Acorns Children's Hospice in the Three Counties

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good	●
Are services safe?	**Good**	●
Are services effective?	**Good**	●
Are services caring?	**Good**	●
Are services responsive?	**Good**	●
Are services well-led?	**Good**	●

Overall summary

Acorns Children’s Hospice in the Three Counties is operated by Acorns Children’s Hospice Trust which runs three children’s hospices. Acorns Children’s Hospice in the Three Counties specialises in providing holistic palliative care to children and young people from birth to 18 years living with life limiting conditions. The hospice has 10 beds. Facilities include two family care suites, two family flats with a lounge area and gardens, activity rooms, a multisensory room, indoor soft play, outdoor play area, a adolescent room and hydrotherapy pool. The hospice also has two chapel of rest special bedrooms where children can stay after they have died.

Summary of findings

The hospice provides holistic palliative care and support at end of life care for children and young people, outreach services, family support, complementary therapy and respite care. We inspected all services provided.

We inspected this service using our comprehensive inspection methodology. We carried out a short notice announced inspection on 18 December 2019. We gave staff one day's notice that we were coming. We also carried out an announced visit to the hospice on 2 January 2020.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

Our rating of this service stayed the same. We rated it as **Good** overall.

We found areas of good practice:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people subject to the Mental Health Act 1983.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Understanding and involvement of children, young people, their families and those close to them. Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.
- The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- Children and young people could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for children, young people, their families and staff. They supported staff to develop their skills and take on more senior roles.
- Leaders operated effective governance processes, throughout the service and with partner

organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

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

- The provider should have a consultant medical director with oversight at executive level
- The provider should ensure that all staff receive regular safeguarding supervision
- Managers should ensure that all staff are aware of feedback and learning from incidents
- Managers should ensure that all staff have an annual appraisal
- The provider should ensure that all audit processes are robust and actions are identified to improve performance.
- Managers should ensure that all staff received feedback from complaints
- Managers should ensure that audit data is included in team meeting minutes
- The provider should ensure they monitor cancelled appointments and delays into the service.

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

Heidi Smoult

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating		Summary of each main service
Hospice services for children	Good	●	Acorns Children's Hospice in The Three Counties provides holistic palliative, respite and end of life care to children and young people from birth to 18 years living with life limiting conditions. The hospice has 10 beds. The service provides support to children, young people and their families both within the hospice, in individuals homes and in the wider community. The hospice supports families across Worcestershire, Herefordshire, Gloucestershire, Warwickshire and surrounding areas

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Good ●

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Summary of this inspection

Background to Acorns Children's Hospice in the Three Counties

Acorns Children’s Hospice in the Three Counties is operated by Acorns Children’s Hospice Trust which runs three children’s hospices. Acorns Children’s Hospice in the Three Counties. The hospice opened in March 2005. It is a children’s hospice located in an urban location in Worcester, Worcestershire. The hospice primarily serves the communities of Worcestershire, Herefordshire, Gloucestershire, Warwickshire and surrounding areas.

Acorns Children’s Hospice Trust provides a holistic service which meets the needs of children and young people up to 18 years old, and their families, including the bereaved. This includes short break provision; emergency and end of life care; therapeutic and psychosocial support; sibling services and family support.

Acorns Children’s Hospice of the Three Counties has supported 191 children and young people with life limiting illness in the hospice and the wider community from October 2018 to September 2019. This included 44 children from birth to three years, 107 children and young people aged four to 12 years and 40 children and young people aged 13 to 17 years old.

The hospice has 10 bedrooms, two family care suites and two family flats with lounge areas and gardens. Facilities include a hydrotherapy pool and two chapel of rest special bedrooms where children can stay after they have died. The service has a complementary therapy team and provides treatments for children, young people and their families.

The hospice care team offers holistic care to each child and young person to support their health and social needs as well as providing recreational activities. The hospice provides end of life care and support. The care team consists of paediatric palliative care nurses, health care assistants and physiotherapists. The hospice has daily visits from local GPs. The service is supported by 54 volunteers involved in a variety of tasks including housekeeping, reception, maintenance, gardening, supporting children and families at home through group work.

Other services offered include day care, planned short breaks, emergency short break care and family splash where children, young people and their families can use the hydrotherapy pool.

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

The hospice had been previously inspected in April 2016.

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 18 December 2019 and 2 January 2020.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and a specialist advisor with expertise in end of life and palliative care for children and young people. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection and an Inspection Manager.

Information about Acorns Children's Hospice in the Three Counties

Acorns Children’s hospice provides care for babies, children and young people up to 18 years and supports their families. Care teams provide a range of specialist care services for life limited and life threatened children across the region. Most of the children and young people require specialist care 24 hours a day, seven days a week. The hospice offers care to 10 children and young people as inpatients and also provides support and advice to around 300 children, young people and their families including bereaved families.

Summary of this inspection

The service provides a range of services including palliative short breaks for children, young people and their families, day care, symptom control, emergency care, end of life care, complementary therapies, specialist physiotherapy, hydrotherapy, one to one sibling support and bereavement support. Support was offered across all age ranges to support all family members.

Acorns Children's Hospice of the Three Counties has 10 beds across two wings and is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury (TDDI)
- Personal Care

During the inspection, we visited the main inpatient areas and undertook two home visits. We spoke with 20 staff including registered nurses, health care assistants, family team workers, volunteers and senior managers. We spoke with 10 children and young people and their families. We observed the environment and care provided to children and young people. During our inspection, we reviewed seven sets of patient records and four prescription charts. We also looked at a range of performance data and documents including policies, meeting minutes, audits and action plans.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The hospice was last inspected in April 2016, which found the service was meeting all standards of quality and safety it was inspected against.

Activity (October 2018 to September 2019)

- In the reporting period October 2018 to September 2019, there were 1022 admissions to the service. Of these 191 inpatient and day case episodes of palliative care were recorded at the hospice; these included 44 children aged nought to three years old, 107 children and young people aged four to 12 and 40 children and young people aged 13-17 years old. In the same time frame the service had 1015 admissions for respite care. The service provided 877 hours of care and support in the community in the 28 days before data was submitted to the Care Quality Commission. No date was provided for this.
- The service had not yet recorded the number of children and young people with a learning disability or autism spectrum disorder, those with a sensory impairment or a physical disability.

Acorns Children's Hospice of the Three Counties employed 40 qualified staff including registered nurses and allied health professionals, 11 health care assistants, and 11 non-qualified staff as well as having its own bank staff. No agency staff were employed. The service employed 22 qualified nursing and allied health care staff and eight health care assistants on zero hours contracts. The service also had 152 volunteers, 54 of these volunteered in a direct patient contact caring capacity. There were no staff with practising privileges working for the service. The accountable officer for controlled drugs (CDs) was the Director of Care.

Track record on safety

- Zero Never events
- Zero serious clinical incidents
- Zero serious injuries

Zero incidences of hospice acquired Meticillin-sensitive staphylococcus aureus (MRSA),

Zero incidences of hospice acquired Meticillin-sensitive staphylococcus aureus (MSSA)

Zero incidences of hospice acquired Clostridium difficile (c.diff)

Zero incidences of hospice acquired E-Coli

Four complaints

Services accredited by a national body:

- Achieved Diversity Award from 2014 to 2019 for work in supporting equality and inclusion for all.
- UNICEF - Rights Respecting Award (Rights of the Child) - working towards Bronze.
- Winner of the Downtown Business Social Media Presence of the year 2018.
- Winner of the Great Birmingham Chamber of Commerce; Excellence in Contributing to the Community 2018.
- Birmingham Post Business Awards 2018 Finalist for Best Non for Profit Organisation of the Year 2018.

Summary of this inspection

Services provided at the hospital under service level agreement:

- Staff support counselling
- GP support from local GP practices
- Consultant paediatricians to provide paediatric palliative care support
- Pharmacy services
- Infection control advice

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good ●

Our rating of safe improved. We rated it as **Good** because:

We found the following areas of good practice:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.
- 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.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

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

- Managers should ensure that all staff receive regular safeguarding supervision

- Managers should ensure that all staff are aware of feedback and learning from incidents

Are services effective?

Good ●

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

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff gave children and young people enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for children and young people's religious, cultural and other needs
- Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes
- The service made sure staff were competent for their roles.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave children, young people and their families practical support and advice to lead healthier lives.
- Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children and young people who lacked capacity to make their own decisions or were experiencing mental ill health

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

- Managers should ensure that all staff have an annual appraisal

Are services caring?

Good ●

Summary of this inspection

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

- Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. Managers and staff had developed a strong and visible child, young person and family centred culture. We observed that all staff were friendly and saw many examples of positive interactions between staff, children, young people and their families.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. Staff gave children, young people and their families help, emotional support and advice when they needed it. We saw that staff interactions with children, young people and their families were not rushed, and children, young people and their families were given sufficient time to speak to staff about their care and any concerns
- Staff fully supported and involved children, young people and their families to understand their condition and ensure they were active partners in their care and treatment. Staff routinely empowered children and young people to have a voice and ensured a family centred approach.

Are services responsive?

Good ●

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

- The service effectively planned and provided care in a seamless way that met the needs of local children, young people, their families and the communities they served. It also worked proactively with others in the wider system and with local organisations to plan the best possible care.
- The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. There was a proactive approach to understanding the needs and preferences of different groups of children, young people and their families and to delivering care in a way

that met those needs, was accessible and promoted equality. All staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers in a holistic way.

- Children and young people could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them within an agree timeframe and shared lessons learned with all staff. The service included patients in the investigation of their complaint. The service received many compliments about the care, treatment and support that children, young people and their families had received.

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

- Managers should ensure that all staff received feedback from complaints

Are services well-led?

Good ●

Our rating of well-led stayed the same. We rated it as **Good** because:

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for children, young people, their families and staff. They supported staff to develop their skills and take on more senior roles.
- The hospice had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Summary of this inspection

- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- 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.
- 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.

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

- Managers should ensure that audit data is included in team meeting minutes

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good ●

Hospice services for children

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

Are hospice services for children safe?

Good ●

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. The service had a target of 85% compliance for the 10 mandatory training topics. As of June 2019, the target of 85% had been met or exceeded for all mandatory training topics. This included but was not limited to compliance for basic life support was 95%, infection control 92%, mental capacity 92%, safeguarding level three 89%, equality and inclusion 88%.

Mandatory training was comprehensive and met the needs of children and young people and staff. Courses covered key areas such as fire safety, health and safety, basic life support, infection prevention and control, information governance, safeguarding, mental capacity and equality and diversity. Training was provided through e-learning courses and practical face-to-face sessions such as manual handling and basic life support. Staff understood their responsibility to complete mandatory training and told us the training was relevant to their roles.

Managers monitored mandatory training and alerted staff when they needed to update. Staff could monitor their own training needs through the hospice's electronic system, which sent an email alert when due. Managers received regular reports about mandatory training compliance for staff teams. This meant they had oversight of staff compliance and could address any areas of non-compliance when needed.

The service closed for one week each year to enable staff to undertake most of their mandatory training. Some staff had been unable to complete their mandatory training during this week of closure due to a child being resident at the hospice during the training week. Further training had been provided and managers told us staff had now attended training that they had missed.

Clinical staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism. Staff we spoke with were aware of how to meet the needs of children and young people with additional needs. We saw that staff interacted appropriately with children, young people and their families to meet their needs.

Safeguarding

Staff understood how to protect children and young people 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. Levels of safeguarding training was dependent upon staff roles. All staff received level one safeguarding training during their induction programme. All care staff received mandatory safeguarding training at level two or three in accordance with guidance from the intercollegiate document "Roles and responsibilities for Health Care Staff" (Royal College of Paediatrics and Child Health 2019). Bank staff received the level three safeguarding training.

Additionally, all volunteers who had unsupervised contact with children, young people and their families received level two safeguarding training. The service had a target of 85% compliance for safeguarding training. As of June 2019, 89% of eligible staff had undertaken safeguarding level three training, 97% of eligible staff were trained to level two and 94% of staff were trained to level one. Adult safeguarding compliance was 97% for level two and 94% for level one. The designated and deputy safeguarding leads were trained to level four.

There were clear systems, processes and practices to safeguard adults, children and young people from avoidable harm, abuse and neglect that reflected legislation and local requirements. Safeguarding policies and pathways were in-date and were accessible to staff through the service intranet system. Policies included details of types of abuse including neglect, physical, domestic, sexual, psychological and financial abuse as well honour-based violence and modern slavery. The service also had policies for missing children and the provision of safeguarding supervision for staff. Links to external resources were available to staff through the trust's intranet, with flow charts and advice on how to refer children and young people, and who to contact for advice and guidance on all matters relating to safeguarding. Safeguarding information was displayed in all locations we visited during the inspection.

