

Shooting Star CHASE

# Christopher's Children's Hospice

## Inspection report

Old Portsmouth Road  
Artington  
Guildford  
Surrey  
GU3 1LP

Tel: 01483230960

Website: [www.chasecare.org.uk](http://www.chasecare.org.uk)

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## Ratings

Overall rating for this service

Outstanding ☆

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Outstanding ☆

Is the service responsive?

Outstanding ☆

Is the service well-led?

Outstanding ☆

# Summary of findings

## Overall summary

Christopher's Children's Hospice is provided by Shooting Star Chase, which is a registered charity caring for babies, children and young people with life-limiting conditions, and their families. Christopher's Children's Hospice provides support from babies to young people up to the age of 21, they support families from diagnosis to end of life and throughout bereavement with a range of nursing, practical, emotional and medical care. Their care service includes overnight short breaks, Hospice at Home, day care, symptom management, end-of-life care, bereavement care and a comprehensive range of therapies and support groups for the whole family.

The hospice is a nurse led service and children and young people's health needs are met by a range of health professionals during their stay. This includes specialist children's nurses, adult learning disability nurses, occupational therapists, physiotherapists, social workers and the care team. A local GP practice provides daily medical cover for the hospice to review children's medicine and respond to any health needs. A children's palliative care consultant oversees the symptom management and end of life care.

This inspection was carried out 28 and 29 July 2016 and was unannounced. Christopher's Children's Hospice is registered to provide bed based care for up to nine children at a time. At the time of our visit six children and young people were using the bed based unit and the hospice service had around 700 families registered as qualifying for the service.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Christopher's Children's Hospice is an outstanding service. It is focussed on the individual needs of the children, young people and parents who they support, at the time they need it in a way and place that best suits them and their whole family. Parents spoke overwhelmingly of the positive support, guidance and healthcare interventions their children had received. They were full of praise for the staff in terms of their kindness, compassion and knowledge about end of life matters. Parents viewed the staff as experts in their knowledge and skills when supporting children and young people with complex health needs.

Staff were playful, full of energy and maintained a high level of engagement with children, young people and their parents and parents consistently told us how much they valued the normality of the service and the effort staff made to ensure their children had the same experiences as other children.

Parents and professionals spoke of a service that was tailor-made for children and their families saying that staff went 'the extra mile' with empathy and compassion. Throughout the end of life care of children and young people parents were given information and kept involved to enable their children to continue to receive parent led care. Informed consent was embodied into all work that was undertaken at the hospice.

The various departments within this hospice worked well together so that people had a seamless experience of moving from one department to another as the need arose.

The end of life support provided was highly personalised and tailored to meet the needs and wishes of each individual child, young person and their family with sensitivity and compassion. The hospice was supportive of family's spirituality. They strived to offer support that recognised spirituality as that 'which connects us to each other and includes whatever gives each person meaning, purpose, value, self-worth and hope'. Staff were sensitive to parents' individual spiritual needs and thought of ways to meet these needs when they experienced difficult times.

Staff were motivated and keen to convey to inspectors their pride in working at the service. Staff were involved in the development of working practice, listened to, empowered with training and supported to offer excellent end of life healthcare and support.

The registered manager promoted a culture of openness and excellence. They listened to people and staff, involving them in the running and development of the service. They actively sought out their views and used feedback as an opportunity to improve and develop the service. There was a kindness and warmth about the management team that made them approachable to everyone and people knew them by their first names and told us they were visible and solved matters raised.

The provider creatively launched their new values 'Professionalism, Respect, Integrity, Diversity and Excellence' under the acronym PRIDE. Throughout our inspection we observed and heard from parents, young people and professionals that staff always demonstrated these values in how they behaved. Staff demonstrated a strong person centred culture. This was represented by the provider's fingerprint logo the Friendlies, a group of lively fingerprint characters designed to 'break down the misconception that children's hospices are sad places'. By using multiple logos the provider had created interactive branding which allowed the community, parents, staff and children to engage with the aims and values of the service in a creative way.

Governance of the service was of a high standard that was benchmarked against similar services and communication was very good. The Board of Trustees were appropriately informed and closely scrutinised how the hospice operated ensuring the registered manager was held to account in ensuring a high quality service was delivered. There was parent representation on the board of Trustees and we found examples that showed parent representatives had real influence and involvement in a number of issues within the hospice. The quality assurance systems in place showed that people were right to have the confidence in this local hospice.

The hospice worked innovatively in partnership with many local and national organisations to develop local services for their community and to inform and improve practice in the children's hospice movement. We saw how this partnership working had enabled young people to access appropriate adult services when they became too old for children's services. The hospice had also developed close working with the neo-natal team to support families with new born babies at the end of their lives.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good ●

The hospice was safe.

Staff knew how to protect people from abuse or harm. Parents and health care professionals felt children and young people were safe and trusted using the service. There were sufficient staff on duty to meet children and young people's needs safely.

Any health and safety or individual risks were identified and action was taken to keep children and young people as safe as possible. The staff team learned from any accidents or incidents to reduce the likelihood of a similar event occurring again.

Recruitment processes for new staff were robust to ensure they were suitable to work with vulnerable people.

Medicines were administered safely. Processes were in place to ensure that children and young people received their medicines as prescribed.

### Is the service effective?

Good ●

The hospice was effective.

Staff were skilled in their roles and had the knowledge to meet the complex health needs of the children and young people effectively.

Staff were aware of and worked within legislation relating to children and young adult's consent to care and treatment, so that their rights were protected. Staff supported children and young people to make choices about their everyday lives.

Mealtimes were family orientated. Children and young people were appropriately supported and encouraged to eat and drink a balanced diet that met their individual needs, preferences and wishes.

### Is the service caring?

Outstanding ☆

The hospice was exceptionally caring.

Children and their families were supported by kind and compassionate staff in a way that respected their privacy and dignity.

Staff had developed good relationships with children, young people and their family and there was a happy, relaxed and energetic atmosphere throughout the hospice.

Parents and their children were involved in planning their care which included what they would like at the end stages of life. Parents told us this was done sensitively and at a pace that was appropriate to them. Support was offered to bereaved families and contact maintained if this was what the family wanted.

The spiritual needs of children, young people and their families were supported in whichever way they wanted taking account of what gave them meaning and hope.

### Is the service responsive?

**Outstanding** 

The hospice was outstandingly responsive to the needs of children, young people and their families.

Children and young people were supported to pursue activities and interests that were important to them.

The hospice worked innovatively in partnership with other agencies to respond to the needs of the children and families in their local community, for example the hospice had worked with the local neo-natal team to provide care to new born babies at the end of their lives..

