable for advice outside of this time.

Staff checked that children and young people had the correct medicines when they were admitted, or when they moved between services and staff ensured that their medicines continued to be administered in their normal way. If there was any discrepancy it was followed up with the doctor or pharmacist to ensure that people's existing medicines were continued appropriately. At discharge the person's medicines were returned to them or their families.

Staff completed medicines records accurately and kept them up to date. Instructions for the administration of medicines on the MAR chart were clear, safe and child centred so that each member of staff knew exactly how to give a medicine i.e. 'dissolved in squash'. Instructions for administration was confirmed with the doctor or pharmacist if necessary. Care plans included monitoring requirements after the administration of 'as required' medicines i.e. post seizure. Timings were adjusted appropriately to allow the young person to take their medicine at a time that suited them. Medicines were not used to control behaviour.

Staff stored and managed all medicines and prescribing documents safely. Emergency medicines were available should they be required. Young people who received medicines via patches on the skin were monitored closely.

There was a procedure in place to allow young people to be involved in the administration of their medicines. Their competency was assessed and if the wished they could have shared administration with nurses or self-administer their medicines on their own. We saw one person who was currently sharing responsibility for administering their own medicines. Staff understood their roles and responsibilities with regards to the administration of medicines and the Mental Capacity Act 2005.

The service also supported families with their medicine needs including the administration of homely remedies (medicines to treat minor ailments) to siblings if they were required.

Staff learned from safety alerts and incidents to improve practice.

Staff reported medication incidents and near misses. Incidents were reviewed by the senior leadership and we saw evidence that actions had been completed and learning shared with hospice staff.

Incidents

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

Staff knew what incidents to report and how to report them. There was a high level of incident reporting. This included when anything went wrong, near misses and accidents within the hospice. Staff understood what constituted an incident and reported these appropriately and in line with the provider policy.

Good ●

Hospice services for children

Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation if things went wrong. We viewed records that demonstrated open and honest conversations with children, young people and their families.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to children and young people's care. Staff involved in incidents or near misses completed individual reflections to support the identification of why things went wrong. These reflections were recorded for each incident reported and were completed comprehensively. The process enabled staff to identify potential improvements and actions to prevent a similar incident from happening again. Weekly clinical governance meetings included a time for incident discussion and further discussion was facilitated at staff meetings to explore issues and concerns.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations. There was evidence that changes had been made as a result of feedback. Managers audited incidents on an annual basis and identified trends. Examples included inconsistencies with controlled drug and medicines reconciliation recording. Action included ensuring greater emphasis on these areas within regular medicines management training.

Managers took action in response to patient safety alerts within the deadline and monitored changes.

Are Hospice services for children 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 evidenced-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people 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. Care and treatment was evidence-based and staff managed end of life care in accordance with the National Institute of Health and Care Excellence guidance NG61 (End of life care for infants, children and young people with life limiting conditions). Staff followed policies based on guidance in 'Together for short Lives'; guidance for children and young people who are expected to have short lives. Senior care staff monitored compliance with national guidance and evidenced-based practice.

Staff protected the rights of children and young people subject to the Mental Health Act and followed the Code of Practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of children, young people and their families. Psychological, emotional and social needs were clearly prioritised in line with the hospice's holistic approach to care for the child, young person and their family.

Nutrition and hydration

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

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs. Registered nurses had completed relevant competency assessments in relation to artificial nutrition and training in this was part of routine induction and training updates. Catering staff liaised with nursing staff and the child, young person and their family. Nutritional plans were created, and catering staff ensured that individual preferences were catered for. For example, staff ensured soft fruit was make available, including at times when the main kitchen was closed, following a request by one young person.

Staff fully and accurately completed children and young people's fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor children and young people at risk of malnutrition.

Specialist support from staff such as dietitians and speech and language therapists were available for children and young people who needed it. Staff made relevant referrals and liaised closely with specialists. This included seeking guidance when changes to individual needs were apparent.

Nutritional assessments included the identification of religious, cultural and other needs and how these affected the nutritional needs of the child or young person. Nursing and catering staff worked together to ensure these needs were met and families were involved.