The director of care services was the designated safeguarding lead. The head of care was the deputy safeguarding lead along with the heads of care for the two other hospices within the Acorns group. This ensured that there was an on-call system for safeguarding twenty-four hours a day, seven days a week. At the time of our inspection all managers who acted as "first on call" were undertaking designated safeguarding officer training. This ensured that there was robust advice and support available twenty-four hours a day.

Managers monitored safeguarding training compliance and safeguarding incidents. Safeguarding training records and incidents were reviewed by the head of governance quality and engagement. Results were reported to the safeguarding steering group and care governance group. Safeguarding processes were also monitored through compliance visits from senior managers.

Staff could give examples of how to protect children, young people and their families from harassment and discrimination, including those with protected characteristics under the Equality Act. The service had an up to date chaperone policy. There was signage throughout the building to inform children, young people and their families that chaperones were available.

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 attended safeguarding meetings with the appropriate local authorities and local children's safeguarding boards. Staff received safeguarding supervision, which was either through individual or group supervision sessions. Group supervision was multidisciplinary to promote shared learning across professions. Managers and staff told us that supervision occurred as both planned and on an as required basis following any specific safeguarding incidents.

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.

Cleanliness, infection control and hygiene

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

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. At the time of our inspection all areas of the hospice we observed were visibly clean and tidy, including the grounds and the gardens. All areas were clutter free.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw that staff washed their hands and used appropriate PPE for clinical tasks. Hand hygiene audits were undertaken quarterly. We saw audits from October 2018 and September 2019 which demonstrated 100% compliance. Staff did not wear uniforms, but all staff were observed following the 'bare below the elbows' protocol. All staff wore name badges.

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

Hand washing facilities and sanitising dispensers were available throughout the hospice. Hand sanitising dispensers were available at the entrance and exits to all the clinical areas. Hand washing technique information posters were displayed, however, we did not see hand washing techniques posters displayed in all areas. We informed managers of this during our inspection and they took immediate action to ensure there were hand washing posters in all areas.

The service generally performed well for cleanliness. The service undertook an annual external infection control audit. Data provided for the latest audit, undertaken in December 2018, demonstrated 97.85% compliance. An action plan to address areas of non-compliance was implemented. For example, there was an action to ensure that all baths were visibly clean. During our inspection we saw all baths were visibly clean. Information received from the service demonstrated that clear action plans were in place, details of immediate actions taken and a timescale for review.

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

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We reviewed five weeks of cleaning schedules and saw they were split into daily, weekly and deep clean tasks. We saw all cleaning records were up to date and had been completed appropriately. We observed housekeeping staff thoroughly cleaning all areas. During our inspection we saw a bedroom being deep cleaned after a child had returned home.

Staff we spoke with were aware of their roles and responsibilities in relation to the control of substances hazardous to health regulations (COSHH). We saw that COSHH substances were stored in a secure cupboard away from communal areas. Cleaning cupboards were clean and tidy and mops and buckets were colour coded and separated. Clinical waste disposal systems were used which included sharps bins for the safe disposal of used needles and other equipment. Clinical waste and domestic waste bins were emptied by the cleaning staff on the ward area and disposed of through the provider's waste disposal procedures. Staff adhered to correct principle for managing and disposing of sharps. Sharps bins were correctly assembled and were not overfilled.

Processes were in place to monitor water for legionella on a quarterly basis. There had been no incidents of water contamination in the reporting period.

There were two cold rooms, referred to as 'special bedrooms'. These provided facilities for relatives such as comfortable seating and privacy. There were various 'cooling' items such as blankets, cots and a bed to keep the deceased cool. The air conditioning was also reduced to 12 degrees Celsius.

The service had up to date infection control policies and processes in place. Staff could access the policies through the intranet.

The service had an infection control lead who provided support and advice to staff. There was also a service level agreement for external infection control advice and support.

Environment and equipment

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

Children, young people and their families could reach call bells and staff responded quickly when called. We saw that staff responded quickly when called.

The design of the environment followed national guidance. Access to the service was through a set of wide double doors. Visitors to the hospice gained entry through a call bell system where staff would allow entry. All visitors to the hospice signed a visitor's book so that staff knew who was in the building and declined entry to anyone who was not allowed to visit. The reception desk was manned throughout the day by volunteers. Access to clinical areas was through an electronic swipe card access system.

All patient care was based on the ground floor over two corridors of five bedrooms each. One corridor was mainly used for adolescents the other was used for younger children. We saw that staff ensured that doors remained securely closed.

There was a large central hub area for activities, this included a large dining area with room for children and visitors. There were wipe clean chairs and tables, a large lounge area with a range of comfortable seating and a sensory room. There was a large well maintained and secure garden. This was accessible from all communal areas. There was an outside play area for children with a cushioned surface. Each bedroom had patio doors which opened onto a private patio area.

The service had enough suitable equipment to help staff safely care for children and young people. The service had a large equipment store. This was crowded but contained a lot of large pieces of equipment for example. hoists and wheelchairs. The service maintained a stock of wheelchairs, car seats, four-way glide sheets and specialist beds. Additionally, there was a large supply of nappies and personal care items. Medical consumables were stored in the store room. These were well organised, labelled and stored off the floor. We checked 10 items of medical consumables for example, syringes and swabs. These were all in date. Spare oxygen cylinders were stored in line with guidance.

Specialist equipment was available for all ages of children and young people. There were two ceiling mounted hoists for transfer of children in the lounge. Pillars within the lounge and kitchen were padded for safety. Bariatric equipment was available as necessary. Specialist beds and cots were available to meet the individual needs of children and young people.

Staff carried out daily safety checks of specialist equipment. We saw that equipment was checked and maintained. There were processes to ensure equipment was maintained and serviced. Equipment had undergone safety testing to ensure it was safe to use. All equipment we checked had been electronically tested and was in date. The service also employed a maintenance worker to ensure any immediate repairs were made and specialist servicing of equipment was arranged as necessary.

Resuscitation equipment, suitable for all ages, was available in the main hub area. We saw evidence this was checked daily. No emergency drugs were kept on the trolley but were available in the medication room. The resuscitation trolley was covered with a child friendly cover so that it was not intrusive to the environment.

The service maintained up to date risk assessments. This included risk assessments of all clinical areas, the use of bedrails and client and sibling outings. We saw risk assessments of plug sockets had been undertaken to reduce the risk of injury to young children. During our inspection we identified a ligature risk in one of the family rooms. We raised this with managers who took immediate action to address this. We saw that risk assessments had been undertaken of ligature risks and an action plan was in place. Managers had purchased new pull cords and all pull cords that had been identified as a ligature risk was to be replaced in January 2020. Regular health and safety meetings took place where risks were discussed.

Private access for ambulances was available to enable dignified removal of deceased children and young people from the hospice.

Staff disposed of clinical waste safely. Clinical waste disposal arrangements were in place throughout the hospice. People could access bins clearly labelled, for example, clinical waste only or domestic waste only. Bins were lidded and operated with a foot-pedal in clinical areas and toilets, to prevent hand contamination.

A fire evacuation procedure was in place and a printed copy of this was available next to the fire panel. Hi-visibility jackets and walkie-talkies for staff to use during an emergency were also stored. A log of all incidents in relation to the fire alarm being activated was kept.

Assessing and responding to patient risk

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

Staff completed risk assessments for each child and young person on admission or arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed seven 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 buccal medicines, for example for treating seizures. (Buccal administration involves placing a medicine between the gums and cheek, where it dissolves and is absorbed into the bloodstream).

Staff knew about and dealt with any specific risk issues. For example, staff understood each child and young person's vulnerability to infection and acted to protect them from the spread of infection. We saw staff were diligent about washing their hands prior to undertaking any procedures and when delivering care. Physiotherapists and occupational therapists undertook full functional assessments of children and young people admitted to the hospice to assess what aids and adaptations to equipment were needed for each child or young person.

Staff did not routinely use a nationally recognised tool to identify children or young people at risk of deterioration. Staff told us that they did not use charts but would contact the GP if a child was deteriorating. Managers told us that the service did not require staff to take baseline observations for children and young people on admission for respite care or end of life care. This was because trends of observations could vary depending on factors such as the time of day, anxiety or pain. Staff would however take baseline observations to support care plan information when a parent or clinician specified a known deviation for example, if a cardiac patient required oxygen saturation recordings to support the identification of future deterioration in their condition, Routine observations were only recorded if a child or young person required ventilation and the observation chart was completed as part of their care plan requirements. In the event of a medical emergency staff would call an ambulance.

Following our inspection, we requested risk assessments for managing a deteriorating child or young person. Managers told us they had implemented the use of age appropriate paediatric early warning score (PEWS) charts and the sepsis six forms. The PEWS Identifies paediatric patients at risk of clinical deterioration. The sepsis six is the name given to a bundle of medical therapies designed to reduce mortality in patients with sepsis. Policies, guidelines and training had been updated.

Managers told us they were working with the sepsis trust to develop an assessment tool that was more appropriate for children with palliative care needs as this does not currently exist. Managers wanted to avoid unnecessary visits to hospital for children, because children and young people who required complex care generally deviated from standard age-specific paediatric or adult observation values as supported by the PEWS and the national early warning score (NEWS2). What is ‘normal’ for these children often triggered concern on PEWS tools.

Acorns were working within the NICE Guidelines 2017 criteria indicating high risk of severe illness or death from sepsis and Nice Guidelines 2019 and 2020 for managing fever fives and sepsis overview. The clinical educator was to attend a sepsis train the trainer course in January 2020.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff liaised with the multidisciplinary team to access additional support for children and young people requiring mental health support. Escalation processes were in place to ensure that emergency referrals were made to access mental health services. For any mental health crisis in the community staff would liaise with other health professionals, contact the emergency GP or emergency ambulance service.

Staff completed, or arranged, psychosocial assessments and risk assessments for children or young people thought to be at risk of self-harm or suicide. If the crisis was stabilised and there was hospice capacity, an emergency stay at the hospice supported by family or friends could be arranged if assessed as safe and appropriate.

Shift changes and handovers included all necessary key information to keep children and young people safe. There were planned handovers from the nurse in charge to the next shift. In addition to child summaries staff maintained a handover folder to ensure that other key information was handed over. This included information about, for example, visitors, safeguarding issues, health and safety, planned activities and any medical or health alerts.

Staff shared key information to keep children, young people and their families safe when handing over their care to others. Staff liaised with other members of the multidisciplinary team to share information. Staff held weekly panel meetings which included case discussions, reviews of new referrals, end of life care, sibling updates and respite care updates. Staff also attended meetings with external agencies to ensure collaborative working and the sharing of information to provide safe and appropriate care.

Nurse staffing

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

The service had enough nursing and support staff to keep children and young people safe.

Managers monitored and assessed staffing numbers and skill mix. This was measured against a child or young person's dependency and the numbers of children and young people requiring care.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The managers could adjust staffing levels daily according to the needs of children and young people.

Staffing levels were monitored at planning meetings and on a shift by shift basis. Managers ensured there was a minimum of two registered nurses on each shift. Managers told us this was often exceeded and was increased when there were children requiring end of life or a higher level of care, for example, caring for a child or young person who had a tracheostomy (a breathing tube inserted into their windpipe through an opening in their neck) or who required artificial ventilation. We reviewed staffing records and saw there was an appropriate skill mix of staff. In addition, managers ensured duty rotas were flexible to ensure staff were able to respond to the needs of children and their families, for example, to accommodate emergency short breaks or end of life care. Staff told us there was a good skill mix and sufficient staff with additional competencies for example ventilation and tracheostomy care competencies.

The service had an established "on call" system if staff were required out of normal working hours. This included offering clinical support and advice. There was a "first on-call" manager supported by a clinical on-call nurse for clinical advice and a family team worker to ensure families were supported out of hours. There was also a non-medical prescriber (NMP) at the hospice available out of hours.

Service demand was reviewed daily and at weekly multidisciplinary panel meetings to ensure that care was safe and responsive. The hospice trust issued guidance for safe staffing in July 2018 where immediate action was to be taken if there were insufficient staff and skill mix on duty.

The number of nurses and healthcare assistants on all shifts matched the planned numbers. Actual staffing was compared and matched to planned staffing by the senior clinical staff. Unmet need was considered and reported monthly. Cover was provided for staff absence by a combination of flexible working, bank staffing and overtime. Where necessary the workload (number of children) was adjusted to ensure safe care. Families told us that they had sometimes had their day care cancelled due to staffing shortages, for example if a nurse with specific competencies, for example, tracheostomy care not available. There were sufficient family team staff to visit families in their homes, in the event of sickness or absence they provided cover within the team. There were currently no community nursing staff in post and this service was not being offered at the time of our inspection. The service was actively recruiting for the community nursing team.