Information was shared effectively when children and young people moved between services. Young adults were supported to move to appropriate adult hospice services that understood their needs.

Complaints investigations were very thorough and the hospice used complaints to challenge their practice and improve the service.

### Is the service well-led?

**Outstanding** 

The hospice was outstandingly well-led.

There was excellent leadership. The registered manager had developed and sustained a positive culture encouraging staff and parents to raise issues of concern with them and to be involved in improving the hospice.

The values and aims of the hospice were visible throughout the service and were developed and sustained through creative and innovative methods.

The service worked in partnership with other organisations to make sure they were following current practice and providing a high-quality service. They strived for excellence through consultation and reflective practice. We saw evidence of the hospice sustaining their outstanding practice and improvements over time.

# Christopher's Children's Hospice

## **Detailed findings**

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was unannounced and took place on 28 and 29 July 2016.

The inspection team was made up of an inspector and a specialist advisor. The specialist advisor had experience of children's and young people's palliative and hospice care.

Before the inspection, we reviewed all the information we held about the hospice including previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the service is required to tell us about by law. We used this information to help us decide what areas to focus on during our inspection. We did not request a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We gathered this information on the day.

We spoke with four children some of whom were attending day care. We spoke with six parents of children and a young person during the inspection, one sibling, one grandparent and with three bereaved parents by telephone following the inspection. We spoke with the registered manager and 23 staff. This included the head of practice development and quality team, a family support and bereavement counsellor, nurses, care workers, the transition coordinator, volunteers and a music therapist. In addition we spoke with one of the trustees of the board, a second year student nurse on placement, one GP and three musicians supporting the Festival of Music.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to

help us understand the experience of children and young people who could not talk with us. We observed how the staff interacted with the children, young people and their families.

We looked at how children and young people were supported during their stay. We reviewed a range of care records for six children and young people. We also reviewed records about how the hospice was managed. This included staffing records, audits, meeting minutes, training records and governance records. We also attended two shift handover meetings. Following the inspection we spoke with the specialist community midwife (screening and fetal medicine) who worked with the hospice.

The hospice was previously inspected on 26 February 2014 and no concerns were found.



# Is the service safe?

## Our findings

We observed that children and young people were relaxed with staff at the hospice. They played, participated in activities, chatted, smiled, laughed and gave staff eye contact. Children and young people who were independently mobile sought out staff company and physical contact. This indicated they felt at ease and safe with staff. Parents told us they felt their children were safe when staying at the hospice and when they received support in their own homes. Their comments included "I will not leave her with anybody else, just the hospice staff as I trust them and know she will be safe" and "Staff know how to use the equipment, they are always taking their time to make sure she does not get bruised with the hoist". Parents told us they would be confident speaking to a member of staff or the registered manager if they had any safety concerns.

Staff and volunteers had completed safeguarding training as part of their induction and ongoing training. They were able to identify the procedures they needed to follow should they suspect a child in their care had been or was at risk of abuse. The registered manager was aware of their responsibility to report allegations or suspicions of abuse to the local authority. The service had a dedicated safeguarding lead who received and reviewed all safeguarding concerns to ensure they were actioned in accordance with local safeguarding procedures.

The registered manager had not needed to report any safeguarding concerns to the local authority relating to the service since our previous inspection. The service was aware of their wider safeguarding responsibility to keep children and young people safe from abuse and discrimination. The registered manager gave examples of child protection referrals staff had made when children and young people had been deemed as being at risk of avoidable harm at home or whilst accessing other services. Staff had supported safeguarding investigations as required and were able to describe the positive outcomes this had brought for families.

Staff knew how to follow whistleblowing procedures and raise concerns. They were confident that any issues they raised would be addressed and that this process would be used effectively to improve the service for children and young people. Staff and volunteers told us "I have no doubt that the manager will take concerns we raise seriously", "If I had any concerns about other staff I will talk to the nurse in charge and I know she will take action" and "Everybody that works here knows the most important thing is to make sure the children are safe".

Risks to children and young people's safety and staff supporting them had been identified, effectively managed and reviewed. These areas of risk included any potential hazards in the environment, risks when children and young people were supported by staff to move or transfer, choking risks and risks relating to people's health conditions. Staff demonstrated that they knew what action to take to keep children and young people safe. The GP told us they had never seen the hospice compromise on safety and that the hospice would never provide care to a child or young person if they could not be assured they could manage the risks relating to their care.

There were emergency plans in place for children and young people who experienced epileptic seizures.

Staff had received training in administering emergency epilepsy medicine and were clear about the actions they needed to take when children and young people experienced seizures. Individualised epilepsy protocols were in place which gave staff clear direction on how to identify seizure activity and how staff should use medicines to respond. Staff we spoke with were aware of the possible side effects of the emergency medicines and described how they would observe children and young people for signs that might require further medical intervention.

Some children and young people required Long Term Ventilation (LTV); this is the ongoing use of mechanical ventilation to help them breathe. Staff understood the risks when children and young people required the use of mechanical ventilators. For example, they could describe how they would identify possible mucus build up and had been trained to perform the required suction to prevent children and young people from choking. Records showed checks had been completed routinely to ensure the ventilation equipment was in working order and remained safe to use.

There was a focus on positive risk taking so children and young people could participate in activities or try new experiences. For example, children and young people who were ventilated and had experienced a tracheostomy (a medical procedure in which a tube is surgically implanted into the windpipe) had been supported to use the hydrotherapy pool. They were supported with high numbers of trained staff and specialist floatation devices to make sure they were safe at all times. We saw during a swimming session that each child had an allocated member of staff with them in the pool and in addition there were a member of staff on the side of the pool as per their policy. The pool safety policy was in the pool area for everyone to read to ensure staff would adhere to this staffing requirement.

Staff understood each child and young person's vulnerability to infection and took action to protect them from the spread of infection. We saw staff washed their hands prior to undertaking any procedures and when delivering care and they had easy access to hand washing facilities in the hospice. There were sufficient supplies of protective equipment such as gloves and aprons and staff used these appropriately. The hospice was well maintained and clean throughout the inspection. Parents told us staff also followed good infection prevention practices when visiting them at home, ensuring they used gloves and keeping their uniforms clean to prevent cross contamination.

Processes were in place to ensure children and young people received their medicines as prescribed. Qualified nurses were responsible for looking after and giving children and young people their medicines. Most medicines were brought into the hospice by children and young people's families for planned respite care. Staff met with parents prior to each admission to ensure they had up to date information about each child and young person's medicine. There was an effective system in place for obtaining medicines in an emergency. For example, there was a supply of oxygen for emergency use, and records showed these were checked regularly to make sure they were suitable for use if needed.