Catering staff provided nutritious meals based on individual preferences. Children, young people and their families had choices of meals and these were tailored to needs.

Pain relief

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

Staff assessed children and young people's pain using a recognised tool and gave pain relief in line with individual needs and best practice. A visual tool was used where children and young people were unable to verbalise their pain. Staff developed a thorough understanding of the children and young people in their care and looked for non-verbal cues that indicated if pain was a concern. They administered pain relief promptly and evaluated how effective it was.

Children and young people received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately. When children or young people were approaching the end of life, anticipatory medicines were appropriately prescribed.

Patient outcomes

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

Outcomes for children and young people were positive, consistent and met expectations, and in line with national standards.

The hospice participated in Hospice UK national benchmarking against other hospices where patient falls, pressure ulcers and medicines incidents were compared. However, as the majority of these were adult hospices, results were limited in value. Hospice leads were actively engaging with Hospice UK with a view to future benchmarking specifically for children's hospices.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. There was a comprehensive audit programme. Audits included medicines records, care plans, medical records and incident reports.

Managers used information from the audits to improve care and treatment. Audit results were shared with staff and reviewed in the clinical governance meetings. Managers shared and made sure staff understood information from the audits.

Improvement is checked and monitored. Audits were compared with previous cycles and improvements identified. For example, the 2021 audit of medical records demonstrated improvements in the legibility and accuracy of records. Clinical decision making and instructions were clear and free from ambiguity.

The hospice commissioned research following contacts from families regarding older siblings and some issues with attempted suicide. The research had been presented to the board of trustees in October 2021 and senior managers told us it will inform how the hospice provides emotional and bereavement support to young adults, including ongoing support when they no longer used the hospice services.

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.

Managers supported the learning and development needs of staff. There was a comprehensive training programme that included training weeks where new and existing staff completed mandatory and essential training for their roles.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families. Registered nurses and care staff were experienced in the care of children and young people with life limiting conditions.

Managers gave all new staff a full induction tailored to their role before they started work. There was a comprehensive induction programme that included required training, for example, in end of life care for children and young people. The week-long initial induction included working shadow shifts and plans for ongoing support were tailored to individual staff based on their experience. We spoke with one new member of staff who told us there were good training opportunities and support available to help them build their confidence within their role.

Managers supported staff to develop through yearly, constructive appraisals of their work. All staff received an annual appraisal which helped to identify performance and development needs. New staff had regular probationary review meetings. Appraisal compliance was 90%.

Managers supported staff to develop through regular, constructive clinical supervision of their work. Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers made sure staff received any specialist training for their role. Staff completed a range of training modules. These included tracheostomy care, seizure management, oncological conditions and enhanced communication. Staff received assessments of their competence in relation to medicines administration, artificial feeding and tracheostomy care. Training sessions were organised based on the needs of individual children and young people and included local palliative care teams providing palliative care and symptom control training, diabetes training from a local diabetes specialist nurse and a local ventilation team providing training on non-invasive ventilation.

Managers recruited, trained and supported volunteers to support children, young people and their families in the service.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings (MDT) to discuss children and young people and improve their care. There was a comprehensive MDT approach to planning and delivery of care. Meetings included staff from nursing, medical, therapy, discharge, community end of life and spiritual care services. Staff held daily de-briefing sessions at the end of the shift to identify what went well and what could have been improved. This enabled staff to share concerns and learning to ensure that care was effective.

Clinical leads held caseload reviews with local palliative care and community teams. Discussions included information sharing about meeting the needs of supported children and young people, their current needs and support and advocacy. There was also a 3-month case review with the local community paediatrician and Francis House medical coordinator.

Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families. At the end of life, a discharge planning meeting was held with relevant professionals involved in care to ensure that the place for end of life care was in the best interest of the child, young person and family. The clinical leads established a strong working relationship with family Liaison and bereavement sisters at the local children’s hospital.

Clinical leads and the homecare team acted as advocates to support families in accessing services, equipment and care provision. Examples included liaising with wheelchair services when a young person’s wheelchair was no longer appropriate and liaising with speech and language therapists and dieticians where appropriate.

Staff also liaised with social workers and community teams on a regular basis regarding support in the home in relation to adaptations required or additional care packages.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health, depression.

