Butterwick Limited

Butterwick House

Inspection report

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

Ratings

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

Summary of findings

Overall summary

Our rating of this service improved. We rated it as requires improvement because:

- Mandatory training had not been completed by all staff.
- Not all staff had had an appraisal at the time of inspection.
- Leaders had improved the way they managed the service since the last inspection in 2021, but there was work to do to sustain and embed improvements.
- The service had started to engage with the community to plan and manage services but these relationships needed to grow and establish.
- There were no Fit and Proper Person checks undertaken for the five hospice trustees.

However:

- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and measured patient outcomes. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information.
- Staff treated patients 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 patients, families and carers.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and 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	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Background to Butterwick House

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

We previously inspected Butterwick House in September 2021 and raised significant concerns with the provider by issuing a warning notice under Section 29 of the Health and Social Care Act 2008, relating to breaches of Regulation 12 and 17. In addition, we issued the provider with a notice of decision to impose conditions on the providers registration. In response, the provider issued an action plan outlining how the service had taken action to address the concerns outlined within the warning notice. The conditions limited the provider to admit a maximum of two service users, already known to the provider, for respite care only.

We carried out an unannounced comprehensive inspection on 1-2 February 2022. At the time of our inspection there was a registered manager in post. This inspection was undertaken to check the service had made sufficient improvements ensure compliance with the Section 29 Warning Notice and to follow up on concerns that had been raised with us.

The provider's last comprehensive inspection took place on 05 November 2019 and 05 December 2019 at which it was rated inadequate overall, with all domains rated 'inadequate' apart from caring which was rated as 'good'.

At the time of the inspection the hospice was only admitting a maximum of two children each week. This service re-commenced in January 2021, following a period of voluntary suspension. The service was also offering a limited day care service, which involved a nursing assessment, followed by physiotherapy and therapy, as indicated.

How we carried out this inspection

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. Our team consisted of an inspection manager, inspectors, a pharmacist specialist, and a specialist adviser with relevant experience in hospice care.

We spoke with 12 staff including; the Human Resources Manager, Quality and Compliance Manager, the Director of Care and the Chief Executive Officer. We also reviewed six patient files, staff training records, all trustee files and current policies and procedures.

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

Areas for improvement

Action the service MUST take to improve:

Summary of this inspection

- Fit and Proper Persons Requirements (FPPR) reviews were not undertaken for the five hospices trustees. This is a breach of **Regulation 5** of the Health and Social Care Act. This is a recurring breach in regulation that had been identified at the last inspection in 2021.
- The provider must assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. **Regulation 17 (2)(a)**
- The provider must assess, monitor, and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. **Regulation 17(2)(b).**
- The service must ensure that staff received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform **Regulation 18 (2) (a)**

1.

Action the service SHOULD take to improve:

- The service should ensure staff are compliant with the mandatory training requirements for the service.
- The service should ensure that all policy documents are updated when their review date expires.
- The service should consider and be prepared for upcoming changes in legislation that will impact their service.
- The service should ensure that the resuscitation bag is secure and is tamper proof.
- The service should ensure that all staff know how to use the call bell system.
- The service should consider meeting the needs of the local population to enable those who need it, have access to it.
- The service should ensure it is prepared for the Liberty Protection Safeguards system that comes into force in April 2022

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Hospice services for children

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

Are Hospice services for children safe?

Requires Improvement

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff but did not ensure everyone completed it.

There were some training modules that had low levels of compliance. These included refresher training and some gaps where staff had not completed initial training. The provider had an action plan and a deadline to complete outstanding training. Basic life support training and incident report training was scheduled for February 2022 and bereavement training for March 2022.

Improvements had been made since the last inspection so that the provider had assurances that training compliance levels were monitored and actions completed for all staff. Records for trustees who previously lacked training showed that courses that had been undertaken.