The doctors followed processes to pre-approve a range of discretionary medicines for the nurses to administer without delay when required. This allowed nurses to respond in a timely way to treat children and young people's minor ailments. The medicine charts we saw were accurately completed and signed when they had been given, showing that children and young people received their medicines in the way prescribed for them. Nurses completed a 'Drug Calculation test' as part of their annual medicine competency. This ensured they were competent to complete the required complex medicine calculations and reduce the risk of medicine errors occurring. This test was also used when nurses were recruited to assess their medicine management skills.

Staff were able to access up to date information on the safe use of medicines. Policies and procedures were

available for staff and these were kept under regular review. Staff received training on giving medicines and the use of syringe drivers and pumps, and they were checked to make sure they could give these medicines safely. A syringe driver is a portable device that can be used to give a continuous dose of medicines through a syringe.

Staff carried out regular medicine audits to check medicines were being managed safely. Recent examples included a controlled drugs audit and medicine chart audit. The audits identified any recommended actions and these were followed up. Medicines incidents, including any risks identified, were reported and reviewed at regular meetings. Actions were fed back to staff and recorded to help reduce the risks of similar incidents happening again. Staff described examples of learning from incidents, and changes in practice to reduce the likelihood of a similar event occurring again, for example, following medicine errors a system of additional checks had been put in place to reduce the risk of errors occurring. A new medicine error reporting system had also been developed to support managers to better identify trends in medicine errors.

Staff and volunteers told us they had been required to undertake full pre-employment checks before they were offered employment and could work with people unsupervised. Staff files showed criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). Nursing and Midwifery Council (NMC) checks had been completed to ensure health professionals were fit to practice. There were copies of other relevant documentation including character references, interview notes, full employment history and proof of identification. The provider had used the interview process to demonstrate staff's relevant skills and experience and to support the registered manager to plan the induction for new staff. This meant the provider had undertaken appropriate recruitment checks to ensure staff were of suitable character to care for people safely and had taken into account all known risks relating to each candidate's suitability when making recruitment decisions.

There were enough staff on duty in the hospice to meet the needs of the children and young people and keep them safe. Staff were deployed effectively on the two days of our inspection. Staffing levels were determined following the assessments of each individual child or young person. Each child or young person was supported on a one to one basis by a nurse or a care worker depending on their needs. Following risk assessments some children or young people were supported by two staff or nurses when required. Parents and staff had no concerns about staffing levels at the hospice. An out of hours on call system ensured emergency management and medical cover was available if needed.

The hospice operated health and safety systems effectively to protect children and young people from harm within the hospice. Regular audits and daily checks by nominated staff ensured that the environment and equipment used was safe and fit for purpose. The premises were secure and systems were in place to ensure that visitors to the service signed in on entry. The hospice had contingency plans to manage emergencies, for example; evacuation in relation to a fire or flood. We saw at staff handover meetings the personal evacuation plan for each child was shared so that staff would know how to safely evacuate the children or if appropriate, keep them safe until emergency services arrived. The provider prioritised children and young people's safety and ensured they would continue to receive the care they required if an emergency was to occur.

## Is the service effective?

### Our findings

Parents and other health professionals were highly complementary about the skills and knowledge of staff and described them as "Highly skilled", "Very well trained", "Confident in their knowledge of the care they need to provide" and "Very professional". Children and young people with complex health needs were supported by highly skilled staff who had received specialist training tailored to their professional needs and to the individual needs of the children and young people. Staff told us this training had enabled them to meet the increasingly complex health needs of the children and young people using the hospice.

Where children and young people had complex health needs staff implemented excellent clinical skills in accordance with best practice when providing care and treatment. Nurses and care staff had been trained to provide ventilation care to children and young people with the highest priority level of need and ventilator dependence. This priority level is described by the Department of Health's National Framework for Children and Young People's Continuing Care (2016) as children and young people who are 'unable to breathe independently and require permanent mechanical ventilation; or have no respiratory drive when asleep or unconscious and requires ventilation, disconnection of which could be fatal'. Training was provided by representatives from different ventilator manufacturers to ensure staff were competent to use different types of ventilators. The hospice worked in partnership with other organisations to ensure they were training staff to follow best practice. Staff had the opportunity to complete study days and secondments at the Paediatric Intensive Care Unit (PICU) of two local hospitals to further develop their competency in providing complex ventilation care. The specialist skills and knowledge of the staff had enabled children and young people with complex health needs to access the hospice, partake in the opportunities on offer to enhance their wellbeing and provide their families with much needed respite.

Nurses and care staff were required to complete a set of competency assessments annually to evidence that they continued to maintain the skills and knowledge required to undertake specialist clinical tasks. For nurses these included epilepsy and seizure management, tube feeding and ventilation. The provider had developed an internet based competency survey and staff completed this on-line survey annually to test their knowledge in the key clinical areas. We saw additional training and support was provided for staff where the survey showed gaps in their knowledge so they would remain up to date with their skills to effectively care for the children and young people in accordance with current best practice.

Parents were involved in training staff to develop their knowledge and skills in providing parent-led care. For example, one bereaved parent told us of the training they had developed and provided to staff that will also be incorporated in the upcoming Care Team Conference in September 2016. During this training the bereaved parent had supported staff to understand the importance of planning and preparing parents for their children's end of life care. This included honest communication and the use of individualised language to enable parents to understand what was happening so that they could continue to support their children through the end of their life.

The provider hosted an annual care team conference for their own staff as well as other health and social care professionals to aid their understanding of current good practice. For example, the 2015 Care Team

Conference provided communication sessions to support staff to understand how they could support children and young people's with limited verbal language to make their views known. Staff had improved their practice following this conference. The hospice's communication improvement group was reviewing children's communication care plans to ensure they provided clear guidance to staff about each child's communication support. An electronic picture communication application had been introduced and staff demonstrated how this was used to aid children to express their choices.

The service developed and offered training opportunities to other health and social care professionals involved in the care of children and young people with life limiting conditions. For example, the service admitted children and young people requiring ventilation from outside their local area with the aim to provide training and mentoring to staff from the child's local service. At the time of our inspection one child was supported by their staff from another area during their stay. Staff could explain how they were supporting this staff member to develop their ventilation skills. Through this mentoring scheme the hospice had enabled long term ventilated children and their families to access effective local services closer to home. As a result, the strain on families who may have limited resources to travel and needing the time to carry out other family responsibilities had been reduced.