Seven-day services

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

The inpatient unit provided seven day support to children, young people and their families. The community homecare team provided scheduled support for individual children and young people and this was available seven days a week if required.

Staff could call for support from GPs 24 hours a day, seven days a week. Access to emergency and diagnostic support was provided through close liaison with local NHS children’s services.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives and live well until they died.

The service had relevant information promoting healthy lifestyles and support on the inpatient unit. Staff worked closely with children, young people and their families, as well as other professionals to maximise health and wellbeing. Care was planned on an individual basis and took account of individual health needs.

Staff assessed each child and young person’s health when admitted and provided support for any individual needs to live a healthier lifestyle and support end of life care as appropriate. Staff received training on supporting children, young people and their families in the last year of life. This included multidisciplinary case reviews and discharge/end of life care planning. Training included advance care planning to facilitate conversations and involvement of those close to the child/young person.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. There were clear policies and guidance available and staff had received training in mental capacity and best interest decision making.

When children, young people or their families could not give consent, staff made decisions in their best interest, taking into account their wishes, culture and traditions. The Clinical Leads facilitated best interest and mental capacity meetings for young people requiring Deprivation of Liberty Safeguards (DoLS) Assessments. Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Staff clearly recorded consent in the children and young people's records. This was regularly audited to ensure compliance with hospice policy and relevant guidance.

Staff understood Gillick Competence (where a young person had sufficient understanding and maturity to enable them to understand fully what is proposed) and supported children who wished to make decisions about their treatment. Staff supported young people to consent to care and treatment based on their ability to do so.

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.

Good ●

Hospice services for children

Staff gained consent from children, young people or their families for their care and treatment in line with legislation and guidance. Individual communication aids were used for young people with speech or language impairment to allow them to consent and plan their own care. Young people had flexibility and choice over their daily activities, including when to get up or go to bed, when and where to eat and activities during the day.

Clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards achieving the trust's target. This was provided by the deputy chief executive who was a qualified lawyer. In addition, they supported families with deputy power of attorney and medical advocacy issues.

Managers monitored how well the service followed the Mental Capacity Act and recorded consent and made changes to practice when necessary. An April 2021 audit showed that 85% of records showed that consent had been appropriately recorded. Action to improve included feedback to staff groups and discussion at clinical governance meetings. An April 2022 re-audit was scheduled.

Are Hospice services for children caring?

Good ●

Our rating of caring stayed the same. 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.

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 consistently responding to individual care needs with compassion.

Children, young people and their families said staff treated them well and with kindness. Feedback was consistently positive.

Staff followed policy to keep care and treatment confidential. Care records were stored securely, and action was taken to improve this, for example, by purchasing lock boxes for the storage of community records following a GDPR audit. Staff held conversations with children, young people and their families confidentially and were respectful of privacy and dignity.

Staff understood and respected the individual needs of each child and young person and showed understanding and a non-judgmental attitude when caring for or discussing those with mental health needs. The hospice was committed to improving the care of young people with mental health needs, including siblings who were impacted by children and young people with life limiting conditions. They had commissioned research to explore ways to better support siblings at potential risk of suicide. We observed staff caring for children and young people in a way that respected their individual needs. Staff showed rapport and understanding.

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.

Hospice services for children

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people’s personal, cultural and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it. The hospice philosophy was based on care for the whole family and we saw that this was consistently applied in practice. Staff provided help and support when it was needed and demonstrated compassion consistently. Support was given in a caring and respectful way to meet the needs of patients and families. Feedback was continually positive.

Staff supported children, young people and their families who became distressed in an open environment and helped them maintain their privacy and dignity. Staff ensured that patients and family members were given privacy to talk through issues and concerns. They provided patients with safe environments to help manage distress, including the use of sensory rooms and activity spaces.

The Emotional support team offered support to parents and siblings following the death of a child or young person. Support was provided individually or as a family and took place at the hospice or in the family home. Parents evenings were held for bereaved parents, enabling them to meet with other parents. There was a Chaplain available on site to offer spiritual support regardless of religious background and they provided support with funeral arrangements.