Following our inspection, we requested data about cancelled day care sessions. Managers told us that the reasons recorded included staffing capacity, emergency bookings for end of life or a social care emergency.

There were two registered nurses on duty each shift, one of whom was a registered children's nurse. A picture board was on display in the central area of all nursing, kitchen, maintenance and cleaning staff on duty that day.

The service had low vacancy rates. At the time of our inspection there was one nurse/physiotherapy vacancy, two health care assistant vacancies and one non-qualified staff vacancy. Managers were proactively managing the vacancies and the impact on the delivery of safe care was monitored. However, due to financial pressures there had been redundancies within the previous year which had resulted in the loss of an adolescent worker, a transition worker and a volunteer co-ordinator. Other team members were incorporating some of these roles within their posts. Managers reported that one staff nurse post was not currently being recruited to. There was also a reduction of catering staff hours. This equated to 22 hours. Workforce issues were recorded as a risk on the risk register with clearly identified mitigations and review processes in place.

The service had low turnover rates.

From July 2019 to September 2019 the service had sickness across all teams this included .50% sickness for managers, 5.60% for nursing and physiotherapy staff, .80% within the family team, 1.5% for health care assistants and 3.00% for other non-qualified staff.

The service used bank staff but had not used any agency staff from October 2018 to September 2019. Numbers of bank staff used were not provided.

Managers limited their use of bank and agency staff and requested staff who were familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service. All bank staff had a full recruitment screening, references and data barring service (DBS) check and were given induction training. In addition, they worked a minimum of two supernumerary shifts to support them developing into the role. Bank nurses were not left "in charge" of a shift.

Medical staffing

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

The service had access to enough medical staff to keep children and young people safe. GPs provided support for the hospice, a service level agreement was in place with local GP practices to support this. A general practitioner visited the hospice on a daily basis to review children and young people. Additional palliative care and end of life training was provided for GPs from the palliative care consultants who were based at a local acute NHS trust.

The service did not currently have a consultant paediatrician. The post had been vacant since May 2019. The post had been advertised but not filled and was to be re-advertised. However, the service had a service level agreement in place with two palliative care consultants from a local children's NHS hospital for further advice and support about the specialist care and treatment of children and young people. The medical director vacancy was not recorded on the risk register. This meant that we were not assured that there was medical oversight at executive level. There had not been any incidents recorded as a result of this and consultant level arrangements were in place for palliative care and end of life cover to ensure that all children and young people received safe care and treatment twenty-four hours a day, seven days a week.

Records

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

Children and young people's notes were comprehensive, and all staff could access them easily. The service used an electronic patient record system, with templates designed specifically for the hospice. These included a range of risk assessments as well as individualised care plans. Some paper records were also used. These included emergency contact details and any patient alerts for example allergy status or any safeguarding issues.

Paper care plans were maintained and were kept in the children and young people's rooms. All records, both electronic and paper contained a photograph of the child or young person, this provided an additional form of identification. We reviewed seven sets of patient records and found them to be comprehensive and contemporaneous. They contained details of children and young people's emotional, social and spiritual needs, alongside their physical health needs. Children and young people's mental health, any learning disability and behavioural needs were evident, where appropriate. However, we saw that a staff signature was missing in two of the records we reviewed. We raised this with managers during our inspection. They took immediate action to investigate and review these records.

Patient records included advanced care plans and DNA/CPR documentation, where appropriate. The DNA/CPR forms we reviewed were completed in line with national guidance (Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, Decisions relating to cardiopulmonary resuscitation: 3rd edition (2016)). They included whether the patient had capacity to make a decision and a summary of communications with the patient and family.

Managers audited the standard of patient records against best practice and identified areas for improvement, where indicated. The care plan audit, completed in October 2019, demonstrated an overall compliance of 88.5% which was below the service target of 100%. An area of non-compliance, included staff failing to sign and date children and young people's photographs, this was a new requirement and was not yet fully embedded in practice. A further area of non-compliance included some pages with omissions of names and dates. An action plan was in place and was to be reviewed in January 2020.

An audit of electronic records was undertaken between July and September 2019. Managers considered six fields for this audit:

- Was the NHS number recorded?
- Was the date of birth recorded?
- Was the next of kin completed?
- Were activity entries completed?
- How many (%) families had activity recorded?
- How many entries were added retrospectively?

Compliance ranged between 93% and 100% in all areas. Recommendations and an action plan were in place to address issues of lower compliance.

When children and young people transferred to a new team, there were no delays in staff accessing their records. The electronic record was an internal system and was not shared with other agencies. However, staff communicated clearly with other members of the multidisciplinary teams. Letters and reports from other teams were stored in the paper files before being scanned onto the electronic record.

Staff who cared for children and young people in the community had laptops. This meant they could update patient records at each visit. Access was password protected which increased security.

Records were stored securely. Paper records were stored in locked filing cabinets. All staff had secure password access to electronic records and we saw that computer screens were closed when staff were not using them.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The hospice commissioned pharmaceutical products and clinical pharmacy services from an external provider through a service level agreement. Arrangements were in place with two local pharmacies for pharmacy support. Specialist advice was also available from the local clinical commissioning group (CCG), who also supported the development of medicines audits and visited the service on an annual basis. Stock control was managed by nursing staff. Staff could access out of hours pharmacy support from a local NHS hospital when needed. There were also two non-medical prescriber (NMP) at the hospice with out of hours availability. Non- medical prescribers were nurses with additional competencies who could prescribe a range of medicines to children and young people so that they received appropriate medicines and pain relief in a timely manner.

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and their families about their medicines.

Staff stored and managed medicines and prescribing documents in line with the hospice policy. Medicines were stored securely. Controlled drugs were checked, and short dated stock was disposed of safely. Checks were in place to ensure emergency medicines were available and safe for use. Controlled drugs (medicines subject to additional security measures) were stored securely within wall mounted cupboards. Two members of staff were required to check the physical stock against the stock level recorded in the controlled drugs register daily. We reviewed the controlled drug register and saw stock was reconciled daily. Controlled drugs brought in by children and young people were stored securely and there were adequate controls to prevent misuse. Children's and young people's own controlled drugs were recorded in a separate controlled drug register on admission and were reconciled daily and every time they were administered.

Managers had audited the storage of controlled drugs from June to September 2019. This was a planned observational audit and was the first audit undertaken in this format. Compliance was recorded at 83% against a target of 100%. Areas for improvement were identified including governance and prescribing. An action plan was in place to include feedback on prescribing through a GP non-medical prescriber group and annual audit. Arrangements were to be put in place to benchmark against other children's hospices. This was planned to be in place by April 2020

Medicines that needed to be kept below a certain temperature to maintain their efficacy were stored in a locked fridge. The treatment room where medicines were stored was air-conditioned. This meant the temperature was maintained within the recommended range (below 25°C). We saw storage temperatures were checked daily to ensure medicines were effective and safe for patient use. Temperatures recorded for all days seen were within the recommended range. Staff we spoke with knew what action to take if temperatures were out of the recommended range. Processes were in place to ensure that daily fridge and room temperatures were checked. We saw that all checks had been fully completed. Staff had recently started to record room temperatures following recommendations from the CCG pharmacist. This was being audited through the audit plan.

Blank prescription pads (FP10 prescriptions) were stored securely in keypad safes and monitoring systems were in place to ensure all prescriptions were accounted for. The audit record for June 2019 identified 100% compliance with safe prescribing practice, correct completion of FP10s and communication with key members of the multidisciplinary team and families. This was in line with national guidance (Department of Health, Security of prescription form guidance (August 2013)).

Staff followed current national practice to check children and young people had the correct medicines. During our last inspection in April 2016, we saw that although staff had received training to support children and young people in receiving their medicines not all staff were following Nursing and Midwifery Council [NMC] guidance on standards for medicines management which increased the risk that the child or young person may be given their medicines differently from how the prescriber intended. During this inspection we saw that all children and young people were receiving their medicines correctly.

The service had developed a system to record medical alerts and recorded any actions taken. Staff knew how to report medicine errors or incidents and we saw these were investigated and learning was shared with all relevant staff. Managers audited medicines management against best practice and identified areas for improvement, where indicated. There had been 26 medication incidents reported from December 2018 to November 2019. Of the recorded incidents, 10 were a result of an error by a staff member, none had a significant impact on a child. All incidents were reviewed and responded to in accordance with policy.

Following our inspection, we requested details of medicine incidents and review of the investigations for this service. Themes included administration, transcribing and supply/labelling of medicines. Information supplied by managers demonstrated that actions were taken immediately. Families were informed of any incident; individual staff were spoken to and training was implemented.

We reviewed four prescription charts. We saw that these were fully completed, each prescription chart contained a photograph of the child or young person. Weights and allergies were clearly documented, this meant that medicine doses could be accurately calculated according to patient weight and staff were aware of any allergies.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely. Nursing staff double checked medicines for children and young people before administration. Following a compliance visit from senior managers a memo was sent to staff as differing medicine checking practices were identified across the three hospices. Research has shown that single checking is more effective. However, some medications, for example, controlled medicines, required double checking. Managers identified that staff would continue the practice of double checking where felt necessary. All medicines policies were up to date. Staff told us that they were informed of safety alerts at staff handover and team meetings.

Decision making processes were in place to ensure children and young people's behaviour was not controlled by excessive and inappropriate use of medicines. Some children and young people required continuous medication administration through a syringe driver to control their symptoms. Staff were knowledgeable about syringe drivers and the medicines used. All staff were required to undertake specific competency training for managing syringe drivers. We saw thorough assessment practices were in place.

The director of care was the named individual for medicine management and the accountable officer for controlled medicines. The named individual was aware of the responsibilities of the role and had been in post for over 10 years. The named individual was supported by a team of accountable individuals. All post holders had the appropriate qualifications for the role.

During our last inspection in April 2016 we saw that, in the event of an anaphylactic reaction (severe allergic reaction), there was no emergency treatment pack available. Staff told us children and young people usually brought in their own emergency medicine if needed. However, there was no risk assessment available to show the risk of not having a treatment pack available. During this inspection we saw that the service had an emergency treatment pack available.

The service had two nurse independent non-medical prescribers who supported and monitored medicines management. Nurse independent prescribers known as (non- medical prescriber) (NMP), may prescribe any licensed medicine within their sphere of competence and observe any legislative restrictions, including those governing controlled drugs (CDs). This meant that children and young people were prescribed medicines and pain relief in a timely manner. A further staff member was due to undertake the prescribing course at a local university. This role was being developed to strengthen the medicines management advice available out of hours. Prescribers had access to evidence based and up to date resources to ensure safe prescribing. Additionally, support was available from the consultant paediatrician at the local NHS trust and nurse prescribers across the three hospices. Independent prescribers told us that they felt adequately supported and could access further advice if necessary from their prescribing colleagues or the consultant. Practice was audited four times a year. Data available for June 2019 identified that not all prescriptions included an NHS number or duration of the course of medicine, however all of the medicines were reported to be ongoing prescriptions but no examples were given. There were no recommendations and learning, therefore we were not assured that the audit process was robust. In addition, a CQC controlled drug self-assessment audit in October 2019 identified that prescribers would only receive feedback on their prescribing if there was an incident.

Staff dispensing medicines undertook competencies in medicines management which included the safe administration of medicines, the use of nebulisers and the use of syringe drivers. Assessment processes were robust. Staff were assessed using a taxonomy which demonstrated their increasing competence and knowledge.

Incidents

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

Staff knew what incidents to report and how to report them. The hospice used a paper reporting system for reporting incidents. All grades of staff could report incidents using the paper system. Staff we spoke with said they were encouraged to report incidents and felt confident to do so.

Incidents were collated by the registered manager. Monthly summaries were shared with all staff. Senior managers were discussing the introduction of an incident database but no date had been set to introduce this. This system would support the monitoring and analysis of trends of incidents.

During our last inspection in April 2016, we saw staff reported medicine incidents using a specific form and incidents were discussed at monthly meetings. However, no record was kept of investigations, discussions or action plans. This meant that there was no evidence of learning from the incident and we could not be assured that the risk of the incident happening again was reduced. During this inspection we saw the service had systems and processes to report incidents and concerns and to analyse and report any trends. Actions taken, and responses made, were shared with staff and trustees.

Staff raised concerns and reported incidents and near misses in line with the provider policy. Staff mostly received feedback from investigation of incidents. Staff told us that they were informed if they were involved in an incident, but some staff said they did not always receive feedback.