The service had also run the first paediatric version of a course called Quality End-of-Life care for All (QELCA). The course had previously been run by adult hospices and the hospice had redesigned the course for external professionals to support them in developing their understanding of children's end-of-life care. The registered manager told us following this training they continued to see an increase in the appropriateness of referrals made by the community children's nursing team (CCN) as their understanding of hospice care developed. This meant children and young people could be offered an appropriate and effective hospice service much sooner after a referral had been made by the CCN team.

Nurses described excellent support for professional development. This included an active professional development team who supported staff with training and organised in-house education initiatives. Nurses are required by their regulatory body to have their practice re-validated every three years. The 2015 Care Conference had included workshops on the re-validation programme to support nurses through the NMC assessed process. The hospice was using the revalidation process as part of their appraisal of the nurses' competence to ensure their practice remained safe and current.

Staff were highly complementary of the supervision they received and the opportunity this gave them to identify their development needs, reflect on their practice and receive emotional support. Several supervision and mentoring opportunities were available to staff throughout the year. This included the monthly 'Doughnut Club' run by a counsellor to provide staff with an opportunity to share their work experiences and receive emotional support. A monthly 'Journal Club' took place to discuss recent relevant research and publications to support staff with staying up to date with developments in hospice care. When speaking with staff we found the hospice had created a culture where ongoing clinical supervision and training were embraced and staff could explain how this benefited their wellbeing and the care they offered.

Consent about children's care was sought from their parents and this was reviewed at each stay. One parent said, "They always meet with me before each stay, we then discuss the care that is going to be provided during the stay and I have to sign to say I give my consent." Staff verbally sought children and young people's consent before supporting them or providing any care. Records showed young people gave their own consent where they were able to and this was included in their care records.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Young people over the age of 18 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in hospices are called the Deprivation of Liberty Safeguards (DoLS). The hospice had made appropriate referrals to the supervisory bodies under DoLS for young people prior to their stays.

Some young people and adults had been assessed as not having capacity to make decisions about some aspects of their care and treatment. Best interest decisions had been made on their behalf in consultation with their parents and health and social care professionals where needed.

Children and young people's health needs were assessed and planned for to make sure they received the care they needed. All of the children we met had complex health needs. The hospice was a nurse led service and children and young people's health needs were met by a range of health professionals during their stay. This included specialist children's nurses, adult learning disability nurses, occupational therapists, physiotherapists, social workers and the care team. A local GP practice provided daily medical cover for the hospice to review children's medicine and respond to any health needs. A children's palliative care consultant oversaw the symptom management and end of life care. The GP received on-going support and training from the consultant which had supported the GP practice to develop their skills and knowledge when treating children and young people with complex life limiting conditions. Children and young people and other professionals involved in a child's care received a discharge summary at the end of each symptom management stay to ensure their health care needs would continue to be met.

The hospice had a dedicated Symptom Management team to ensure children's symptoms and pain was managed effectively when they stayed at the hospice and received support at home. We saw good examples of symptom care plans which were clear and easy to follow. They contained key information about the support staff were to provide children and young people to manage their pain and included an escalation plan if for example, the initial pain medicine did not prove to be effective. One parent told us "I never worry that my child will be in pain because I know the nurses and GP will sort it out quickly".

Children and young people's nutritional needs were assessed and care plans were in place. Children and young people had varying levels of independence in meeting their own nutrition and hydration needs. These needs were well described in their support plans. For example, some children and young people were being supported to eat a healthy and balanced diet of their choice, whilst others with more specialised needs received specific nutritional meals and fluids through their feeding tubes. Records were kept of children and young people's food and fluids intake where required.

Staff were familiar with each child's nutritional requirements and we saw children and their parents enjoyed meal times. Staff chatted with the children and young people and supported them as noted in their care plans. During the mealtime staff provided extra visual and tactile stimulation for some children by giving them toys to touch and hold. This meant their mealtime experience was as enjoyable and stimulating as possible. Children's and families' meals preferences were recorded and acted on. Parents told us how they appreciated being cooked for and that the food was fresh and a good quality.



## Is the service caring?

### Our findings

Parents and young people valued their relationships with the staff team and felt they often went 'the extra mile for them' when providing care and support. One parent told us about the work a nurse had done in their child's school in helping them support and understand their child's needs. They told us "I could not have done that without the hospice nurses". One young person told us "They always play my games and keep me company, not just the staff working with me on the day but everyone". Parents and young people were highly complimentary of staff's caring nature and approach. A bereaved parent told us "They were really there for me when I needed a shoulder to cry on or just some company". As a result they felt cared for and that they mattered. We observed many examples of tenderness between staff and children, for example when staff combed the children's wet hair when they had been in the hydro pool and when staff reassured children when they needed to use their equipment. All the young people and parents we spoke with emphasised the high quality of care provided by the hospice and the kindness, compassion, friendliness and approachability of staff.

Staff were playful, full of energy and maintained a high level of engagement with children, young people and their parents which made the joint music session for example, a happy, uplifting and social experience. Parents consistently told us how much they valued the normality of the service and the effort staff made to ensure their children had the same experiences as other children. One parent told us "At home I always have to make her aware of danger. But here it feels so normal, she is just a little girl like other little girls. I love seeing her get excited when she knows she is coming here". Lunch time was a big event at Christopher's Children's Hospice, with families, children, young people and staff chatting and laughing and enjoying each other's company. Some parents told us this was the highlight of their stay as it allowed them to enjoy time with their family without feeling different. There was a relaxed atmosphere at the hospice and parents were encouraged to make a drink, use the toys and games available and treat the hospice as a home from home.

The provider ensured staff were of a caring nature by continually monitoring their caring approach. This included asking feedback from the rest of the team about their behaviour with parents, children and young people during their probation and annual appraisal. The provider was mindful of the emotional challenges staff experienced and the registered manager told us they believed a "resilient, happy and valued team" was essential to ensuring staff remain caring. The provider had implemented Hospice UK's 'Resilience: A framework supporting hospice staff to flourish in stressful times' and was making the recommended adjustments to increase staff wellbeing and resilience to stress. This included empowering all nurses to lead shifts so that they could develop their confidence and experience of managing concerns from families and staff. This resilience work ensured staff could sustain their caring, energetic approach and remain highly motivated and inspired to offer care that was kind and compassionate. We heard many examples of how staff and volunteers overcame obstacles through their commitment to meet the needs of children and young people and enabled them to enjoy life. For example, staff offered transport when parents were not able to bring children for a stay, arrangements were made so children could be supported by their nurses from home and staff gave of their own time to support young people to social activities and the teenage Youth Club.