Younger children were invited to a bereaved siblings group call ‘Shining Stars’ where children had the opportunity to explore and express feelings about their grief in a safe environment. The group also supported children to develop their own way of remembering their sibling. Older siblings could access individual bereavement support.

Francis House had a trained psychotherapist who provided support for young adults and parents. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a child or young person’s care, treatment or condition had on their, and their families, wellbeing. We spoke with the family of one young person who had been provided with crisis respite due to the poor health of a parent. The hospice provided care and support for the whole family, including support for the parent to access appropriate healthcare and recover. The whole family stayed at the hospice. A parent told us that this enabled them to support their spouse, knowing that their sick child was cared for and that they could also spend time with their other children without any additional pressure. They told us that staff were consistently supportive and that they provided whatever help was needed, be that emotional or practical help.

Understanding and involvement of patients and those close to them

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

Staff made sure children, young people and their families understood their care and treatment. Staffing levels took account of practical, emotional and physical care needs of the whole family. This enabled staff time to prioritise spending time with them to ensure that they had a good understanding of care and treatment options to meet their needs. Records showed that children, young people and their families were actively involved in decision making and staff worked consistently to ensure they were active partners in their care. Specific examples of involvement included supporting young people to check their own medicines when administered, ensuring they understood and were active partners in their treatment and care.

Good ●

Hospice services for children

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

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. Feedback from children/young people and families was collected in a variety of ways. This included informal feedback during a conversation. Comments, concerns, and suggestion leaflets were available throughout the Hospice including parents' accommodation and in reception which could be completed anonymously if they wished. The Francis House website and Facebook pages allowed for comments and feedback. However, the hospice did not conduct a regular patient or family survey where feedback was actively sought with a view to improving services. Following our inspection, hospice leads told us they had sought to address this by commissioning an external survey of patient and family experiences.

We saw examples of how feedback had been used to improve services and care. These included the provision of Bluetooth speaks so that young people could stream their own music. One parent fed back that they were concerned some staff were not confident when caring for their child's cochlear implant. As a result, managers sourced training aids and arranged training sessions to assist staff to develop their confidence.

Staff supported children, young people and their families to make advance decisions about their care. Staff had received training in advance care planning, and we saw that this was integral to care planning and decisions around preferred place of care and other care wishes. When children or young people were approaching the end of live regular multidisciplinary meetings and discussions were held with them and their family to ensure their wishes were met.

Patients and their families gave positive feedback about the service. One patient we spoke with described the care they received as 'amazing' and told us that they loved going to the hospice. They said that staff provided the support they needed and the environment staff created was homely, supportive and caring. Family members we spoke with were consistently positive about the staff and the service they provided, describing a family atmosphere and staff who were kind, caring and supportive. Parents consistently told us that the care provided was for the whole family. They talked of support for siblings as well as the practical support provided by staff alongside care for emotional and spiritual needs.

Are Hospice services for children responsive?

Good ●

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

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the changing needs of the local population. They regularly engaged with the local paediatric palliative care network and leads attended regular network meetings. Clinical leads also attended the neonatal hospice care meeting and a local heads of care meeting with other local hospices. This ensured hospice leads were engaged with the wider hospice and paediatric care systems and had an understanding of the needs of the local population as a result. Staff and managers were actively involved in building links with local services and the community to ensure that they continued to meet the needs of patients.

Good ●

Hospice services for children

Facilities and premises were appropriate for the services being delivered. Francis house provided care for children under the age of 13 and their families. Francis Lodge provided care for young people from age 13 who stayed within accommodation that was independent from their parents. The facilities allowed for siblings to stay alongside the child or young person and parents were able to stay in separate en-suite accommodation.

Both Francis Lodge and Francis House were accessible to people with a range of disabilities. Facilities were age appropriate and included televisions and electronic games. Francis House had appropriate toys and play facilities including soft play areas and garden toys that included a wheelchair accessible pirate ship and a trampoline.

There was a cinema room, music room and two sensory rooms. Sensory rooms had ceiling hoists and were accessible to all children and young people.