The array of mandatory training modules was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training. We reviewed the training matrix for staff working within Butterwick House. The training matrix specified the mandatory, statutory and additional training for all staff. We reviewed the training files and certificates for all staff working within the unit, which corresponded with the training matrix provided.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse. All staff received level 3 safeguarding training and 100% of staff were up to date with training. The director of care services was the designated safeguarding lead.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff described actions they would take in the event of any safeguarding concerns and would discuss concerns with the designated safeguarding lead in the first instance. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff followed safe procedures for children visiting the hospice.

The service had an up to date chaperone policy which was written in February 2022 though had no date for review.

There was no process for safeguarding supervision for staff working with children and families. Staff did not receive either group or individual supervision. Documentation to check if this happened was requested after our inspection. Managers acknowledged that there was a gap in providing supervision and were working to establish this.

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients on wards and transporting patients after death.

Areas throughout the unit were kept clean and had suitable furnishings which were both clean and well-maintained. Cleaning records were up-to-date and demonstrated that the domestic team regularly cleaned all areas.

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

Each area of the hospice had a daily checklist detailing what needed to be cleaned and when. There were dedicated 'touch point' places where cleaning happened more frequently because of high intensity of use and footfall. Healthcare staff followed this checklist and signed when completed.

The provider's hand hygiene audit showed consistent high compliance. We saw evidence of corrective action taken when issues were raised. The audits seen scored over 92%.

Environment and equipment

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

The hospice was on two floors with a stairlift available to the overnight accommodation that was provided for families on the second floor. As well as six individual bedrooms, there was a large play area, a sensory room and the sunflower room. The sunflower room was a private place equipped to accommodate and care for the deceased.

The inpatient unit was located on the ground floor and patients arriving by ambulance could be accommodated. Most patients were wheelchair users and the environment met their need, with wide corridors and double doors. Accessible toilets were available for patients, staff and families. Private access for ambulances or funeral directors was available in the sunflower room for the dignity of deceased patients.

The unit was secure and access was restricted for safety. Staff ensured that doors remained securely closed.

Records showed that electrical equipment was serviced, and safety tested. An external company provided clinical equipment and compliance checks. All portable equipment seen had an up to date portable appliance testing sticker. Equipment used by staff, such as hoists, were in date for their maintenance checks. All fire exit signage was clear, and all fire exits were free of obstructions

The service maintained up to date risk assessments. This included risk assessments of all clinical areas and for individual risk such as the use of bedrails.

There was a call system in each bedroom that could be used to ask for help. However, not all staff were able to explain to us how this functioned.

Resuscitation and emergency equipment was available onsite and easily accessible. We checked the emergency equipment in the unit and all bag contents were correct as listed. There was no defibrillator, however this was not a legal requirement but a workplace recommendation. The resuscitation bag was not secure with a tamper proof seal. There were no medicines in the bag but no way either of ensuring that the bag was not tampered with in between checks.

Assessing and responding to patient risk

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

Staff completed risk assessments for each child and young person using a recognised tool, and reviewed this regularly, including after any incident. We reviewed six sets of patient notes. These included up to date care plans and risk assessments. Risk assessments included paediatric tissue viability with skin condition documented on a body map, moving and handling and the use of medicines, for example for treating seizures.

Staff did not routinely use a nationally recognised tool to identify children or young people at risk of deterioration. Staff told us that they would contact other healthcare services if a child or young person's health was deteriorating. The service did not require staff to take baseline observations for children and young people with complex needs on admission for respite care. This was because trends of observations could vary depending on factors such as the time of day, anxiety or pain.

Staff knew about and dealt with any specific risk issues. These issues were detailed on each child or young person's Emergency Health Care Plan (EHCP).

Shift changes and handovers included all necessary key information to keep patients safe. Staff shared key information to keep children, young people and their families safe when handing over their care to others. There was a morning meeting before admission where staff discussed the children or young people attending that day.

The pre-admission assessments were undertaken a week prior to admission. No child would be admitted on the day if they were unwell or did not have the medicines needed for the stay.