Feedback from incidents was shared with staff in a variety of ways such as team meetings, email, newsletters and staff noticeboards. Incidents were a standing agenda item at monthly governance meetings, minutes of meetings we reviewed confirmed this. Staff met to discuss the feedback and look at improvements to children and young people's care. There was evidence changes had been made as a result of feedback. Staff provided examples of actions taken to improve services to children, young people and their families.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations. All staff who investigated incidents had received incident investigation training. Managers had introduced a significant event analysis tool to support the learning from incidents and identify trends and themes.

The service reported 12 incidents in July 2019. Additional information provided following our inspection for October and November 2019 identified that 31 incidents were reported at the hospice. No significant adverse events or themes were reported. Incidents were reported across all three hospices and included documentation, clinical practice issues, medication issues, safeguarding and equipment failure or absence of equipment. A monthly incident summary was produced. However, although numbers of incidents were identified for each hospice the information provided did not indicate themes of incidents specific to Acorns hospice of the Three Counties. This meant that we were not reassured that staff and managers were aware of the themes of incidents that related to their service and how the service compared with the other hospices in the trust. Following our inspection, we requested specific data of incidents and evidence of investigations and learning. Evidence of investigations of incidents was not provided. However, examples of good medicines management practice were highlighted, errors identified and themes and reminders relating to incidents that had occurred at the hospices were shared with staff in a monthly newsletter. Managers reported that although there had not been any significant incidents during the reporting period they had introduced significant event analysis system. This system was aimed at considering significant and serious concerns more robustly. Influencing factors including people's behaviours, process and system issues, communication, education and organisational factors were considered. It was anticipated that transparency and rigor would be improved and the risk of developing a blame culture would be reduced.

Never Events

The service had no never events. From August 2018 to September 2019 the service had reported zero never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From August 2018 to September 2019 the service had reported zero serious incidents. Managers debriefed and supported staff after any serious incident. While the service had not had any serious incidents occur during the reporting period, staff confirmed that managers supported them when they were involved in incidents.

Managers took action in response to patient safety alerts within the deadline and monitored changes. There were systems and processes in place to manage patient safety alerts. Staff were informed through team meetings, emails and newsletters. There was also a folder kept with details of safety alerts.

Staff understood the duty of candour and could explain it clearly. They were open and transparent and gave children and young people and their families a full explanation when things went wrong. The hospice had a duty of candour policy which staff could access through the trust intranet. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A notifiable safety incident includes any incident that could result in, or appears to have resulted in, the death of the person using the service or severe, moderate or prolonged psychological harm. Staff we spoke with were aware of the importance of being open and honest with children and young people and their families when something went wrong, and of the need to offer an appropriate remedy or support to put matters right and explain the effects of what had happened.

Are hospice services for children effective?

(for example, treatment is effective)

Good ●

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 high quality care according to best practice and national guidance. This was evident from our observations of care, review of patient records and hospice guidelines, and discussions with staff. Policies and procedures were readily available for all staff on the intranet and could be accessed easily. Policies appropriately referenced current good practice and national guidelines from organisations such as the National Institute for Health and Care Excellence (NICE) and Royal Colleges. All policies were in date and version controlled so that staff were assured that they were using the most up to date version. The documents contained flow charts and contact details of relevant agencies, as well as clear guidance for staff. The director of care was responsible for ensuring the NICE policies and procedures were kept up to date and in line with national guidance.

The service had an annual audit schedule in place that included records, controlled medicines use and infection prevention control. The audit schedule was updated to implement follow up audits where needed or for new audits which were implemented when a new process was introduced. For example, managers had identified through the audit process that not all staff were aware of the difference between management supervision and clinical supervision. A more robust framework had been implemented to address this.

Audit results were shared with staff by email and at team meetings. All on-going work, recommendations from the audits and updates were incorporated into any action plans and monitored by the clinical governance committee.

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

When adolescents were transferring to adult care services they were fully involved in the process. Staff worked collaboratively with all agencies to support the transition for adolescents and their families. Staff gave examples of how this was managed.

Children's mental health, physical and social needs were holistically assessed. Support was delivered in accordance with legislation, standards and evidence-based guidance, including NICE and other expert professional bodies.

Hospice services for children

When children or young people were accepted to the service the child and family's holistic needs were assessed to ensure services were tailored to meet their individual needs. If it was identified the child needed clinical care provided either in the inpatient unit or through the outreach service. A care plan was always completed with the family prior to care being delivered. This was reviewed before any period of care and fully re-written either on an annual basis or following any significant changes in condition. We saw assessments and care plans were updated.

Health passports for children and young people were also used by the service. Health passports are designed for the parents or care givers to have the opportunity to advise the health professionals about their child or young person so their care experience is a positive one, as far as is possible. The health passport aims to give staff extra information about the child or young person without the parents and or care givers having to regularly repeat everything about the child or young person in different care settings. Each child and young person had a health passport in place.

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

Nutrition and hydration

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

Staff made sure 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 and religion were identified, monitored and met. A cultural, religious and spiritual assessment was completed on the child or young person’s care plan. Dietary preferences were given to the catering team so that they could make arrangements in advance of a child, young person or their families stay at the hospice. This included consideration of cultural or dietary preferences for example likes and dislikes, halal, kosher, African Caribbean or vegan diets. Food was available 24 hours a day for children, young people and their families to support individual needs and cultural practices for example Ramadan. There was access to chilled tap water, snacks and fresh fruit.

Consideration was given to the child’s age and physical ability to provide appropriate foods. Children and young people were assisted at meal times as necessary. Meals were cooked freshly by trained staff to provide fresh nutritious food. We saw food was well presented and age appropriate.

Allergies were recorded in the child or young person’s care plan and communicated to the kitchen staff by the clinical lead or nurse in charge and added to the daily menu request. There was a list of allergens displayed at mealtimes which enabled staff, family members and visitors to avoid foods if indicated. We saw menus were displayed a week in advance. The service had a good hygiene rating of five for the kitchen, this was the highest level of achievement. The rating was awarded in April 2018 and the certificate was clearly displayed.

Each child had a detailed care plan with specific details on dietary, feeding and hydration regimes which was updated at every admission to the hospice. We saw all aspects associated with dietary requirements were covered. For example, how the child and young person was fed, how often and their preferred mealtimes.

Care plans included enteral feeding routines. Enteral tube feeding (ETF) is the intake of food via the gastrointestinal (GI) tract. This means nutrition normally taken through the mouth, is instead taken through a tube that goes directly to the stomach or small intestine. Enteral tube feeding is used to feed patients who cannot achieve an adequate oral intake from food and or oral nutritional supplements, or who cannot eat or drink safely. The aim is to improve nutritional intake and so improve or maintain the patient’s nutritional status. All nursing and care support staff were competent to give enteral feeds. Competency records confirmed this.

Staff fully and accurately completed children and young people’s fluid and nutrition charts where needed. We saw fluid and nutrition charts were completed and clearly identified whether the child required a special diet or regime, for example a blended diet. Consent was clearly documented.

Staff used a nationally recognised screening tool to monitor children and young people at risk of malnutrition. We saw that risk assessments were completed. Policies and associated risk assessments were up to date and available on the intranet.

Specialist support from staff such as dieticians and speech and language therapists was available for children and young people who needed it. When a child or young person required a specialist diet this was clearly written in the care plan alongside the dietary advice from the child or young person's dietician. We saw that food supplements were recorded on the medicines' administration record. Staff liaised closely with dieticians and speech and language therapists. The service also had a special interest group on enteral feeding which met every three months.

Pain relief

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

Staff assessed children and young people's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Children and young people's pain was assessed and managed using recognised pain assessment tools. We saw pain levels were regularly assessed using a faces pain score. Other recognised tools were used to help identify distress cues in children and young people who because of age, cognitive impairment, or physical illness, had limited communication. For example, the neonatal infant pains scale (NIPS) was used to monitor pain in neonates.

Staff assessed children and young people's ability to tolerate oral medicines and alternative administration routes would be prescribed when indicated, such as subcutaneous infusion or pain relief patches.

Assessment charts were completed to monitor pain levels and respond accordingly according to the care plan. The effectiveness of regular analgesia was assessed twice daily.

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

Children and young people received pain relief soon after requesting it. We saw nursing staff prioritised and responded promptly to requests for pain relief. Children and young people had been prescribed pain relief medication as and when required (PRN) so that breakthrough pain could be managed. Breakthrough pain can occur in between regular, planned pain relief. Staff confirmed syringe pumps were accessible if a patient was receiving end of life care and required subcutaneous medication for pain relief.

Staff prescribed, administered and recorded pain relief accurately. The service had processes in place to ensure the accurate prescription, administration and recording of pain relief. Nursing staff double checked medicines and controlled drugs to ensure safe and accurate administration. The service had two nurse prescribers who could prescribe a wide range of medicines to ensure that children and young people received pain relief promptly.

In addition to the provision of pain relief moving and handling assessments were reviewed on each visit and completed annually. Specific training was provided for staff for individual children with specific needs to ensure appropriate techniques were used to minimise pain and discomfort during moving and handling procedures.

Regular audits were undertaken to monitor the frequency and effectiveness of pain assessment. Managers had identified there was a need to improve and record compliance for pain assessment. Pain assessment audits were planned to be undertaken twice during the 2019/2020 audit schedule. Following our inspection, we requested data and any action plans following the pain management audit. Audit data supplied for June 2019 identified there had been an improvement in the number of pain assessments completed once per shift since the previous audit in October 2018. However, only four out of 10 children had had their pain assessed once per shift for the full duration of their stay. Recommendations and learning identified from the audit included:

- reminding staff of the importance of undertaking pain assessments
- reminding staff to complete all documentation
- to continue attending at twice yearly pain meetings with the pain leads
- to organise in house pain meetings with members of the pain group

The service participated in a cross organisational pain group which aimed to ensure consistency across all hospice sites. Children, young people and their families were advised when they needed to seek further help or if their condition deteriorated.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people. The service had been accredited under relevant clinical accreditation schemes.

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. The service participated in clinical audits. The hospice had an annual audit plan which included national audits for Hospice UK such as care of the deceased, and local audits. Data supplied for the 2018/2019 audit programme identified that only 66 of the planned 78 audits, 85% were completed. Of the 13 audits not completed, five were to be included in the 2019/2020 audit programme. These included complimentary therapies, special bedroom and the family service audits. Some audits were reported to have been superseded, however, no examples were provided. Other deviations from the audit plan were reported to be due to operational issues, workload and staffing issues. Of the audits completed the external infection control audit undertaken in October 2019 demonstrated 100% compliance in the new build kitchen, but only 80% compliance in the main kitchen. An action plan was in place with a timescale for completion and lead person identified. Overall external infection control audit results provided for September to December 2018 demonstrated compliance of 97.85%. This included hand hygiene, the general environment and clinical areas. Areas of good practice and areas for improvement were identified with time scales for improvement.

From 2018 to 2019 the hospice was ineligible to participate in the national clinical audit. This was because there were no audits or enquiries relating specifically to specialist palliative care in 2018 to 2019. This was reported in the services quality accounts for 2018 to 2019.

Managers and staff carried out a comprehensive 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 implement follow up audits where needed or to review new processes. Managers used information from the audits to improve care and treatment. Improvement was checked and monitored. Action plans were in place and were monitored through clinical governance meetings. For example, managers planned to repeat all the clinical audits including tissue viability, pain, moving and handling, safe use of oxygen infection control and medication in the 2019/2020 audit plan. This was to include the review of the documentation of actions taken in each of these areas. Medication audits were to be undertaken every quarter with a different focus for each audit for example prescribing, transcribing, administration and controlled drugs.

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

Managers used patient and relatives feedback tools to measure patient outcomes. Managers and staff used the results to improve children and young people's outcomes. Quality and outcome information showed the needs of children and young people who used the service were mostly being met. Feedback was sought on a range of quality indicators and the findings were used to make improvements where indicated. For example, from June to September 2019, feedback from the family feedback survey showed that 90% of respondents of 104 responses, would recommend Acorns services to another family. Themes included the benefits of sharing their experiences and being able to talk with others about them. Areas for improvement included ensuring that the heating was maintained at a good temperature, including more sports and games at the sibling groups, increasing the age limit for some groups, and more respite nights were available each year. No reason was provided for those who would not recommend the service. Child feedback identified that in 100% of responses children felt that they could talk to staff and felt listened to. However, in two responses they stated that they were unsure if their pain control had been fully met. The service was undertaking additional pain audits to ensure these issues were addressed. Of the sibling feedback 100% of siblings would recommend the services to others. Managers were undertaking work to improve the uptake of responses to the survey and further analyse themes from the feedback so that issues were addressed.