The hospice had three rainbow rooms. These were rooms that were cooled where a child or young person could stay after death, with additional cooling blankets to ensure that family members could have limited restrictions on the time they spend with their child after death. The hospice provided this facility for children within their care who had died at home, enabling families to spend time at the hospice with the child or young person and at the same time receive support from staff.

The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services. Because of the specialist needs of the children and young people, those who had received established care from the hospice were able to stay at the hospice beyond the age of 18. Hospice leads understood the issues faced by young people transitioning to adult services and supported the planning for this by engaging in research and working collaboratively with other providers to develop solutions. The hospice had plans in place to develop a young person’s service to help support transition.

Meeting people’s individual needs

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

Staff made sure children and young people living with mental health problems, learning disabilities and long term conditions received the necessary care to meet all their needs. This included support with accessing other services. For example, a patient over 18 required hospital treatment but the family were concerns about them being cared for as an adult and they may not be able to have a parent with them. Francis House staff liaised with hospital staff and advocated on their behalf to ensure they had the support required in view of their lack of mental capacity. Staff regularly spoke with adult services to ensure that the needs of the patient and family were met.

The homecare service provided support to families in their own home and this was provided to those with additional requirements. The range of support for homecare included providing at home respite care so that parents could go out where they might otherwise be unable to. Day service provision was also provided to support the families’ respite needs.

Crisis and emergency admissions were available for children, young people and their families. We saw numerous examples of emergency admissions facilitated due to issues within the family such as ill health of a family member, flooding and other pressures.

Good ●

Hospice services for children

Wards were designed to meet the needs of children, young people and their families. There were facilities to support children and young people to maximise their independence. All patients were cared for in their own room and all facilities including bathrooms, dining areas and therapy rooms were accessible to patients in wheelchairs and hoisting facilities were available throughout the hospice.

Staff supported children and young people living with complex health care needs by using personalised care plans. They assessed needs prior to and during admission on a continual basis. In order to understand the needs of individual children and young people. Staff worked closely with other services during the referral process.

Staff understood and applied the policy on meeting the information and communication needs of children and young people with a disability or sensory loss. We were told of an occasion where a young person was having difficulty with their hearing. They were reviewed by one of the GP’s who felt they required audiology referral, but the service was not available on the NHS. The hospice leads therefore provided funds so that the young person could attend a private appointment.

Some staff had sign language skills and they could readily access translation services when needed.

The service had information leaflets available in languages spoken by the children, young people, their families and local community.

Children, young people and their families were given a choice of food and drink to meet their cultural and religious preferences. Catering staff met with children, young people and their families to ensure these needs were met.

Staff had access to communication aids to help children, young people and their families become partners in their care and treatment.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.

Managers monitored referral activity and made sure children, young people and their families could access services when needed and received treatment within agreed timeframes. Respite care was planned one year in advance to ensure that each family received 14 nights respite per year. In addition, the hospice provided crisis support either in the child or young person’s home or within the inpatient unit as needed. Additional respite was offered to families with particular needs when hospice capacity allowed for it. Occupancy was monitored at clinical governance meetings and information was fed back to trustees through the regular board meetings.

There were seven beds available at Francis House and seven at Francis Lodge (teenager and young person unit). However, at the time of inspection the maximum occupancy was seven beds in total. This was due to capacity and staffing issues which were analysed alongside anticipated need. The hospice did not have a waiting list as they managed respite in line with available bed days based on the current staffing capacity. However, there were clear plans to increase capacity over time and we saw that action to recruit new staff was in place. Managers understood the staffing requirements to increase capacity and had plans in place to increase staffing levels by seven over the course of the next year which will enable them to increase occupancy by one.

Good ●

Hospice services for children

Referrals were made through a variety of channels. These included self-referral, GPs, hospital and community professionals. The admission criteria included that the child or young person had to be diagnosed with a life limiting or life threatening condition. Referrals were triaged through a hospice panel that included GPs, the director of care, clinical leads and members of the homecare team.

Rapid referral was provided for end of life care and referrals for more urgent support were managed by the senior staff on duty who took action to consider planned occupancy, staffing, skill mix and the dependency needs of the young person and their family.

Managers and staff worked to make sure that they started discharge planning as early as possible. They had regular discharge meetings and involved the child/young person and their family in discussions to ensure that their needs were appropriately met.