All children and young people when resident were for active treatment and resuscitation unless the EHCP or a Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) was in place. Any protocols were agreed with the individual's parents and their consultant paediatrician. This protocol was kept in the nursing documentation and the original copy attached to the individual's wheelchair.

Requires Improvement

Hospice services for children

Nurse staffing

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

Senior leaders planned nurse staffing levels in advance against planned admissions. Senior leaders reviewed the clinical needs of all patients and planned staffing levels in accordance with this to ensure staff had the required clinical competencies to deliver care and treatment.

There were five registered nurses and five health care assistants. The registered nurses were a combination of paediatric nurses and learning disability nurses.

The hospice used a clinical decision tool to calculate the dependency needs of children using the service for respite care. Staffing was planned based on the calculated dependency of those children booked to come in.

The service was not offering emergency placement at the time of our inspection and had restricted opening to three days per week. The service had enough staff to work the reduced number of shifts that were in operation, however, there were staff vacancies and ongoing recruitment.

There was a staffing board visible to patients and visitors showing a photo of the staff on duty and their job role.

Records

Staff kept detailed records of patients' 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. Each patient had three sets of notes – one archived set (blue), one for medicines (red) and a current set of notes on admission (green).

We reviewed six sets of care plans dating from September 2021, including multi-disciplinary team discussion notes, medicine records and nursing notes. Care plans were comprehensive of patient needs, personalised and up to date. Correct patient names and genders were used throughout all records. The plans included assessments for nutrition, moving and handling and mouth care. All care plans were commenced were patient specific and were updated as the patient's condition or need changed.

Documentation audits were being undertaken. In all records reviewed, the nurse pre-admission check audit form was present and had been completed. We saw evidence of actions being taken after audit findings.

In all records reviewed, the service had taken action to archive information that was no longer current or accurate. This information had been removed from current care plans and placed into an archived folder in order to ensure care plans were reflective of the patients' current need.

Medicines

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

Staff followed systems and processes to transcribe patients own medicines on admission so these could be safely administered. All transcribing and administration of medicine was checked by two members of staff.

Requires Improvement

Hospice services for children

Care plans and medicine administration records contained information on the use of when required medicines, however, for some people these records lacked detail.

The hospice stocked a limited amount of medicines as patients brought their own medicines for their stay. A limited service level agreement was in place for supply of medicines, audit and review of records and pharmacy support was provided for three hours once a fortnight. Pharmacists were contactable for advice outside of this time.

Incidents

The service had improved incident reporting since the last inspection, although there was further improvement needed to ensure incidents were investigated and lessons learnt in a timely way. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

No serious incidents or never events had been reported since the last inspection. Incidents were reported using a paper-based system. Staff told us that they knew how to report incidents and were encouraged to do so.

Incidents were reviewed at the governance meetings and meeting minutes indicated that staff were actively reporting incidents within the children's unit. The incident tracker showed lessons learnt, initial action taken and incident investigation. Lessons learnt were submitted for incidents and monitored by managers. These lessons learnt were shared with staff via team meetings or staff bulletins. However, there was a backlog of incidents waiting to be actioned and closed.

A patient safety alert log was also circulated to ensure staff were aware of changes and updates in medicines and equipment.

We reviewed an incident where a young person's medicines had not been thoroughly checked on admission. When this error was later discovered it caused a delay in a patient receiving their night-time dose. The incident had been investigated and actions taken to prevent reoccurrence of this

Are Hospice services for children effective?

Good

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver care according to best practice and national guidance. The service had been reviewing all their policies and procedures and updating them.

Policies appropriately referenced current good practice and national guidelines from organisations such as the National Institute for Health and Care Excellence (NICE) and Royal Colleges. Most policies seen were in date and version controlled so that staff were assured that they were using the most recent version.