Family support was seen as essential to children and young people's wellbeing and the needs of parents, grandparents and siblings were supported. A bereaved parent told us "Their support meant we could be together as a family for the first time in months. They played so much during that time." The Therapy team offered for example, grandparents' days which focused on how to understand and enjoy your grandchild. They had also introduced 'Dad's days' which gave dads the opportunity to share experiences with others and through activity-based days. Parents told us these group activities did not only provide an opportunity to meet others and do something enjoyable but taught them new skills they could use at home to enhance their family's wellbeing. One parent told us "After these days I am always going home with new things to try like a new sensory activity or massage that I had not thought about". The counselling and therapy team was also available for practical and emotional advice and support. One parent told us "This was also a safe place where we could discuss with our children what was going to happen and give them the opportunity with support to say goodbye".

Complementary therapies were available to the whole family and provided an opportunity to relax and switch off from the stresses associated with their caring duties. This included aromatherapy, Indian head massage, reflexology and therapeutic massage. One young person proudly showed off their newly painted nails and told us how much they enjoyed their hand massage. The hydro pool and sensory room facilities were also available for families to use. One parent told us "This gives me a weekly opportunity to spend time with all my children, there are not many activities we can do together as a family". Families were also kept up to date with text messages about activities and events at the hospice and in the community. One parent told us "Recently they attended the Farnborough Air show. They told us they were going and we then met up with staff as a family, so even if it is not your respite weekend there are things going on that you can still attend as a family."

Parents told us of the practical support they had received from the hospice that had helped them cope with their caring responsibilities. This included help from the social workers with housing, equipment, benefits and signposting them to other agencies when needed. Staff supported children when they were in hospital to give their parents a break and supported them to work with other services and professionals. One parent told us "My daughter was not well and I was really struggling to get hold of her specialist, he was on leave. I was so stressed because I did not know what to do. The staff took this on and got hold of someone at the hospital who could see her and advise me, it was such a relief".

There was a wide variety of counselling, end of life and bereavement support services available for the whole family. Information leaflets were provided covering different bereavement situations such as 'Living with grief', 'The bereaved single parent', 'What about me' and 'When your grandchild dies' to support families with practical information as well as emotional support.

The end of life support provided was highly personalised and tailored to meet the needs and wishes of each individual child, young person and their family with sensitivity and compassion. Bereaved parents told us how staff respected and understood their desire to retain autonomy over their children's care and support their children to the end of their lives. One bereaved parent told us "Due to emergency complications, we could not care for my son at home as we had planned. I remember the first day at the hospice I got his clothes out to start his day and I was ready for a battle to convince staff that I wanted to care for him. But it was such a relief when they came into his room and told me 'What do you need us to help you with?' Being able to remain his mother to the end was the biggest gift they could have given me."

Other bereaved parents gave us many examples of how staff had immediately responded when end of life plans changed to ensure parents had the information they needed to make alternative plans about their children's end of life care and place of rest. They told us when they had felt anxious and overwhelmed that



their wishes would not be met due to unforeseeable circumstances, that staff had understood what was important to them. Staff had ensured those important elements were delivered throughout any adapted end of life arrangements to ensure truly parent led care. One parent told us "Although the plan had to change staff made sure what we had wanted to achieve with our original plan stayed the same. I thought he needed to be home for me to be able to be his parent to the end as I had wished to be. But I realised that in the hospice I got more of an opportunity as staff were always there to guide me and show me how to do things if I was not sure. They knew that was so important to me so even when things changed last minute I still got what I needed from it".

Bereavement support was provided to the whole family when a child died. Each bereaved family was allocated a bereavement key worker who had regular telephone or face to face contact with them and explained all the services the hospice and other agencies could offer. The hospice continued to provide bereavement support for the family for up to three years or longer if needed. This included bereavement groups for parents, grandparents and siblings. One bereaved parent told us "They have been in regular contact and I have attended several groups and individual counselling. Sometimes I just go in for a cup of tea. It is coming up to a year and I am looking forward to attending the annual remembering day and placing my leaf on the tree". The hospice had a copper remembrance tree in the remembrance garden where family could place a copper leaf in remembrance of their child on the first anniversary of their death. The registered manager told us as time goes by the leaf changed as it was exposed to wind and rain which provided families with visual representations of the change of their grief as time passed. An annual Festival of Music was held and it took place during our inspection. The hospice worked with professional musicians and a local school during this festival during which bereaved children got an opportunity to compose a piece of music that reminded them of their siblings. The three musicians we spoke with told us "It is always a pleasure to do the Festival of Music. The children really get involved telling us about their siblings, what they liked and remember about them, and work with us to reflect this in the music".

The hospice had seen an increase in the demand for bereavement support since the last inspection and had trained eight more volunteer counsellors to ensure families would get psychological support when they needed it. A translation service was available to ensure all families could benefit from this support. The hospice was supportive of family's spirituality. They strived to offer support that recognised spirituality as that 'which connects us to each other and includes whatever gives each person meaning, purpose, value, self-worth and hope'. Staff were sensitive to parents' individual spiritual needs and thought of ways to meet these needs when they experienced difficult times. One parent told us "They knew being busy and giving back gives me meaning in life. So when I was there not being able to do anything to make my child better, they gave me things to do. I sewed things for them and it made me feel useful. I still do that for them and it gives me a sense of purpose". Another bereaved parent said "They understood the importance of my family in giving me a sense of hope and arranged for all of them to have the opportunity to come to the hospice to see us and say goodbye. They even contacted our priest who we had not been in contact with for many years and it meant so much that he came all the way to see us". We saw a spirituality workshop was included in the provider's upcoming Care Conference to further development staff's skills in providing individualised spiritual support to parents, children and young people.

Where children and young people received end of life care at the hospice their family could stay for as long as they received care and this could be for a few days or some months. During this time staff supported families to make memories with their children and spend as much time with them as possible. One staff member told us "We always take the lead from the family. One of our young people was really creative and we did a lot of arts and crafts with the family to create visual memories. Like printing pictures on large canvasses, decorating memory boxes, families can have hand casts made there are so many things they can do to remember the last days with their child". We also saw staff were sensitive to those families who

preferred to spend time with their child in private and provided them with the space to do this, whilst sensitively checking on them throughout the day.