Staff supported children, young people and their families when they were referred or transferred between services.

Learning from complaints and concerns

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

Children, young people and their families knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. There had been one complaint in the last 12 months. This related to incorrect use of equipment relating to their care and concerns about oral care. Managers took immediate action to address these concerns, including amending the care plan to ensure that mouth care was provided at the required level. They recorded the correct method for the use of equipment using photographs and shared this with staff to ensure correct positioning in the future. There was clear communication with the family to ensure they were satisfied with the action taken.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. This included team discussions and involvement in resolving concerns and action to ensure improvements.

Staff could give examples of how they used patient feedback to improve daily practice. This included promptly addressing issues and concerns as they were raised and before they became complaints.

Are Hospice services for children well-led?

Good ●

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

Good ●

Hospice services for children

Leadership

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

The hospice was led by the chief executive and the director of care who was also the CQC registered manager. There were two clinical leads, one for Francis House and one for Francis Lodge, they were both registered nurses.

The chief executive reported to the board of trustees who were accountable for the management of the hospice. Trustees were from a range of backgrounds including medical, GPs, nursing, business and finance. Hospice leads were aware of fit and proper persons requirements and this included trustees who had received disclosure and barring service (DBS) checks and had up to date references on file.

Day to day management of shifts within the hospice was by senior staff who were supported by clinical leads and the director of care. Staff we spoke with told us that leads were supportive, accessible and approachable.

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 hospice had a vision that was focused on the comfort, quality of care and dignity of the individual. They were also focused on the care of the whole family and viewed this as part of the care of individual children and young people. Staff understood the vision and consistently acted to achieve this when caring for children, young people and their families.

They had a strategy that focused on sustainability of services for the young people in their care and took account of the views of relevant stakeholders in the development and shaping of services. While there was clearly an agreed strategy for the future of services, that included increasing staffing and developing services for young people transitioning from children's services, this was not formally recorded within a strategic plan. However, the hospice had an annual strategic report that addressed challenges to sustainability and a clear focus on how this was being addressed. Such challenges included a reduction in funding as a result of the pandemic and restructuring of services to ensure the continued delivery of care for children with life limiting illness within the greater Manchester area.

Culture

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

Staff felt positive about working in the hospice. They were focused on providing a family centred approach to care and felt proud about the service provided. There was a strong sense of teamwork. There were development opportunities and managers provided training in a range of subjects including 'train the trainers' courses for key staff and attendance at relevant conferences.

The hospice had not undertaken a recent staff survey, however, there were mechanisms for staff feedback including comment cards and feedback from appraisals and staff meetings. One example of changes in response to staff feedback included amendments to the care planning processes which were being updated with input from staff.

Families felt able to raise concerns and told us that these were acted on quickly. There was a strong sense of learning to ensure improvements and there was adherence to the requirements of the duty of candour, including ensuring any issues were raised with children, young people and their families within an honest and transparent approach.

There was a whistleblowing policy in place and staff told us they were able to raise concerns with assurance that these would be addressed. Managers were visible and staff told us they were approachable. A programme had been implemented to provide staff with strategies on recognising and dealing with stress in relating to working in a children's hospice.

Staff attended debriefing sessions at the end of each shift. There were regular information sharing sessions where specialist subjects were presented and discussed. Full staff meetings were held twice a year and there were written information briefings shared regularly to ensure staff kept up to date with hospice activities.

Staff had received training in equality and diversity and promoted this in their work practices.

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 was a clear governance structure and effective governance processes. Governance accountability was from the board of trustees, delegated through to the chief executive, senior managers and staff for operational management.

Trustees met on a quarterly basis and reviewed activity, risk and performance data. Regular trustee reports contained updated information on the objectives of the service. The chief executive and director of care had close working relationships with the board of trustees and there was a committee structure in place with information shared openly with the board. Committees included finance and management and health and safety. A pandemic planning meeting was held regularly with involvement of senior staff who reviewed changes to national guidance and took action as appropriate.

Senior leaders held weekly clinical governance meetings and information from these was shared as part of the director of care's report to the trustees. The clinical governance meetings covered aspects of management such as incident reporting, complaints, infection control and training. Internal meetings were held with staff and regular 'information exchange' bulletins were sent to staff to ensure that everyone kept up to date with changes within the hospice.