The Clinical Review Working Group (CRWG) had been set up to ensure that clinical documents were reviewed by a multidisciplinary team before being ratified by the senior leadership team and the quality, risk and safety committee. Managers wanted to improve the quality and standardisation of documentation and to have continuous oversight of policies and procedures.

The service had an audit schedule in place that included records, medicines use and infection prevention control. The audit schedule was updated to implement follow up audits where needed. The audit schedule had been introduced since the last inspection. Managers did more audits than scheduled as they were conscious of the need to improve and learn. An external pharmacist attended site to audit medicines. Audit results were shared with staff by email and at team meetings.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' 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. Children and young peoples' nutrition and hydration needs, including those related to culture, religion and special diets were identified, monitored and met. Dietary preferences were given to the catering team so that arrangements were made in advance of a child, young person or their families stay at the hospice.

Staff assessed the dietary needs of patients on admission, based on discussion with their family or carers. Children and young people were weighed on admission to keep a check on weight loss or gain. Food was prepared onsite by catering staff employed directly by the hospice. Pureed and other special diets were available. Feeding and managing hydration were undertaken in line with current NICE guidelines.

Each child or young person had a detailed care plan with specific details on dietary, feeding and hydration regimes which was updated at every admission to the hospice. Care plans included enteral feeding routines. Enteral tube feeding is the intake of food via the gastrointestinal tract. All nursing and care support staff were competent to give enteral feeds. Competency records confirmed this.

Pain relief

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

The hospice used a tool developed in house by specialist staff. They recognised that while there were a range of available tools to assess pain in children there was little for children with complex needs or those who communicated non-verbally so used this tool. We saw in patients' notes that this was being used correctly and revisited as needed.

Staff explained that the children using the service had been visiting for months or years, and they were used to the non-verbal cue's children used to show they were experiencing pain.

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

Requires Improvement

Hospice services for children

Patient outcomes

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

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

Managers used patient and relatives feedback tools to measure patient outcomes to improve children and young people's experiences of care. The patient outcome tool which had been designed by a manager was based on a range of quality indicators and the findings were then used to make improvements. The quality indicators included, for instance, time spent with a therapy animal or art and sensory play. Families were also asked about outcomes for themselves which were also monitored. Parents often measured how well they slept whilst their child or young person was in the hospice for example. Quality and outcome information showed the needs of children and young people who used the service were mostly being met. In January 2022, six parents participated in the outcome monitoring and 92% of outcomes were achieved.

All children and young people had an individualised care plan, that set out their advance care preferences. It covered activities of daily living, family and carer support, infection control, mental capacity, tissue viability, advance care planning and symptom management.

Managers and staff carried out a programme of repeated audits to check improvement over time. The audit schedule included quarterly hand washing audits, audits of complimentary therapies, spiritual care, medicines management, documentation and national guidance. The audit plan was updated to review new processes. Managers used information from the audits to improve care and treatment.

Competent staff

The service made sure staff were competent for their roles. Managers had appraised some staff's work performance and were in the process of ensuring everyone had an appraisal.

The service only used permanent staff and had no volunteers. Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families. A registered children's nurse or learning disability nurse was always on duty.

New staff attended a corporate induction day to gain a holistic overview of the service. Managers provided all new staff with a full local induction tailored to their role before they started work and allocated them a mentor. The induction included any relevant clinical competencies that needed to be undertaken.

A team member had worked as a domestic assistant in the hospital and had been inspired to become a health care assistant so applied and were successfully recruited. Managers were keen to help staff progress and develop. Health care assistants had completed theory modules for clinical competencies that were not necessarily required for their roles to expand their current knowledge and skills.

However, not all staff had received an annual appraisal that gave them the opportunity to explore aims, objectives and development opportunities for the coming year. Staff had dates booked to have their appraisal but there had been a backlog that a new manager was trying to rectify. 73% of staff had a completed appraisal at the time of inspection.