We saw the hospice was well equipped to support end of life management with quiet rooms and staff who knew how to support parents to make the necessary practical arrangements. For example, where parents had expressed the wish for their children's organs to be donated after death, staff had ensured this took place sensitively within the required time scale. The end of life suite had a bedroom which is specially cooled so a child can stay there as a place of rest for several days after death, usually until the time of the funeral. One bereaved parent told us how the hospice had arranged for their child to be transported from home to rest at the hospice. They said "It meant so much that we could be with her until everything was completed". The Sanctuary space at Christopher's Children's Hospice was an area of calm and contemplation and accessible to families of all cultures and faiths. Families could receive visitors to children in the bereavement suite or hold a small remembrance service.

The staff promoted the privacy of children, young people and their families. The service kept any private and confidential information relating to the care and treatment of children and young people secure. Children, young people and their families had access to private spaces in the hospices. For example, music therapies were provided in separate private rooms. Personal care was offered discreetly. Staff had a good understanding of the balance between maintaining children and young people's privacy whilst also acknowledging the need to monitor their complex health needs. Where appropriate, staff ensured children and young people were provided with opportunities to have some alone time with less intrusive observation. For example, listening devices were then used to alert staff when they required assistance.

## Is the service responsive?

### Our findings

Parents and young people told us that they had been involved in planning their stays at the hospice, their care and the activities they wanted to enjoy. One parent told us "I love the fact when she comes here they give her so much control and choice over what she wants to do". Parents told us children and young people's care plans were updated as their needs changed and before each stay. There was an annual multi-disciplinary review meeting held that included feedback from children, young people and their parents. These were coordinated by the child and young person's key contact. We saw reviews included feedback about children's educational needs to ensure these would be met during their stays at the hospice.

There was a daily handover report between staff shifts and we observed this during the inspection. This meant important information about the children's medical, personal care and well-being were handed over to the staff coming on duty. A multi-disciplinary meeting (MDT) was held every Wednesday. This was an opportunity for the different professionals involved with children and young people to discuss new referrals, parents' wishes and receive feedback about children or young people to ensure they received a planned, person centred and coordinated service.

Children and young people and their families had their social, cultural and spiritual needs considered and planned for. The therapy team offered a large variety of therapeutic groups to meet the needs of the whole family. These included creative therapy (art, music and play therapy), sibling groups, pamper days for mums, dad's days, sensory days, parents workshop, Tweenies (for 8-11 years old) and Little Chasers (pre-school group). Parents and their children attend the pre-school Little Chasers group together. One parent told us this had enabled them to build relationships with other parents and for their child to become familiar with being at the hospice. Parents and young people were very complimentary of the groups and activities provided. Their comments included "There is always something to do", "They really enjoy coming", "They get to play and do the things they like" and "I like the pamper days."

Staff understood children's verbal and non-verbal gestures and communication to enable them to make day to day decisions. For example, staff asked one young person to point when making a choice and used a picture communication system with another child to understand what activity they wanted to do. Children could make their choices and needs known to staff. We saw this enable staff to respond to children's requests without delay, children did not get frustrated and confused and were supported to have a positive experience.

The hospice had a proactive approach to understanding and responding to the needs of the children and young people in their local community. They delivered care in partnership with others in an innovative way to ensure they could respond to the needs of the children and young people in their community who may not have previously accessed hospice services. For example, the hospice had been commissioned by a children's hospice covering areas neighbouring Christopher's Children Hospice to provide a Hospice at Home service for children and young people living in North Hampshire. These families were known to either charity but had not yet received a Hospice at Home service due to a hospice service not being available in their local area. The project was initially a two year pilot project that had recently been reviewed and will

continue for the foreseeable future due to the positive experience of the families involved. We heard examples of families who had taken up respite for the first time following this project as they could now receive a service at home. The project means that the families living in this area were now receiving an equitable service to the children in Surrey.

Because children with complex health needs are living longer, the hospice had employed a dedicated transition coordinator who helped prepare families as their child begins to reach an age where they were too old for a children's hospice service. We heard how the transition coordinator supported families to understand and access the support and respite services available to them in adult services. The transition coordinator and staff were involved in meetings between health, education and social care professionals to ensure a co-ordinated approach for children and young people as it can be challenging for families to find services that can meet their children's needs. The transition coordinator described how four young people and their families had been supported to identify adult hospice services and how their transition had been planned on an individual basis. The hospice had worked proactively in partnership with these young people, their families and adult services to plan their care and support with them and ensure their families would continue to receive the respite they required to enable them to continue to care for young adults at home.

The hospice had developed close links with the local antenatal service to support families where unborn babies had life-limiting conditions. During our inspection we saw an example of this work that was carried out across several services to fulfil a family's wish to spend time with their new born baby at the end of their life. The specialist community midwife who led this work told us they had supported three families in the past year to access the hospice. They told us, "Christopher's enabled a real choice for these families and we knew they could care better for these babies than any other service. It meant that mothers could stay with their babies the whole time as they wished and this gave them the opportunity to support their babies during their short lives". Records showed that the family's wishes had been incorporated in the mother's birth plan, emergency care plan and the involvement of the hospice was documented including the chaplaincy support and memory work that would be taking place. The family was given the opportunity to visit the service prior to the birth of their baby and the grandparents and sibling were able to stay at the hospice and share this time as a family. The grandparent told us "It meant a lot that we knew what was going to happen and my daughter had the opportunity to come and visit and ask all the questions she needed before making her decision about where they wanted to be after the birth". The specialist community midwife noted in their feedback to the hospice, "The joint planning that you and we did with this family, have combined to give the family many memories they will cherish for ever. Between us we have managed to deliver on each of the points that were important to them."

The service had developed a responsive integrated emergency and end of life service for children and young people as part of their Hospice at Home and Symptom Care service. For example, the provider had recently joined up with a cancer hospital to provide a joint PATCH service. The Paediatric Patient Advice by Telephone for Care at Home, Hospice and Hospital (PATCH) service is a 24/7 specialist telephone advice service for children and young people and their families, and for healthcare and allied professionals. There had been a 30% increase in the PATCH service uptake over the past year. This joint working had ensured children and young people with a non-cancer life limiting diagnosis would also receive a 24/7 telephone advice service appropriate to their diagnosis with more individualised symptom management advice. One parent told us "I never worry over weekends or at night because I have the number and if I call they always put me through to someone that knows my child's condition really well".

The hospice at home service had also developed their responsiveness over weekends and since January 2016 nursing cover has been provided every weekend. This increased the symptom management support available to end of life children and young people at home. The hospice at home nurses worked alongside

the community children's nursing team (CCN) over weekends offering support for example, as the second checker for syringe driver changes and other controlled medication. We also heard of an example where the hospice at home nurses had covered all visits in an area where the CNN team did not work over weekends. This meant that an opportunity had been created for children and young people to receive end of life care at home if they wished, as this service was now available to them in their geographical area.