Outcomes for children and young people were positive, consistent and met expectations, such as national standards. All children and young people had an individualised care plan in place, that set out their advance care preferences. It covered activities of daily living, family and carer support, infection control, mental capacity, tissue viability, advance care planning and symptom management. There was provision for recording preferred place of care and death within records. The records were regularly reviewed and audited. Care plan audits supplied for August and October 2019 demonstrated 100% compliance. An audit of electronic records from July to September 2019 demonstrated an improvement in compliance in all areas such as recording of emergency contact numbers, next of kin, and recorded activities with families. Compliance was 93% to 100% compared to 92% to 99% from April to June 2019.

The service had a Commissioning for Quality and Innovation (CQUIN) in place for improving the experiences of children, young people and their families referred for end of life care. A CQUIN is a system to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care. Children and young people were referred to the hospice from a broad geographical area. This meant that hospital specialists, community nursing teams and specialist centres provided varying levels of information when referring a child for end of life care and families. This meant that families were not always as prepared as they could be to ensure the best outcomes for their child’s experience at end of life. This affected the timeliness and effectiveness of referrals and transfers. Staff told us that not all children and young people were referred to the hospice early enough to ensure they had access to the facilities in a timely manner. The CQUIN aimed to ensure that the hospice processes were improved to support the effective transfer of children and young people undergoing end of life care referrals. Actions were identified to improve processes such as increasing engagement and information sharing about referral processes and the facilities available with professionals in all areas, and report on progress to commissioners. Timeframes were identified for meeting these targets and achieving four key outcomes which were:

- Evidence of an advanced care plan including discussions with the family
- A treatment plan containing symptom management and an up to date prescription
- Feedback from families.
- Feedback from staff

A report was to be provided about the number of children who had been referred to the hospice and received end of life care four times a year. The final report was due by the end of March 2020. Initial data indicated that 85% of referrals had achieved positive outcomes for the four key areas. No information was provided about any delays to admissions due to late referrals.

The service was registered with UNICEF (United Nations International Children's Emergency Fund) and were working towards achieving a Rights Respecting Award (Rights of the Child) bronze award. The service had also achieved a diversity award for the last five years due to their work in supporting equality and inclusion for all. The service was the winner of both the Downtown Business

Social Media Presence of the year 2018 and the Great Birmingham Chamber of Commerce; Excellence in Contributing to the Community 2018. Additionally, the service was a finalist for the Birmingham Post Business Awards 2018 best not for profit organisation of the year.

Competent staff

The service made sure staff were competent for their roles. Managers held supervision meetings with staff to provide support but did not always appraise staff's work performance to support their development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families. A registered children's nurse was always on duty along with registered nurses with end of life and palliative care experience. We reviewed five staff files and found they contained relevant information to demonstrate staff suitability and competence for their roles, such as up-to-date Disclosure and Barring Service (DBS) check, references, full employment history, evidence of qualifications and professional registration, where applicable. Managers checked qualified staff had professional registration and we saw 100% of eligible staff had completed revalidation with their professional body. Managers also recruited, trained and supported volunteers to support children, young people and their families in the service. Volunteers were supported by the volunteer manager.

The clinical educators supported the learning and development needs of staff. Clinical educators worked with staff individually and in groups to support and develop practice. During our inspection in April 2016 we saw that the service did not have a framework in place for checking nurse's competency. This meant that the management team could not demonstrate how they knew their nurses could look after children and young people's health, care and medicines management safely. During this inspection we saw the service had a robust competency framework.

Competencies had been developed by the clinical educators. Registered nurses and health care assistants (HCAs) were competent to provide personal and basic nursing care. There were formal competencies which registered nurses and HCA's worked towards for more complex children. We saw competencies had been developed to cover a broad range of clinical areas including enteral feeding through a gastrostomy tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach), medicines management including the use of nebulisers, oral suction, tracheostomy care and non-invasive ventilation). Learning materials had also been developed to support the competencies.

Competencies were assessed by the clinical educators and there was a robust assessment taxonomy to ensure that all staff met the desired level of competency for their role. Evidence based training packs had been developed to support the competencies which were supported by evidence-based policies, learning from incidents and adverse events and risk assessments. The service had developed a learning management system to improve the reporting and monitoring of staff training and competency.

New staff attended a corporate induction day to gain a holistic overview of the charity. Managers provided all new staff with a full local induction tailored to their role before they started work. All new care staff had an induction programme planned around their needs and were allocated a mentor. This included any relevant clinical competencies that were undertaken. Registered nurses received ongoing peer review and health care assistants were delegated duties according to their experience and competence. Assessment of skills and competencies included any clinical skills to be developed and familiarisation with appropriate equipment. Staff told us they had found the induction programme useful. Volunteers also attended induction and received bespoke training dependent on their role. This also included familiarisation on any equipment to be used.

Managers supported staff to develop through regular, constructive clinical supervision of their work. Staff received regular supervision from team managers plus opportunities for formal clinical supervision and support as required. Clinical supervision is a formal process of professional support and learning that addresses practitioners' developmental needs in a non-judgemental way. Its aim is to help them increase both their competence and confidence through exchanges with experienced professionals and the use of reflective skills. Staff were offered regular debriefs (group or one to one) following incidents, safeguarding concerns and deaths.

Staff told us that they received fortnightly clinical supervision with their managers. Peer supervision sessions also took place during team meetings and to review individual cases. Management supervision was also available and provided developmental guidance and development. Staff receiving managerial supervision told us that they found this helpful. Staff also had open access to staff support counsellors both face to face and over the telephone, and regular safeguarding supervision.

Appraisal rates

Managers supported staff to develop through constructive appraisals of their work. However, not all staff had received an annual appraisal giving them the opportunity to explore aims, objectives and development opportunities for the coming year. From August 2018 to September 2019 appraisal rates for staff were low and there was no identifiable target provided. Appraisal rates provided by the service for this period indicated that only 10% of non qualified staff, 20% of health care assistants, 42% of nurses and physiotherapists, 50% of the family support team and 60% of managers had received an appraisal.

During our inspection managers told us that there had been a lack of oversight of appraisals and independent personal reviews due to a lack of managerial time within clinical teams. Managers told us that this had been due to sickness within the senior management team. Senior managers reported that this was now being rectified and because of professional revalidation requirements the appraisal programme was being developed. Appraisal/IPR compliance was also being measured as a key performance indicator (KPI). We requested data from managers following our inspection to review compliance. Data provided indicated that work had been undertaken to ensure that staff had had an appraisal. We saw that staff appraisals had been completed or were planned for all staff groups for those who were eligible. An action plan was in place to ensure the completion of all outstanding appraisals with dates for completion. All staff were accounted for. There were four members of staff who were unavailable due to long term leave. Staff told us they found the appraisal process helpful.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Training needs and development opportunities were identified during the appraisal process, however not all staff had received an appraisal. Staff received mandatory training and have access to wide range of further training and education opportunities. This included access to academic courses where indicated.

The service was part of a regional education group. Regional education group sessions occurred four times a year. Within this group, examples from practice were used to enhance learning. If a staff member wanted to undertake additional education for example a masters' degree, they were invited to present their rationale and the benefits to managers for consideration. The service also had an apprenticeship levy which staff could apply for to develop their skills and expertise.

Managers had developed a training matrix identifying mandatory training. Electronic e-learning opportunities were being rolled out across the organisation.

Managers made sure staff received any specialist training for their role. The service had two nurse prescribers with another nurse due to undertake the course at a local university. One of these nurses had been supported by the hospice to undertake the nurse prescriber role, the other had already achieved the award at the time of appointment. This meant that staff were able to support children and young people by prescribing the medicine or pain relief they needed without having to wait for a doctor to visit.

Managers identified poor staff performance promptly and supported staff to improve. The service had systems to manage poor or variable performance. Performance was managed on a day to day basis by the care team managers. Staff were encouraged to raise concerns regarding their own practice or that of other team members through informal line management and the incident reporting process. Individual action plans were developed with the staff and a mentor could be provided to support staff to improve their performance. Staff support could be accessed if necessary. Tailored training and monitoring was available if necessary.

The service supported students of various disciplines. For example, physiotherapy and nursing students. Students were well supported within the team. We saw there had been letters of thanks sent to managers from a local university for the support and learning opportunities provided to a student physiotherapist and from a student nurse. They specifically thanked the care team for being such great mentors during their time there. They felt they had achieved so much whilst there.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Minutes of team meetings were made available for staff if they were unable to attend meetings.

Multidisciplinary working

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

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

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

Staff worked with colleagues in other services to deliver effective care, treatment and support. For example, speech and language therapists, dietitians and pharmacists.

Staff worked collaboratively with families and adult services if adolescents were transitioning from children to adult healthcare services. Adolescents and their families were supported by family team workers and care coordinators. Each young person had a plan for continuing health and medical support, which was part of their health passport, to assist in the transition from child to adult healthcare services. The hospice worked closely with the learning disability health facilitators, adult hospice teams, social care staff and other relevant professionals.

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

Throughout our inspection, we observed positive interactions between all staff and volunteers. Staff we spoke with confirmed there was effective multidisciplinary team working. They told us they worked together to provide the best care and support they could for children and young people who use the service, their families or carers.

Staff supported colleagues working in end of life care in other services in their community. For example, staff held regular study days for GP’s to promote best practice in end of life care.

Seven-day services

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

The service was available 24 hours a day seven days a week except for one week in the year when the service was closed for staff training. However, within the reporting period there had been an admission to the service during the closure week. Home visits were arranged from Monday to Friday from 9.00am to 5.00pm but would sometimes take place in the early evening if appropriate. These were undertaken by the family team workers to provide family support. There were no community nurses in post at the time of our inspection due to staff leaving, therefore no clinical community nursing service was available at the time of our inspection. Managers were actively recruiting to the community nurse posts. A GP visited the hospice daily.

Staff could call for support from doctors and other disciplines, including mental health services 24 hours a day, seven days a week. There were arrangements with local GP practices for medical advice and support seven days a week with provision for end of life care 24 hours a day.

Managers operated a first and second on-call service 24 hours a day and seven days a week. A senior manager operated as first on call for support and advice for all of the three hospices in the group. A clinical lead for the hospice was second on call for clinical advice. The family team also operated an on-call service. Emergency contractors operated a 24 hour on call service in the event of any equipment or emergency maintenance issues.

Health promotion

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

Staff assessed each child and young person's health when they were admitted and provided support to meet any individual needs to live a healthier lifestyle. The patient records we reviewed and observations we made confirmed this. Emotional, spiritual, psychological and practical support was routinely provided.

The service had relevant information promoting healthy lifestyles and support. There were health promotion materials displayed throughout the hospice; displayed on the walls, in the form of leaflets and helplines and organisations to support ongoing health promotion. This included notice boards containing health eating information with advice about having "Five a day" portions of fruit and vegetables.

There were complimentary therapies available for young people and their families to access to support their emotional wellbeing. These included acupressure and massage.

Consent

Staff made sure children, young people and their families consented to treatment based on all the information available. Staff always had access to up-to-date, accurate and comprehensive information on children and young people's care and treatment. All staff had access to an electronic records system they could all update. Staff ensured they liaised with all multidisciplinary teams to ensure they had the most up to date information available. For example, with consent, staff shared knowledge of the child and documents such as care plans with other agencies. The service used information from documents such has the Education Health Care Plans (EHCP) and actions raised from Children in Need (CIN) meetings to inform the delivery of care.

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

Staff clearly recorded consent in the children and young people's records. Staff gained consent from children, young people or their families for their care and treatment in line with legislation and guidance. Staff did not provide any care without first asking their permission. In the seven patient records we looked at, we saw copies of signed consent forms and observed that consent to treatment was obtained appropriately. However, there were no staff signatures in any of the consent forms we looked at to indicate that staff had discussed consent with the child or young person. We raised this with managers during our inspection and they took immediate action to investigate this. Following our inspection, we requested information about any actions taken. Managers told us that since the inspection the consent form had been reviewed and amended, the staff signature was now immediately below the parent signature. The form had been redesigned to ensure that the staff signature page was before the supporting guidance. These changes were to be agreed at the care data and documentation group and then consent forms would be re-issued with updated guidance to staff.

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

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

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

Following our inspection, we requested data from consent audits from August 2018 to September 2019. Managers told us that they did not audit this routinely due to low numbers. The service had relevant up to date policies in place which included details of monitoring compliance. This included annual reviews of staff training, random examples from practice and the implementation of the act. The policy also referred to undertaking an audit but did not identify the frequency.

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 on the intranet, staff told us that they knew how to access policies.

Are hospice services for children caring?