Requires Improvement

Hospice services for children

Multidisciplinary working

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

The service was nurse led and had no other healthcare professionals permanently based on site. However, staff worked with the community healthcare teams responsible for the care of children and young people admitted to the hospice. Staff worked with closely with social workers, occupational therapists, physiotherapists, dietitians and community nurses to deliver collaborative care and treatment for children.

Managers identified that relationships needed to be fostered with other organisations and they were working to better this. Managers had set up a group with other hospices in the north east of England to benchmark and share best practice with each other. Links had been made with palliative care networks, specialist support services and the clinical commissioning group.

There were now team meetings on site and staff felt that they had positive working relationships with each other. They welcomed recent managerial changes that enabled the team to work well together.

Seven-day services

Key services were not available seven days a week to support timely patient care.

Following the last inspection, the service was operating under restrictive conditions imposed by the CQC. This meant it was not able to provide a seven day service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

The service had an up to date consent policy. Staff could describe and knew how to access policy and get accurate advice. Up to date policies were available and staff told us that they knew how to access policies.

Staff clearly recorded consent in the children and young people's records. Staff gained consent from children, young people or their families for their care and treatment in line with legislation and guidance. Staff did not provide any care without first asking their permission. In the six patient records we looked at, we saw copies of signed consent forms and observed that consent to treatment was obtained appropriately.

The service had two safe space beds that were available to certain children or young people. These were only used if a child or young person had one in their home. These beds were used in the best interest of the individual and after a risk assessment was completed by an occupational therapist. The use of these beds was always undertaken in conjunction with consent and a mental health capacity act assessment. All consent paperwork for any child of young person was reviewed annually.

Staff alerted families when things went wrong. One family told of us a minor medication error that occurred during their child's admission that was immediately brought to their attention.

Requires Improvement

Hospice services for children

However, managers were unaware of upcoming changes to the Deprivation of Liberty Safeguards (DoLS) system. The Liberty Protection Safeguards were introduced in the Mental Capacity (Amendment) Act 201. Liberty Protection Safeguards replace DoLS in April 2022 so the service had just two months to implement changes.

Are Hospice services for children caring?

Good

Our rating of caring improved. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We did not observe any direct patient care. Families interviewed said that staff treated their children and young people well and with kindness. Care and activities were facilitated and modified as appropriate to needs. Staff took account of children and young people's individual needs, for example children could personalise their rooms and use their own bedding if preferred. Indeed, after the death of one young person, their favourite bedding was made into a teddy bear as a keepsake for their family.

Feedback from friends and family was overwhelmingly positive. The most common feedback theme related to the comments around staff who were described as "amazing, great and just like family'. Families told us that their child was well cared for and they became excited when they drove close to the hospice. They did many fun things and their children loved it

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. There was a hospice chapel for use, an occasional visiting minister and books that were multifaith. Although children and young people did not have end of life care in the hospice, the sunflower room was available for the deceased. Staff ensured care after death included honouring the spiritual and cultural wishes of the deceased child or young person and those close to them. Families were able to stay with their child or sibling in a private space.

Emotional support

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

Staff understood the emotional and social impact a child or young person's care, treatment or condition had on their, and their family's wellbeing. Staff ensured care was child centred, with children and young people consistently at the heart of the service. Children, young people and their families were given every opportunity to express their views and be involved in making decisions about their care.

Emotional support was given even when children or young people were not inpatients. A manager had received a phone call from a family late at night after their child had died at home. The family felt 'lost' and needed help. The manager drove to the family home to provide comfort and practical help.

Requires Improvement

Hospice services for children

Another young person who had died in a local hospital came to the sunflower room to rest at the family's request. This room enabled families to be with their loved one after death. Staff worked unpaid shifts to accommodate this request and deemed this to be a privilege.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Families were treated holistically and support for families was arranged if needed. Children, young people and their families were supported to undertake a variety of activities, these included arts and crafts and supported play.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. Children's and young people's families, carers, advocates and representatives were identified, welcomed, and treated as important partners in the delivery of their care. Staff described the children and young people as 'our family'.