Parents, children and young people's feedback were highly valued. They were actively encouraged to give their views and raise concerns or complaints. Parents were asked to complete a feedback form after each stay and records showed any concerns noted were discussed with parents and plans put in place to improve parents' experience. The hospice was planning a refurbishment and parents had informed this project of their requirements and wishes through a postal consultation. The Care Trustee told us "Parents came up with ideas like black out blinds in the sitting room of the family flats, something we would not have thought about". We saw these suggestions had been incorporated in the refurbishment plans. Parents and young people told us they would feel comfortable raising concerns with staff if they had any.

The hospice had received five complaints in the past year. There was a process for ensuring complaints were logged, investigated and responded to. Complaint investigations and responses to parents showed the matters they raised were dealt with in an open, transparent and honest way. Full explanations were given about the investigation, its findings and any actions being taken to address concerns. Where concerns related to other services or other staff, hospice staff had worked with those services to help resolve issues, such as concerns relating to work practice. The safeguarding lead also monitored any complaints related to the safeguarding of children and young people to ensure these would be investigated in line with the agreed local safeguarding procedures.

The hospice saw concerns and complaints as an opportunity to learn and drive improvement. We found investigations were comprehensive and aimed to identify the root cause of each concern. The hospice used this information to learn from parents, children and young people's experiences and reflect on their practice. The learning, implementation and monitoring of improvements from investigations, to reduce the likelihood of future incidents occurring, were of a high standard. For example, following concerns raised relating to the incorrect attachment of a feeding tube the hospice's investigation showed that the printed label on the tubes had worn off following sustained use. This had made it difficult for staff to identify the correct tube at a glance and increased the risk of errors occurring. The hospice contacted the manufacturer who altered the tube markings to make them more resistant to wear and tear. Action taken by the provider had resulted in the risk of similar errors occurring being reduced in the hospice as well as in other services where this equipment was being used.

The hospice had identified a series of concerns relating to children sustaining fractures or dislocations around the time of their stays at the hospice. Although it was not proven in any of the concerns that the injuries were caused during their stays it did highlight an issue around the moving and handling of non-weight bearing children and their vulnerability to injury. The practice education team was tasked with researching the issue of the increased risk of fractures in non-weight bearing children and to present the findings to the Senior Care Leadership Team (SCLT) and the Clinical Team Leaders. As part of this research they undertook an extensive literature review and worked with the children's palliative care consultant to identify children that might present a fracture risk. Following delivery of the presentation and discussion at SCLT, team leaders meetings and with parents, a sticker was placed at the front of children's care files, as a reminder to staff that the child was particularly vulnerable to fractures or dislocations. A Postural Care training day was also delivered alongside an independent physiotherapist to develop staff's skill in supporting these children safely and this training was now being delivered regularly across the year.

Action plans had been developed to ensure the learning from complaints and concerns would be implemented. Progress made against these action plans were monitored monthly by the Quality and Risk Group which was chaired by the Head of Practice Education and Quality. Complaints investigations and improvements made were also reviewed quarterly by the Clinical Governance Committee to ensure they were completed in accordance with the provider's complaints procedure and to check whether improvements had been sustained. This also provided an opportunity for independent parent and professional representatives on the committee to scrutinise the process and to ensure the hospice took parents' feedback into account and used it to make improvements across the service.

## Is the service well-led?

### Our findings

Christopher's Children's Hospice strived to be an excellent role model, and is well known and respected within the local community of Surrey and across the south of England. They have a visible profile in local media and make extensive use of social media to inform the local community and professionals of the work they do and to create opportunities for community involvement. Parents and young people were keen to tell us that management of the hospice were visible and approachable. One parent said, "The, [Registered Manager] is always open to new ideas". Volunteers spoke of being well supported and of being valued by the hospice. One volunteer said, "I love working here. It is such a positive place". Staff said that they felt well supported both by their colleagues and by the organisation and that they liked working at the hospice. One staff member said, "If they think things could be done better the managers create new policies and make changes really quickly. I really enjoy working in a service that is constantly looking at ways to do things better."

The provider creatively launched their new values 'Professionalism, Respect, Integrity, Diversity and Excellence' under the acronym PRIDE, derived from a Hospice UK survey which highlighted that their staff were proud to work at the service. As well as launching the values in 2014/15 they put systems in place to embed the PRIDE values in the service culture. This included setting up a working group within the Employee Forum and appointing PRIDE champions dedicated to implementing the values, producing promotional materials and keeping the PRIDE identity visible. We saw examples of these PRIDE values integrated in day-to-day activities. After each shift staff celebrated a piece of work that represented one of the values and a staff member was nominated by colleagues every month for going 'the extra mile' in displaying one of the values. Staff and CEO communication reinforced the values. The July CEO Newsletter celebrated how the work of the Therapy Team reflected PRIDE for example in relation to "Diversity -The Youth Group weekend is an example where disability is not an obstacle and young people are supported and enabled to participate in activities to their potential ability regardless of their disability." These values were incorporated in a value-based recruitment process and kept under review through supervision, appraisal and service reviews. Throughout our inspection we observed and heard from parents, young people and professionals that staff always demonstrating these values in how they behaved.

Staff demonstrated a strong person centred culture. This was represented by the provider's fingerprint logo the Friendlies, a group of lively fingerprint characters designed to 'break down the misconception that children's hospices are sad places'. The fingerprint concept had been created with children and their families to reflect the individualised range of services offered to the whole family. Just as fingerprints were unique each family's needs and service were uniquely reflected in their service. The fingerprint characters incorporate several expressions to reflect the different emotions experienced at the hospice and the range of services on offer to the whole family. The core family of Friendlies included characters called Fitch, Mrs Pinkypops, Sugar and Uncle Bobble. The provider had an online 'create' tool which allows the charity's supporters to create their own branded material for use of fundraisers. We saw these Friendlies were visible throughout the hospice and actively used to represent their person centred care and parent-led approach. We saw Friendlies with chef hats on representing cooking sessions, with ear phones on to support the young people to understand their activities as well as stethoscope to represent visits from medical professionals.



By using multiple logos the provider had created interactive branding which allowed the community, parents, staff and children to engage with the aims and values of the service in a creative way.