Good ●

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. Managers and staff had developed a strong and visible child, young person and family centred culture. We observed that all staff were friendly and saw many examples of positive interactions between staff, children, young people and their families.

Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. We observed staff interact and treat children, young people and their families in a friendly, warm, caring and compassionate manner. It was evident that staff built strong and trusted relationships with children and young people and their families. There was a strong, visible child and young person-centred culture. Staff were highly motivated and inspired to provide care that was compassionate, kind and promoted dignity and told us that they wanted to ensure that children, young people and their families received really good care.

Children, young people and their families said staff treated them well and with kindness. Parents told us they received “fantastic support which enabled one to one care with their child”. Parents said the support for siblings was invaluable. We observed all staff members speaking to children and young people and their relatives with compassion and we observed sensitivity being shown during those conversations. We observed a child in the hydrotherapy pool. The child was fully supported by a physiotherapist, a volunteer “pool spotter” (a trained life guard), and a nurse to provide additional care. Staff were kind and supportive throughout, they interacted with the child through singing, talking and providing reassurance. We saw the child was supported emotionally and physically throughout the session. All staff were responsive to the child’s needs and finished the session early due to the child becoming unsettled.

Feedback from friends and family was overwhelmingly positive. Feedback responses were collected four times a year. The service had received 116 responses from January to April 2019. Children, young people and their families could provide feedback in a variety of ways, for example feedback was through feedback cards, face to face, electronically and following group activities. The most common feedback theme related to the positive comments around staff who were described as “amazing, great, helpful, compassionate and caring”. Other themes included the benefits to families which were “having fun and having a break.” Comments included:

- “we do lots of fun things"
- “Acorns gives us a break from being carers to our child and we have the opportunity to be parents and have fun with both of our children”;

- “we know that our child is well cared for and stimulated by the nurses and volunteers. The facilities are fantastic and give us as a family some much needed respite plus it gives our child great one to one focus also”.
- “Helps me to solve things and helps me be independent “

Friendship and fun for siblings was reported in 86% of the responses about the sibling groups, for example “I really like the group, I have lots of friends, and friends who have disabled brothers and sisters like mine”, “I really enjoy the sibling group and feel I can talk to other siblings about how I feel” and “Because everyone is open, and you can say what you feel”.

We read many thank you cards and messages from children, young people and their families who stated they were “grateful for all of the care and support” and “we feel reassured when we come. It is a very caring environment and there are opportunities to have different experiences”. Parents of a young person who had been with the hospice long term sent a thank you card to staff, wanting to say “a massive thank you” for everything Acorns has done for them during the time their child stayed at the hospice. The family were extremely grateful to everyone for all the help they received, enabling them to finally return home with their child.

Managers were continually working to improve the feedback surveys by updating the questions to reflect any changes in support offered and address issues identified, exploring alternative survey tools and increasing the response rates. For example, managers told us that from June to September 2019 the response rate was 62%. Children and young people were supported by staff to complete feedback surveys if necessary. Feedback cards were being redesigned to make the categories clearer and minimize any confusion as this had been identified as an issue.

Staff followed policy to keep patient care and treatment confidential. All children and young people were treated as individuals, we saw that care needs were discussed and delivered in confidence and the child, young person and their families were involved in decision making.

Staff understood and respected the individual needs of each child and young person and showed understanding and a non-judgmental attitude when caring for or discussing those with mental health needs. We saw staff were respectful of the changing needs of children, young people and their families. Care and activities were facilitated and modified as appropriate to their 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.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs. We saw that in the children and young people’s records we reviewed, and observations we made, the child and young person’s holistic needs were recognised and respected. This included spiritual, religious and cultural needs. For example, the hospice had male volunteers who worked with some young male children and young people to meet their particular cultural and religious needs. A priest from a local church offered pastoral support to children, young people and their families. There was ongoing bereavement support for families which was offered for as long as a family required it.

Staff ensured the care after death included honouring the spiritual and cultural wishes of the deceased child or young person and those close to them. Family members and carers were asked if they wished to assist with the personal care of the body after death, such as bathing and dressing. Families were able to stay with their child or sibling in a private space.

Emotional support

Staff provided emotional support to children and young people, families and carers to minimise their distress. They understood personal, cultural and religious needs. Staff gave children, young people and their families help, emotional support and advice when they needed it. We saw that staff interactions were not rushed, and children, young people and their families were given sufficient time to speak to staff about their care and any concerns

Staff gave children, young people and their families help, emotional support and advice when they needed it. Staff demonstrated a deep understanding of the emotional impact living with a life-limiting condition had on children, young people and their families and consistently took account of this when providing care and treatment. Care was provided in the hospice and in the wider community, including in the family home. We observed staff members spending time talking and appropriately joking with children, young people and their families to help alleviate distress and sadness. Parents, carers, grandparents and siblings' needs were also assessed regularly, and plans developed to meet their needs. Feedback from relatives often mentioned how staff had helped them cope with life limiting illnesses or death of a loved one.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Bereavement support workers were available to help children young people and their families emotionally in coming to terms with a life-limiting diagnosis or the loss of a loved one. Bereavement support included one-to-one support at home or at the hospice and bereavement groups. Ongoing support was offered to families for as long as they required it. Counselling support could be accessed through a referral from the child, young person or families GP.

Volunteers worked with staff both in the hospice, during home visits and in the community to support children, young people and their families to meet their emotional needs. Ongoing support for parents, care givers and siblings was available in a variety of formats for example, from the care coordinator, social workers and family support teams. For example, parent and care giver support groups, sibling support groups, one to one support and complimentary therapies were available.

Staff supported children, young people and their families who became distressed in an open environment and helped them to maintain their privacy and dignity. We saw that if a child or young person became distressed their needs were met by care staff in the privacy of their room or a quiet area in the hospice. We saw all staff offering encouragement to children, young people and their families in a reassuring manner to alleviate their anxiety. All discussions concerning aspects of care involved family members opinions being heard and valued.

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. For example, we saw the views of a young person and their family who was at the end of life were fully respected and facilitated. Arrangements had been made for the young person's pet to be brought to the hospice to provide comfort.

Staff worked with external agencies to support children, young people and their families and to support them to access additional support within the community as necessary. For example, staff worked with schools, social care, health and community teams to ensure that the most appropriate support was available in the most appropriate place where possible.

Spiritual support was available from a local priest and other chaplains. The service ran a spiritual care group which could be accessed by families, staff and volunteers. The focus was on managing mental health issues, spirituality and self-care. A range of resources for different religions were available for children, young people and their families to access.

Understanding and involvement of children, young people, their families and those close to them.

Staff fully supported and involved children, young people and their families to understand their condition and ensure they were active partners in their care and treatment. Staff routinely empowered children and young people to have a voice and ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment. Staff communicated with children, young people and their families so that they understood their care, treatment and condition and any advice given. Family support and bereavement triaged referrals to explore individual's needs with them directly and the appropriate intervention by either the hospice or alternative providers if appropriate.

Staff talked with children, young people and their families in a way they could understand, using communication aids where necessary. For example, the hospice used Makaton signing to communicate with children if they were unable to communicate verbally. Families we spoke with felt they had received the information they needed to understand their child's condition and make informed choices about their care which met their cultural, spiritual and personal needs, as well as their physical health needs.

Families were treated holistically and psychological 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 activities. Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. Children, young people and their families consistently provided positive feedback about the service. Families attending bereavement groups reported how they had enjoyed the craft work and being with other grandparents and parents. Another family reported that "I have found this group very helpful and gives you some hope. Since losing our child it has been very hard but we cannot thank Acorns enough. I think it is great what they do and help bereaved parents and families. Always make you feel welcome".

Staff supported children, young people and their families to make advanced decisions about their care. We saw care plans included advanced decisions about care and they were checked and updated on each admission. Records were available to show regular discussions were held with families. The opportunity to raise questions were given and answers provided, additionally information was provided to support families.

People told us they felt listened to, respected and had their views considered. Parents told us that they received a lot of support from the hospice and that "the flexibility was the best thing". For example, staff had supported parents in staying overnight with their child until all the family felt confident for the child to stay overnight alone. They told us their child enjoyed the activities that they were able to access, for example the sensory room, hydrotherapy pool and craft area.

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. Children and young people were empowered and supported, where necessary, to use and link with support networks and advocacy, so they had a positive impact on their health, care and wellbeing.

There was a family support service provided by the hospice which offered a range of emotional, practical and psychological support to children, young people and their families affected by life limiting illnesses. The family support team allowed relatives to be involved in the patient's journey. Family support was offered both pre and post bereavement.

Support was offered to adolescents who were transitioning to adult services. The post of transitional worker had been lost due to redundancies, however the team were developing these skills to ensure that adolescents and their families remained fully supported and the transition to adult services was fully do-ordinated. For example, the family support team liaised with the multidisciplinary teams, would arrange "team around the child" meetings if necessary and attended consultations with the adolescent and their families to share information. Staff demonstrated an awareness of the changing emotional needs of both adolescents and their parents as they grew and developed. Adolescents were increasingly supported to make decisions about their care and treatment. Staff told us how this was often difficult for parents to come to terms with and provided ongoing support for families to manage these circumstances.

Children, young people and their families were supported to keep in touch with their friends and wider family. Staff welcomed relatives, friends and pets, and recognised the emotional support and comfort they provided. The hospice had an open visiting policy, so family and friends could spend time with their loved one whenever they wished. Accommodation was available to enable families to have uninterrupted time together. Pets were also allowed to stay with children and young people.

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

Good ●

Service delivery to meet the needs of local people

The service effectively planned and provided care in a seamless way that met the needs of local children,

young people, their families and the communities they served. It also worked proactively with others in the wider system and with local organisations to plan the best possible care.

Managers planned and organised services so they met the needs of the local population. The services provided reflected the needs of the population and promoted flexibility, choice and continuity of care. The hospice provided inpatient, day care services and home visiting services. Home visits were arranged by family team workers to support families in the community. These included supporting families to access local groups, taking siblings out so that they had play opportunities and supporting with accessing specialist equipment or funding as appropriate.

At the time of the inspection there were no outreach services available to provide nursing care services at home and all clinical services were provided at the hospice. This was because there being no outreach workers in post. The roles were being advertised. Managers were recording this monthly as an unmet need. The head of governance, quality and engagement reported unmet needs to quarterly care governance and care assurance meetings. This enabled the service to plan effective services to meet the needs of children and their families.

The service was responsive to meeting unmet needs at the hospice by adapting services in a flexible way. Individual needs were reported through the weekly panel meetings and services were reviewed with the allocation of appropriate staff to provide the service. For example, we saw staff discussed the provision and uptake of specific groups and took into consideration services that were available locally. This ensured community services were available in a location across the geographical area for as many families as possible. Volunteers supported services both within the hospice and in the community, assisting at home visits and groups as necessary.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Children and young people had individual bedrooms and their privacy and dignity was ensured at all times. All personal care was undertaken in a private area and care was taken to respect each individual child and young persons' wishes as in the detailed personal care plan. Care was delivered in line with the chaperone policy.

Facilities and premises were appropriate for the services being delivered. The hospice was purpose built and provided private parking spaces for families, visitors and staff. Doorways were wide and suitable for wheelchair and buggy access. Access to the building was through a doorbell entry so that staff knew who was entering and leaving the building. There was a large lounge area with a range of comfortable seating, two ceiling mounted hoists were in place to transfer children in this area. The dining room was large with a range of wipe-able tables, chairs and highchairs. There was an art and craft room, sensory area with a range of sensory equipment including magic carpet lights and soft music. Bedrooms were arranged along two corridors one for adolescents, the other for younger children with access to the enclosed gardens. Those close to children and young people could stay overnight at the hospice.

The hospice had an outdoor area with soft flooring and a range of play equipment. The service had a hydrotherapy pool which was also hired out for other members of the community. Those hiring the hydrotherapy pool were able to access it through a separate doorway so that they did not have to disrupt other activities taking place at the hospice. Parents and carer's had access to a private flat with en-suite facilities Additionally, there were two "cold rooms" (special bedrooms) for use when children and young people died. Families would stay with their child in this room for up to two weeks. There was a separate discreet entrance for undertakers to retrieve bodies prior to burial. The service also had two family suites available so that families could stay at the hospice with their child. The rooms faced onto tranquil gardens and a special garden of remembrance.

Staff could access emergency mental health support 24 hours a day seven days a week for children and young people with mental health problems or a learning disability. Processes were in place to ensure emergency mental health support was available with clear escalation procedures. Known mental health issues were clearly documented in care plans. However, in the event of an emergency staff had access to both local adult and child and adolescent mental health crisis teams. GP's were available in an emergency and there was additional support from nursing and family teams.