The service was able to refer families for holidays provided by a charity. Managers completed applications and paperwork. One family had recently benefitted by being able to holiday for the first time in many years.

When a child or young person died, memory boxes were made and gifts prepared for siblings. Every child or young person received a gift on special occasions even if they were not at the hospice. Staff would deliver gifts in their own time to ensure every individual on their caseload was acknowledged.

Are Hospice services for children responsive?

Good

Our rating of responsive improved. 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 some of the needs of local people and the communities served. It had started to work with others in the wider system and local organisations to plan care.

Managers were unable to plan and organise services to wholly meet the needs of the local population. Due to restrictions, just two patients were admitted at any given time and these children or young people needed to be known to the service. There was a referral list of children and young people waiting to access the service and each child or young person was prioritised according to need.

Leaders told us that there were plans to analyse which demographic of the local population was not using the service or less likely to do so but new managers had not had the opportunity to do this and resources were limited. Leaders knew that they could do more to access hard to reach communities but had struggled to achieve this to date. The service had an equality and diversity policy that was in date and due for review in September 2022.

Families told us that there were gaps in service provision and wished that children and young people could be placed at the hospice for longer stays. It often took a lot of effort to prepare them for a maximum two night stay.

However, managers had started to forge links with other similar providers in the region. They were starting to reap the benefits of benchmarking and shared good practice. Having a better regional support system was a key objective. Managers had started to attend regional palliative care and end of life steering groups regularly.

The service had systems to help care for patients in need of additional support or specialist intervention. If a child or young person needed other support or medical help, the service reached out to community workers allocated to them or used the individual EHCP for instruction.

Managers monitored and took action to minimise cancelled admissions. Staff contacted families frequently and helped to resolve issues that might inhibit admission. For instance, if a child did not have medicine that was critical to admission, staff contacted local pharmacies and hospitals to hopefully resolve the problem.

The hospice had a website that showcased its facilities. The website required updating as it suggested that there was a hydrotherapy pool in use and this was no longer the case.

Meeting people's individual needs

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

Staff made sure children and young people living with learning disabilities, received the necessary care to meet all their needs. All care was individualised to each child. Children and young people who were cared for at the hospice often had complex needs so all their needs, likes, dislikes and preferences were documented in their records. There were six individual and private bedrooms. Facilities and premises were appropriate for the services being delivered and could be adapted easily to accommodate different requirements and tastes.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The hospice had a fully equipped sensory room that had multiple features including light therapies, a projector and a soft play area for children and young people to use.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Translation services were available, and staff knew how to access the service.

Staff told us that they built relationships with families as they returned over months or years for respite care. As a result, they found it easy to discuss planning for children and young people with the family and could identify how much and when family need to be involved.

Access and flow

Patients could sometimes access the hospice when they needed it.

Staff delivered personalised care to each individual when they had capacity. Most referrals to the hospice were funded by continuing health care packages. As just two children were permitted at any given time, this impacted on children and young people accessing the service.

Requires Improvement

Hospice services for children

Every child or young person had a minimum of one member of nursing staff or member of the care team staff dedicated to their care each day, and in some instances two staff dependent upon their needs. The allocated staff were responsible for all aspects of the child or young person's care, which included their personal and health care needs along with their social needs, which included play and relaxation.

All admissions were planned and booked in advance. There were no emergency admissions but if a vacancy became available unexpectedly then staff worked quickly to ensure another child was able to have the place.

Learning from complaints and concerns

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

The hospice had processes to ensure complaints were dealt with effectively, including prompt acknowledgement of the complaint, a written response to the complaint and whether changes had been made because of the complaint. Face-to-face meetings with the complainant were also offered, when indicated. The provider displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. The service had an up to date complaints policy. Staff described the actions they would take if anyone raised a complaint. Where possible complaints were resolved immediately. Emphasis was placed on listening to the patient or relative to identify their needs and to address their concerns in a manner that improved outcomes for them.