Meetings were held with external contractors, for example, those providing pharmacy, human resources or legal advice.

There were a range of policies and procedures. Policies were easily accessible to staff and we saw that these were regularly reviewed and updated.

Management of risk, issues and performance

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

There was a risk management system in place with governance and operational risk registers. Risks were proactively identified, and action was taken to minimise the impact of risk. Hospice leaders identified areas of risk that were a priority and had action plans to address these, for example in relation to staffing. There was a range of risk assessments that included environmental and individual patient risks. Action was comprehensive to support the management of identified risks and there was a comprehensive business continuity plan. Staff were involved in decision-making around the management of risks.

Leaders and senior staff had an understanding of performance and quality issues. There were processes in place to ensure that issues were overseen and addressed. Performance and activity data were shared with the board of trustees. Incidents and complaints were regularly reviewed by the director of care and reported via a service report to the board. Regular audits were carried out to provide assurance. These included incidents, infection control, medicines management and documentation audits. There was clear action to improve identified as part of the hospice's clinical governance processes. Issues relating to finances, care provision, succession planning, research and other areas of performance were included in standing agenda items for the board of trustees.

Information Management

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

Staff had access to quality and performance data. This included incidents, staffing, patient and family feedback, complaints and service activity. Service performance was tracked over time to support the identification of areas for improvement. Where variations in performance were apparent, action was taken to make improvements.

There were effective arrangements to ensure data and statutory notifications were submitted to external bodies, as required. This included local commissioners and the Care Quality Commission (CQC).

Staff had access to up-to-date information about patients' care and treatment. There were comprehensive information governance processes, which included an external audit to provide assurances that information was managed effectively. Action taken as a result of this audit included the provision of locked boxes for the storage of patient information for staff working in the community.

Information was kept securely to maintain confidentiality. Information technology systems were security protected.

Engagement

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

Hospice leads engaged with local and regional networks and were members of relevant national associations such as Hospice UK, Together for Short Lives forum and the Association for Paediatric Palliative Medicine. Through these national associations' hospice leads worked to share best practice in future developments for palliative and end of life care for children and young people.

Senior staff regularly attended regional network meetings, including the Greater Manchester palliative care network, informal meetings with seven children's hospices within the North of England, and quarterly local intelligence network meetings.

Within Greater Manchester they regularly met with the palliative care team and leads from another local children's hospice.

Staff told us they felt that leaders actively engaged with them to plan and manage services. Examples included involvement in changes to the care planning approach which included comment cards and meetings to gather staff views on proposed changes and how to proceed. Managers also sought feedback from staff on training received and looked at ways to improve as a result of this feedback. There was no recent formal staff survey that allowed staff to provide anonymous feedback on the management, leadership and delivery of services. Staff told us, however that they felt able to feedback if there were any concerns and managers held regular staff meetings where staff were encouraged to share their views.

Children, young people and their families were able to complete anonymised comment cards and were encouraged to provide feedback when accessing the service. Staff gave us examples of where changes had been made as a result of this feedback, including purchasing additional equipment to enhance respite stays. At the time of the inspection the hospice did not conduct a survey of children, young people and family views, however they told us they had engaged an external contractor to undertake this in the near future.

Learning, continuous improvement and innovation

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

Leaders and staff worked together to improve services. There was a culture of continuous improvement and learning. At the time of the inspection a process was in place to review and improve the care planning process, with involvement from staff.

Areas of innovation include work to support the transition for children and young people developing into adulthood and the impact this had on their experience of services. Research commissioned by the hospice led to the development of plans to create a separate young adults service as part of the hospice's service provision.

Research into the impact on siblings of life limiting illness had been commissioned by the hospice. This was in the process of being reviewed by hospice leads and trustees with a view to using the findings to further develop services to meet identified needs.

There was a culture of reporting incidents within the hospice. This included reporting any issue where something had gone wrong with a view to learning from it and reducing the risk of reoccurrence. There was consistent evidence of staff recording personal reflections when things went wrong and a culture of learning from this.