The service had systems to help care for children and young people in need of additional support or specialist intervention and planning for transition to adult services. All children's areas were adapted to meet the complex needs of the children who accessed the service. This included recognition of children's and young people's communication and sensory needs. Staff were trained and understood the complex nature and impact of sensory difficulties. Staff and volunteers working with the children had access to a range of specialist equipment and tools to support children to communicate and enjoy the opportunities available to them. There are regular communications meetings to plan sensory experiences for groups and individual children. Communication training was undertaken by all care teams on an annual basis.

Staff worked collaboratively with families and members of the multidisciplinary team when adolescents were transitioning to adult services. The service did not have a transitional care worker as the post had been lost due to redundancy, however staff within the teams supported adolescents transitioning to adult services. Managers had not reported any negative impact from this. Workforce was recorded as a risk on the risk register, there were mitigating actions and review processes in place. For example, learning and development programmes were in place to meet areas of need. Staff told us that they attended consultations with families to provide support and share knowledge. Managers had arranged for staff from the wider multidisciplinary team to talk with Acorns staff about the transition process and support the development of their skills and knowledge.

Managers monitored and acted to minimise missed appointments. Children, young people and their families could arrange appointments at times convenient to themselves and the service. Children, young people and their families were invited to group sessions and arrangements were in place to ensure appropriate staff were on duty, for example, a nurse who had successfully completed tracheostomy care competencies when a child with a tracheostomy was attending the hospice.

A maximum of 16 overnight respite stays were also offered each year. Families told us that occasionally they had their visits to the hospice cancelled at the last minute. These visits included day care and overnight stay visits for children, young people and their families. Following our inspection managers told us that there had been 68 cancelled visits from August 2018 to September 2019 reasons for these included, staffing capacity, emergency bookings for children at end of life, social care emergencies, equipment needs and poor weather. Managers were unable to provide information about how quickly appointments were rebooked but reported that they tried to rebook the appointment at the time of the cancellation.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children and young people access services. They coordinated care with other services and providers. There was a proactive approach to understanding the needs and preferences of different groups of children, young people and their families and to delivering care in a way that met those needs, was accessible and promoted equality. All staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers in a holistic way.

Staff made sure children and young people living with mental health problems, learning disabilities and long-term conditions, received the necessary care to meet all their needs. Processes were in place to ensure that children and young people had access to specialist services to meet their needs. This included mental health services with 24-hour access.

The hospice was accessible to children young people and visitors with mobility difficulties and wheelchair users. There was a lift to the first floor, however all patient services were located on the ground floor.

Wards and facilities were designed to meet the needs of children, young people and their families. All children's areas were adapted to meet the complex needs of the children who access the services. Children and young people had individual bedrooms to ensure their privacy and dignity at all times. The service had specialist equipment including specialist beds and cots for children and young people, this included bariatric equipment if necessary. Sensory bathrooms were available, with equipment to support those with mobility needs. These included lighting and music to support emotional well-being and relaxation.

Staff understood and applied the policy on meeting the information and communication needs of children and young people with a disability or sensory loss. Staff used a range of communication aids to support communication with children and young people. Staff used a range of tools including signing and Makaton to communicate with children and young people as necessary. For example, pain assessment tools were pictorial, so children could point to a happy or sad face to indicate their need for pain relief. However, there was no hearing loop available for those who were hard of hearing.

Staff had access to communication aids to help children, young people and their families become partners in their care and treatment. The service used technology and equipment to enhance the delivery of care and support independence. The organisation was supported by a charity which provided equipment and staff training to aid children and young people's independence. This included eye tracking technology and light show "magic carpet's". Eye tracking is a way of accessing a computer or communication aid using a mouse that is controlled by a person's eyes. The service also had a supply of tablets for the specific use of the children and young people and worked with local schools to ensure staff were kept up to date with children's communication needs. There were cross team activity and communication meetings where managers ensured that all the communication needs of the children attending the hospice or accessing group support was met.

Facilities also included activity rooms such as arts and crafts, a multi-sensory room with sensory light "magic" carpets, indoor soft play and an outdoor play area with a wide range of toys and equipment. There was also have an adolescents room and young person's lounge for adolescent clients. Portable sensory equipment was also available. The service had a hydrotherapy pool where children had therapeutic support from physiotherapists. There were also a wide range of games, digital versatile discs (DVD's) and books available for use.

Assessment planning considered the views and wishes of the child, young person and their family into account and included a base line to assess against. We saw assessments were comprehensive. Individual family members needs were also considered to enable all staff and volunteers to respond in a timely and compassionate manner. For example, respite care could be arranged to support the wider family and give parents and carers a break so that they could undertake activities with other children in the family. Additionally, the service provided complementary therapies such as massages and acupuncture for family members.

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

Staff supported children and young people living with complex health care needs by using 'This is me' documents and passports to support their independence and decision making and took their needs and preferences into account. Children and young people's rights were supported through maximising independence, maintaining the least restrictive options, empowering, involving and maintaining respect and dignity. We saw this occurred during our inspection when the wishes and feelings of a young person at end of life were clearly considered and met in their care planning. For example, arrangements were made for their pet to be brought in to the hospice. Staff worked closely with family members to ensure effective communication. Families were supported to attend appointments if desired so that they had contemporaneous knowledge of the child or young person's condition and could advise families on any changes and support them appropriately.

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

Family members could access 'family splash' sessions using the hydrotherapy pool. There were also play and stay sessions for children under five years old. The service had a complementary therapy team who provided treatments to children and family members, including massage, reflexology and acupressure.

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

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

Staff maintained a weekly activities board. Activities included pet therapy and music, massage, disability sports and gardening. All children, young people and their families were able to participate in these activities. During our inspection we saw children and their families enjoyed pet therapy and participated in a music and singing session.

The service had a range of information leaflets available. Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed. Families who required an interpreter could use the interpreting services available to the hospice so they had a clear understanding of their child's health needs and were involved in the plans for their care. The service was available 24 hours a day. If clients and families required additional services and support from other professionals for example, faith leaders, the service supported access to this. Staff understood the importance of accessing professional interpreters to ensure accuracy of information shared.

Staff endeavoured to provide care that was not limited in terms of diversity, ethnicity, culture or aimed at any particular community group. They demonstrated a holistic, patient-centred approach to care planning and delivery of care. Children, young people and their families spiritual, religious, psychological, emotional and social needs were taken into account. This was evident from the records we reviewed and observations we made during the inspection. Staff maintained a spiritual comfort cupboard with resources to provide support for children and adults of various ages. There was a folder with a list of items available for each main religion, for example, there were Christian bible story books, Muslim cassette tapes, Islamic children's songs and a Jewish scroll. Hindu and Sikh items were also available. There were also information leaflets to take away.

Children, young people and their families were given a choice of food and drink to meet their cultural and religious preferences. The hospice had an on-site catering team able to cater for all dietary needs including vegan, vegetarian, halal, kosher and African Caribbean food. Food and drinks were available 24 hours a day for children, young people and their families. Staff told us they had provided food parcels for some families at Christmas time.

Children, young people and their families could access wellbeing sessions through the spiritual care group. This group focussed on mental health, spirituality and self care. Complementary therapies were also available. Staff signposted children, young people and their families to other support agencies and community services, such as local psychological wellbeing services and carers organisations. Families and carers were offered bereavement counselling after a child or young person had died.

The hospice had developed its care to be responsive to the holistic needs of the whole family by adopting a pathway approach. This was based on the assessed need for each family's journey from referral to end of life and after death. This included symptom management, parallel planning which included supporting families to plan for life whilst also planning for a deterioration in the child or young person’s health or their death. Families were supported in developing advanced care plans. Staff ensured there was choice for families. This encompassed the expressed wishes of the family being considered and supported and included the provision of a therapeutic environment and providing emotional support which included permission to be happy and laugh. Spiritual care, support after death and memory making was provided. Staff provided palliative care including the management of symptoms while supporting the family.

Care after death was managed sensitively and in a way which respected the wishes of families while following appropriate process. This was evident from the conversations we had with staff and observations we made. Staff ensured families understood the practical arrangements needed after the death of their child. Staff were available to provide practical advice and helped families to arrange funerals in accordance with their wishes. The hospice provided several leaflets which offered practical advice for coping with a bereavement and how people could help their loved ones and support them through bereavements.

The hospice had a memorial garden, when a child had passed away family members could engrave a stone to be kept in the stream. Families were allowed to visit whenever they wished to sit in the memorial garden.

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

All feedback was collated and reported back to families through Newsletters and 'You said, We did' display boards in the hospice.

Access and flow

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

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

Staff engaged with professionals to raise awareness of the services offered to ensure there was timely referral for children, young people and their families. This included community staff within the geographical areas covered by the hospice, GP’s and hospital staff.

Managers monitored waiting times and made sure children, young people and their families could access services when needed and received treatment within agreed timeframes and national targets. The hospice had effective processes to manage admission to the service. Referrals came mostly from GPs, specialist palliative care nurses, community clinical nurse specialists and the local acute NHS hospital. The service did not have a waiting list but children were triaged according to their clinical requirements to identify those in the greatest need. These included consideration of whether the referral was for end of life or respite care, the wishes of the child, young person and their family and capacity within the hospice to meet the individual needs. This included ensuring that there was the scope to prescribe appropriate medication for symptom management. If a child or young person’s condition changed or there were any social issues managers would adapt to meet the needs of the young person and their family. Referrals were discussed at the two weekly panel meeting, considered monthly by the senior care managers and quarterly by the Care Assurance Committee. During the reporting period 191 children and young people with a life limiting illness were receiving palliative care. Within this time frame there had been 1,022 admissions to the service, of these 1,015 were for respite care.

When a child was accepted to the service a holistic needs assessment was undertaken to ascertain which services best met the family's needs. Children and young peoples’ need’s assessments were reviewed when clinically appropriate but were also reviewed annually to ensure that they continued to meet the admission criteria. Further medical advice was sought from their lead consultant as necessary.

Managers and staff worked to make sure children, young people and their families did not stay longer than they needed to. Services were tailored to meet the individual needs of all children, young people and their family members. Staff completed holistic needs assessments and support plans took the needs of all family members into account. Support plans were reviewed annually.

Managers worked to keep the number of cancelled appointments to a minimum. Managers told us that they tried not to cancel appointments. From December 2018 to November 2019 there were 68 cancelled bookings for children's and young peoples stays. Managers told us that appointments were cancelled due to staffing capacity for example, late notice sickness, emergency bookings for children at end of life care or a social care emergency. Other reasons were due to equipment needs and snow. Additionally, from June to September 2019 there were four occasions when volunteers were not available to support transport requests, this meant that 10 siblings had not been offered one to one support and were awaiting assessment. In the same time frame there were four occasions when adolescents were unable to access specific services. No data was provided about which services these were. Outreach support was not available on 16 occasions within this timeframe and was related to a lack of staff capacity. Staff sickness was identified as having an impact on unmet needs within the hospice. We were not assured that there was always sufficient forward planning to reduce the amount of unmet need.

When children and young people had their appointments cancelled at the last minute, managers made efforts to rearrange as soon as possible and within national targets and guidance. Managers told us that they did not have data as to when a child or young person's appointment visit was rebooked but aimed to offer a new appointment at the time of cancellation.

Managers ensured that children, young people and their families who did not attend appointments were contacted. Processes were in place if appointments were missed. Staff would contact the families or the local hospital to identify whether the child or young person had been admitted to hospital. If safeguarding concerns existed these were escalated to the safeguarding teams and local authority. We saw that missed or cancelled appointments were discussed at the weekly panel meetings and actions taken to address issues.

Managers ensured that children and young people's moves between services were kept to a minimum and were for clinical reasons only. Staff moved children and young people only when there was a clear medical reason or in their best interest. All children and young people had their own rooms. Following our inspection, we requested audit data about moves between services. Managers told us that they did not audit transfers between services as numbers were very low. Staff reported all emergency transfers as incidents which were analysed for themes and trends. No information was provided about any themes or trends. Emergency transfers were recorded as part of the on-call update. Managers monitored this and highlighted concerns and actions taken. The service had an up to date transfer policy. Compliance was monitored through incident forms and feedback from the staff escort. All staff undertaking escort duty had received escort training.

Some children, young people, their parents, grandparents and siblings were referred for psychological, emotional and practical support. All referrals were discussed and reviewed at the two weekly panel meeting and care was allocated to team members as appropriate. Staff worked with families to access support to external services, however no data was available about waiting times for this. Children and young people with a range of disabilities could access and use services on an equal basis to others.