There was a display board in a communal area of the unit that had examples of 'you say, we did'. Selected complaints that had been made by various people were on show and their resolutions displayed for anyone to read.

Are Hospice services for children well-led?

Requires Improvement

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Leaders did not always manage the priorities and issues the service faced; however, they were visible and approachable in the service for patients and staff.

We reviewed the human resources (HR) files for five trustees. We found that in all files, there was no evidence of Fit and Proper Persons Requirement (FPPR) review. This is a legal requirement to ensure that directors were fit and proper to carry out the trustee role. The provider did not have appropriate systems in place to evidence adherence to the requirements of the FPPR regulation. Trustee files did not consistently evidence checks with appropriate professional bodies and regulators. The files did not contain evidence of occupational health checks or a register of the trustee's interests. The files did not consistently evidence whether references had been obtained prior to each trustee's appointment.

We raised this with senior leaders post inspection who agreed that they needed to review and address this non-compliance. This was a recurring breach in regulation that had been identified at the last inspection in 2021.

Senior leaders had instigated an action plan to address the concerns raised in the warning notice they received following the previous inspection in 2021. The service had broken the action plan down into sections to look at the responsibility for different areas. The service had weekly meetings to review the action plan and look at progress and potential barriers. A key focus was placed on the warning notice. The service had planned a trustee away day to review the warning notice action plan to appoint individual key leads to lead on specific areas.

The service was led by a registered manager (director of care) and a clinical lead, supported by a compliance manager, clinical governance lead and a human resources manager.

The registered manager had been in post only three days at the time of the last inspection September 2021. The registered manager told us they were focussing on addressing the warning notice received post inspection and the actions required to improve and prevent recurrence.

The service set up a clinical working group to review current practice in order to highlight what actions were required and how the service could address them. A workplan was commenced and shared with staff based on priorities to address the warning notice. Updated or amended pieces of work, pathways/policies etc including new documentation are reviewed at clinical governance meetings with a view to improving in a structured way. At this inspection we found improvements; however, it was not possible, given the length of time since the last inspection, to evidence that these improvements were sustained and embedded.

Vision and Strategy

Leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills. The service was re-evaluating the strategy and vison of the service.

Following the last inspection, the service received a notice of decision which imposed conditions limiting the service to offer respite care for two children at any one time who were known to the service.

Leaders were mindful of the need to progress the service strategy. They told us they would not be able to move forward until they had the necessary staff and recruitment was seen as a priority.

The service did not intend to open to the full six beds, the opening would be incremental and would be dependent on recruitment of staff with the right skills and competency. Leaders told us as a hospice they needed to consider end of life care and the unmet need in the service currently on offer. Leaders intended to look at other hospices to see what was needed and what skills and competencies the service could offer currently.

Culture

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

Staff said that they were proud of the service they delivered and described their colleagues and the senior team as supportive. All staff told us they had good working relationships with their colleagues. Staff were patient focused, and the culture was focused on the needs and experiences of people who used the services. Several members of staff told us they were proud of the care they gave to patients and told us they felt the service was patient centred.

Staff were openly encouraged to raise concerns with senior leaders. They felt comfortable escalating concerns. Senior leaders had an open-door policy and encouraged colleagues to be open and transparent with one another.

We had received concerns raised with us regarding senior leadership culture and management of the service. We discussed this with senior leaders at the time of inspection. Leaders confirmed they had experienced cultural issues concerning bullying and harassment historically; however, this had been addressed and culture had improved.

The service had a whistleblowing policy which was available to all staff and information on how to raise concerns was available within this document.

Governance

Leaders had worked to improve governance throughout the service following the last inspection, although further work was needed to sustain and embed improvements. Except for fit and proper persons checks of trustees, most of the concerns identified during the inspection were known to managers and managers had plans to address them.