The hospice found innovative ways of working with local services to implement national good practice guidelines in relation to transition and to influence the development of creative local services for young adults with life limiting conditions. The transition coordinator had worked with local adult hospices to develop a local referral system for young adults with non-cancer conditions. A joint meeting took place with local adult hospices quarterly to review the service needs of young adults and their families who would require ongoing respite to enable them to continue to care for these young adults at home. The hospice had also championed representation on both the children's and adults groups of two local Clinical Commissioning Groups to advocate and influence innovative commissioning of services for young adults. They chaired a South England group of transition workers from both adult and children's hospice to try and benchmark the work they were doing. We saw this had already enabled four young adults to access adult hospice services. We also heard examples of how local adult hospice services were working with Christopher's Children's Hospice to review their services for young adults including some social club pilot projects.

The hospice actively worked with external organisations to develop staff's skills and knowledge throughout the hospice movement. The hospice had worked with other children's hospices to benchmark their staff competencies and had worked with the CHaL Learning & Development Group to share competencies across the CHaL (Children's Hospices across London). This work aims to create greater consistency of knowledge and skills to give staff clarity and confidence especially with clinical skills vital to caring for children and young people in children's hospice with increasingly complex health needs. As part of their commitment to workforce development and continuing professional development the provider had become a 'Recognised CACHE Centre' to facilitate Council of Awards in Care, Health and Education (CACHE) courses. They had also submitted a proposal to develop a Paediatric Palliative Care Qualification with CACHE, and were waiting to hear if this would be a viable proposition for supporting the skills development of care staff across children's hospices. This would enable children and young people with complex health needs to receive consistent care and access a wider range of services closer to home as this course would support the development of care staff's skills nationally.

The provider was also short listed for a national nursing placement award, which celebrated the level of care and support provided to student nurses. The hospice worked with two local universities to continually review their student placements and the two university lecturers were also members of the hospice's Quality Governance and Risk Committee to influence good practice across the hospice. The student nurse we spoke with was complimentary about the support and development opportunities they had received. One nurse told us they had completed a nursing placement at the hospice as part of their training and the quality of the placements had motivated them to apply for a post at the hospice once qualified. The registered manager told us by providing high quality nursing student placements the hospice had encouraged nurses to consider a career in palliative care and children and young people benefitted from newly qualified nurses who already had experience and knowledge of children's palliative care.

Opportunities were available for parents to regularly contribute in a meaningful way to the development of practice to help drive continuous improvement. Parent representatives were part of the Board of Trustees and the Quality Governance and Risk Committee. The Care Trustee told us "Since starting I have been struck by the emphasis put on children and parent's views and experience to influence the way things are done".

We found examples that showed parent representatives had real influence and involvement in a number of issues within the hospice. For example, a Parent Trustee was key in facilitating the use of pureed feeds via



gastrostomy at the hospice. The registered manager told us "It was not common practice and went against common thinking and the guidelines from the manufacturers of the gastrostomy tubes." For these reasons the hospice was initially reluctant to agree this practice. When presented with the information available the Parent Trustee asked 'But why not?'; as parents were doing this at home with the support of their child's dietician. From this a member of the practice Education Team was tasked with undertaking further research into the practice and presented the finding to the Senior Care Leadership Team (SCLT). The research suggested that the practice was becoming more common and there was the potential that more families would request the hospice to undertake the administration of pureed feeds. It was agreed that they would develop child specific guidelines that included written support from the child's lead clinician and dietician. This practice has now become common practice for many of the children and they have shared their guidelines with other hospices. The hospice was also currently reviewing their referral criteria and one of the Parent Trustees questioned the word 'diagnosis'. They rightly pointed out that many children do not have a formal diagnosis at the time of referral, or in fact ever. The sentence was changed to more accurately reflect this to 'the child has a life limiting condition'.

In addition we saw the hospice monitored the quality of experience of parents, children and young people with regular feedback and seeking views. We saw parents completed a feedback form after each stay and managers worked with parents to improve their next stay if their feedback noted any concerns. The bi-annual satisfaction survey was to be completed in September 2016 and we saw this included a child-friendly postcard on which children and young people could write their views or draw a picture. Parents would also be asked during this survey for their views on proposed service developments for example, the possibility of offering services from community hubs. This enabled the hospice to decide where they needed to focus or improve the service on offer.

Staff told us that they felt able to influence the running of the hospice and were consulted about improvements. A monthly staff forum was held. We examined recent actions from these and saw that communication was clear of matters discussed with action points highlighted and then up dated when completed. We saw that staff had influenced the review of the new staff sickness absence policy and the hospice was exploring staff's suggestion to acquire more overhead hoists. This showed the effective staff team followed through on agreed issues and that they were enabled to question developments and change. Different staff teams also did a presentation at each of the Board of Trustees meeting to inform the Board of the work they were doing and influence developments. Staff could also influence practice through a variety of practice development groups and champions for example to improve support to children whose behaviour might challenge, pain management and debrief meetings were used to reflect on and improve end of life practice. The hospice was keen to drive improvement through these link practitioner roles. Managers had actively facilitated the role and ensured that these staff had appropriate support to develop further and champion their individual areas of concern within the workforce. We saw these initiatives had led to improved systems of medication handover and agreed pain management between parents and staff during children's overnight stays.

We found the registered manager promoted a culture of transparency where lessons could be learned to drive improvements. Staff were encouraged to raise concerns openly and without fear of recrimination. We saw examples of this in the implementation of the accident, incident, safeguarding and complaints procedures. Where appropriate, staff had been enabled through closer support and offer of additional training to ensure consistent high quality care for children and young people using the hospice.

The safety and wellbeing of staff was considered and monitored. For example, due to the nature of this service staff may work in children and young people's own homes where they may place themselves at risk of unforeseen events. Lone working was well managed, the hospice had a policy and procedure in place that

all staff knew and we saw evidence of it being regularly reviewed. The provider had recently introduced a system called 'Guardian' whereby staff used their mobile phones to log in and out of the system when they entered and left children's homes. Staff also had the necessary emergency contact details at hand. This was good practice to ensure all staff returned safely from any visit within the community.

The registered manager understood the improvements that needed to be made across the hospice. The hospice had an array of systems for auditing and reporting to ensure a high quality service delivery. This included, but not limited to, patient safety and quality, medicines management, reports to the board of trustees and the Quality Governance and Risk Committee. We had sight of the minutes and reports of the last meetings for all of these events which demonstrated how the service was scrutinised and how safety was being monitored and reported effectively. This showed a transparent organisation that had clear links of accountability from the 'floor to the board'. Information on matters such as infection control, falls prevention, medicines incidents, staff recruitment/competencies, complaint management, safeguarding and finances were known about by those responsible and accountable within the organisation. Effective methods of communication were in place as well as systems to address any matters arising. For example, we saw the registered manager took prompt action to improve the MCA and best interest decision making process when they identified areas that required improvement.