The last inspection of the service in September 2021 identified significant governance issues. At this inspection we found improvements. The improvements to oversight and monitoring of risk and key performance indicators, had occurred only within the last few months. Managers accepted there was further work to do to improve the service and that systems needed to embed.

We saw evidence of current disclosure and disbarring service (DBS) checks were in place for all staff. This was an improvement since the last inspection. The service had a DBS tracker in place and staff files all had evidence to support checks had been implemented and were in date.

Senior leaders told us they held quality safety and risk committee meetings monthly. The meetings had a set agenda to evidence discussion surrounding incidents, learning, action & dissemination, performance & quality audit, inpatient service, complimentary therapies, risk register incidents & complaints, policy, projects and appraisal and supervision.

Management of risk, issues and performance

Leaders and teams had improved 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.

The service had a comprehensive electronic risk register. Risks were reviewed monthly and escalated appropriately. Leaders of the service were aware of current risks and were sighted on plans to address risks. High risks included staff recruitment, financial risk and the need to complete actions to evidence improvements made against the warning notice following the last inspection in 2021.

We reviewed quality safety & risk meeting minutes from the four months prior to inspection. At these meetings, incidents were reviewed and discussed. The meetings were every other month and examined hospice activity and performance, patient safety, quality of care, education and training, policies and governance. Challenges made from board trustees were seen in the minutes and actions noted.

The committee received several reports regarding different streams of risk including corporate risk, clinical risks and operational risks. This committee looked at and scrutinised key information about risks within the service and ensured action was taken to mitigate them. An example of this was the regular presentation of incidents at the group including their grading and a summary of the incidents.

The service had an up-to-date business continuity plan which was accessible to staff and detailed what action should be taken and by who, in the event of a critical incident involving loss of building, information technology or staff.

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.

Policies and procedures were held centrally and available electronically on the service's shared drive.

The service had implemented a care database system that enabled all care documentation including clinical and patient information to be recorded in one place. An administrative assistant was employed to undertake some information management such as uploading documentation and sending letters to patient's GPs.

Computers and laptops were encrypted, and password protected to prevent unauthorised persons from accessing confidential patient information. However, we saw that staff did not always lock their computers when not in use to prevent unauthorised access.

Quarterly reports were generated for the CCG commissioned contract that was in place.

There were plans to upgrade systems within the hospice. Testing stages and piloting had commenced to trial new electronic systems. Some of the current systems were deemed to be slow and in need of modernisation.

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 staff explained that they used the friends and family test to seek views but the uptake was low due to the limited of number of patients they had. However, those families who responded did so positively.

The hospice had a good presence in the local community with local charity shops and a hospice site in Bishop Auckland providing day-care services.

There were staff engagement mechanisms and opportunities for staff to meet to provide feedback. The provider had information exchange opportunities held at both the Stockton and Bishop Auckland sites. An information exchange bulletin was produced for all staff as well as a regular email from the chief executive.

A staff survey was launched in January 2022 but the results of this had not been collated for scrutiny at the time of inspection.

Leaders were collaborating and networking with other hospices in the locality. There was more effective engagement with other providers and with hospice networks than seen at previous inspections.

Requires Improvement

Hospice services for children

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.

Senior leaders recognised the need to continuously adapt and improve policies and processes. Leaders told us that staff recognised the need to take ownership of work that needed to be completed. Staff acknowledged and recognised the need to be cohesive and inclusive in the adaptation of the service moving forwards.

Leaders told us they were more cohesive, they shared information, discussed concerns and were more transparent and open.

At the last inspection, the service did not have any way of measuring patient outcomes. A manager had taken action to research and produce an outcome tool. They checked what resources were available and what other hospices did. Having found little information, they decided to design their own monitoring tool that was both qualitative and quantitative. The manager had shared the tool with an institute for research into palliative care and had been invited to meet with the team to discuss further. There were plans to disseminate this outcome monitoring tool with other hospices.