Staff supported children, young people and their families when they were referred or transferred between services. If children and young people were transferred between services; for example, to transition to adult services, staff worked closely with them and their families. Additionally, they liaised with the multidisciplinary team to ensure that transfer of care was coordinated. If a child or young person no longer met the criteria for the hospice, staff signposted them to other services and supported the transition. Adolescents who had reached their 18th birthday no longer met the criteria for the service, younger children may have not continued to meet the criteria if they had shown significant clinical improvement or stability in their condition. In these circumstances a criteria review was undertaken, and additional information sought from the lead consultant.

Managers and staff worked to make sure they started discharge planning as early as possible. Staff planned children and young people's discharge carefully, particularly for those with complex mental health and social care needs. Discharge arrangements ensured that children, young people and their families understood prescribed medications, dates of follow-up appointments and follow-up telephone call and emergency telephone number.

Managers monitored children and young people's transfers and followed national standards. All young people were discharged after their eighteenth birthday. Staff supported families and young people and signposted them to other relevant services on discharge.

Managers and staff always prioritised end of life care over planned respite care. Families of children were made aware of the criteria. We saw actions taken to prioritise the needs of a young person at end of life.

There were processes in place for the urgent referral of children, young people and their families for counselling and mental health services. Staff liaised with the local child and adolescent mental health service (CAMHS), and mental health crisis team and the GP if a child or young person required an urgent referral to mental health services. No data was supplied about the number of referrals made to mental health services.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them within an agree timeframe and shared lessons learned with all staff. The service included children and young people in the investigation of their complaint. The service received many compliments about the care, treatment and support that children, young people and their families had received.

The hospice had processes to ensure complaints were dealt with effectively, including prompt acknowledgement of the complaint, a written response to the complaint and whether changes had been made because of the complaint. Face-to-face meetings with the complainant were also offered, when indicated.

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

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

Staff could give examples of how they used feedback to improve daily practice. For example, clarity on open visiting times was provided following a complaint about visiting times for extended family. This was cascaded to the multi-professional teams outside the hospice and updated on the website. Additional training was provided to staff regarding sensitive conversations with families whose child was at end of life following concerns raised about poor communication. However, some staff told us that they did not always receive feedback on complaints unless they were directly involved. Staff they told us they would be informed if anything needed to change or be reviewed following a complaint. Minutes of the in-house team meetings that we reviewed for June, October and November 2019 did not refer to complaints. Themes and trends of complaints were monitored at the care governance meeting. Minutes of meeting we reviewed confirmed this was a standing agenda item.

Children, young people and their families knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. We saw information was displayed in the reception area about how to raise a complaint. Families we spoke with told us they would know how to raise a complaint if necessary. Children and their carers or parents could raise concerns verbally with staff, through social media, or in writing.

Managers investigated complaints and identified themes. Complaints were reviewed cross organisationally, this meant that any learning was shared. Complaints were discussed at the care governance group and themes and trends were considered at the care governance meetings and care assurance committee of trustees. Complaints were monitored by the Director of Care. Managers responded to complaints within 20 working days, if there was a delay in the process managers told us that families were informed.

Summary of complaints

From September 2018 to June 2019 the service received four complaints. No complaints were received by the service from July to September 2019. We saw complaints were responded to within the 20-day time frame. Communication themes were identified in two of the complaints received. We saw action plans were developed with policies updated and learning shared at quality meetings and during the annual training week.

Within the same reporting period the hospice received 76 written compliments. However, we saw many more expressions of gratitude during the inspection. Common themes from compliments included the care and kindness of staff and the difference this had made to families in their time of need. The benefits of the group activities and the respect and dignity staff gave to children, young people and their families were also recurring themes.

Are hospice services for children well-led?

Good ●

Leadership

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

The service had managers at all levels with the right skills and abilities to run a service which provided high quality sustainable care. We saw compassionate, inclusive and effective leadership at all levels. The leadership team consisted of a board of trustees with a range of relevant expertise to contribute to the service. The service had managers who carried out key accountable safety roles. These included a director of care, head of care, head nurse, head of governance, quality and engagement and head of facilities. The senior management team met regularly with the board of trustees. The service did not have a medical director in post at the time of our inspection. This was not recorded on the risk register. This meant that there was no medical consultant at executive level. However, the service had senior medical representation through a service level agreement with a palliative care consultant at a local children's hospital to provide medical support and leadership.

The service had a stable leadership team. Senior leaders worked across the three hospices within the group to provide leadership and consistency across all sites. The hospice had a registered manager who was also the head nurse and a head of care services who were responsible for the day to day running of the service. They were supported by a volunteer manager, family services manager and administrative lead. Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver high quality and sustainable care.

There was a system of leadership development and succession planning which aimed to ensure the leadership represented the diversity of the workforce. Leadership development training included management of sickness, disciplinary and performance management. To further develop leadership senior managers had instigated development and cross organisational groups for care middle managers. These were led by one of the heads of care, relevant staff met regularly to develop care services priorities and agree and implement action plans. Development opportunities were provided for all staff, for example staff were supported to undertake further specialist courses and further degrees.

The executive team ensured there were comprehensive and successful leadership strategies in place to ensure and sustain delivery. Leaders had a deep understanding of the issues, challenges and priorities in their service. This included financial risk and difficulties in recruiting and retaining sufficiently skilled clinical staff, maintaining the required level of volunteers and awareness of the importance of preparation in the event that a member of the senior leadership team other key post holder left the organisation. These were recorded on the strategic risk register.

Following staff rationalisation the service no longer had an adolescent worker or transitional care worker. However, there were strategies in place for other team members to support families.

The board of trustee’s skills and competences were assessed at the time of their appointment and reviewed annually and were supported by a 'Fit and Proper Persons' Policy which ensured all required checks were undertaken when appointing trustees. The board of trustees had an equal balance of business and clinical skills and included a parent representative. The diversity of the board of trustees meant that the services provided were reviewed and considered from differing perspectives. This enabled the provider to be confident a range of opinions and voices were heard to ensure the service was well led and have a positive impact on those who received a service.

Staff told us leaders were visible and approachable. All staff told us leaders were accessible and responsive. Staff at all levels told us they felt valued and could openly discuss issues or concerns. The leadership team were well-respected by staff for their collaborative working and influence to improve patient care outcomes within the geographical area the served. Staff and volunteer development were also highly valued.

Staff who worked in the community felt connected and integrated with the other teams within the service

Vision and strategy

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

The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff. Although the service was engaged with children, young people, families and the wider community, we were not assured that those using the service and the local community had been involved in the development of the vision. This was an overarching strategy for all the services offered by the provider. There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans. Staff views were sought through staff surveys in the development of the vision, mission and values statements. The new strategy had taken account of research which had identified the growing population of children across the West Midlands with life limiting and life-threatening conditions.

The service had launched a new three-year strategy in 2018 and had revised the vision, mission and values statements. High quality care featured as the top priority and sustainability was identified as key to the strategy. The vision for the service was for “Every baby, child and young person living in our region who is life limited or life threatened will receive the specialist care and support they need.” The service had a mission to provide a range of holistic, specialist, palliative care services to babies, children, young people and their families in partnership with others.

The values of the service put the child at the heart of all care provision and underpinned the vision. The values were to be:

- Compassionate
- Honest
- Inclusive
- Local
- Dedicated

The service had set out five strategic goals which were to:

- Provide outstanding care quality
- Develop the skilled and dedicated workforce
- Engage with supporters

- Safeguard finances
- Plan for the future

Since launching the strategy in 2018, the service had experienced unexpected financial challenges. This included the proposed closure of a sister hospice and the reorganisation of services. Managers said that this was due to insufficient cash reserves to support three hospices within the trust and that the cost of delivering care was far higher than the total that had been raised. Managers and trustees worked with families using the service, members of parliament, local councillors and NHS commissioners to secure additional funding for the service. Managers took into account the potential impact on children, young people, their families and staff and had sought to protect services to enable the continuation of a range of services and family support. Within the strategy a new model of care was developed to continue to provide short breaks, family support, end of life care, clinical support and complimentary support for the whole family. Managers had developed an operational plan to support the development and provision of the new service model and meet the five strategic goals.

The leadership team monitored and reviewed progress against delivery of the strategy and local plans. The service strategy aligned to local plans in the wider health and social care economy, and how services were planned to meet the needs of the population. Managers and staff worked closely with local hospitals, commissioners and other NHS partners to support families most effectively. The leadership team worked collaboratively with staff in achieving a three-year service plan that helped with business and financial planning. Teams had work plans, objectives and key performance indicators to allow systematic monitoring. Leaders met regularly to discuss outcomes. Minutes of board meetings confirmed this.

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

Culture

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

Leaders had an inspiring shared purpose to deliver and motivate staff to succeed. There were high levels of satisfaction across all staff. There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people’s experiences.

There was a culture of inclusiveness to support people who worked for and used the services. For example, training to understand equality, diversity and inclusiveness of those with protected characteristics. Staff felt supported, respected and valued. We saw this evidenced in the commitment to staff learning and development. There was support in ensuring staff were competent and there was scope for career progression.

Staff felt positive and proud to work for the organisation. The culture centred on the needs and experience of the children, young people and their families who used services. Staff told us that they felt pride in the organisation and the work the carried out to ensure children, young people and their families received good quality care.

Staff behaviour and performance that was inconsistent with the vison and values, regardless of seniority was addressed. Some staff had had an appraisal to set out objectives and address values and behaviours. However, appraisal rates were low. Senior managers had an action plan in place to ensure that all staff had an appraisal. Staff who had received an appraisal told us that it was a beneficial process and they were able to identify areas for development. We were given examples of when staff performance had been addressed and action taken to support staff to make positive changes.

The culture encouraged openness and honesty at all levels within the organisation, including with people who used services and in response to incidents. Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution. We saw evidence of learning and action taken because of concerns raised.

Staff at every level were supported with their development needs. We saw evidence across the service of career progression opportunities and support in achieving higher level qualifications, including master's degrees. There were apprenticeship programmes and a highly supported volunteer programme. However, career development conversations took place as part of the appraisal process and not all staff had had an appraisal. Although there were plans in place to rectify this we were not assured that all staff had had these opportunities.

There was a strong emphasis on the safety and well-being of staff. Counselling services were available to support staff individually in group sessions or on the telephone if needed. Debrief sessions were offered to all staff regardless of the area in which they worked when a child or young person died. Staff also received ad hoc safeguarding, clinical and restorative supervision to reflect, address any clinical issues and the emotional impact these may have had on them. This ensured that staff had adequate support to undertake their roles and responsibilities. Additional initiatives were in place including access to line management supervision, a formal employee assistance programme and flexible working arrangements. Other wellbeing initiatives included the Acorns choir, social events organised by volunteer managers for staff and volunteers for example, quiz nights and access to complementary therapies.

All staff were knowledgeable about the duty of candour, there was a standard operating procedure that provided guidance to the requirements of duty of candour.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Shared governance systems were in place across the three locations. Managers monitored working practices through reports, meetings and a programme of audits and forums. There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. These were regularly reviewed and improved. There were five sub-committees that met quarterly, each with terms of reference and nominated attendance from trustees and managers. These were the care assurance committee, financial resources, retail, fundraising, marketing and communication and board development. Quality and activity reports were also provided to the care commissioning group (CCG) and were reviewed and discussed at quarterly commissioner review meetings. We saw that audit results were regularly discussed at senior management meetings but were not a standard agenda item at team meetings. Therefore, we were not assured that staff were always aware of the issues raised.

All service committees received reports and discussed key issues at committee meetings. The main trustee board met quarterly. They received minutes from each of the trustee board governance committees. They also received hospice update papers, updates on strategic priorities, financial information and sometimes a presentation on a service area and/or an issue for debate and discussion. The senior management team were present for the whole board meeting.

The service had a head of governance, quality and engagement. All levels of governance and management functioned effectively and interacted with each other appropriately. The leadership team attended governance meetings and information was fed in to local teams at team meetings, in the form of minutes and emails.

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

Staff at all levels were clear about their roles and they understood what they were accountable for, and to whom. There were clear lines of accountability, with team leaders overseeing staff and helping them to achieve their objectives. This was evidenced in staffing structures and understanding of roles and responsibilities. Staff were committed to improving the quality of service provision and safeguarding high standards of care. Staff knew how to report incidents and were encouraged to do so.

There were health and safety representatives across all departments and a health and safety committee who met quarterly. The hospice had a medicines management committee responsible for policy and practice within the hospice.

There was evidence of regular engagement with other professionals within the health economy to improve care outcomes.

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

Effective governance processes were established at shop-floor level. The nurse-in-charge of the inpatient unit checked all daily checks had been completed, such as emergency equipment and medicine storage temperatures.

Arrangements were in place to manage and monitor contracts and service level agreements with partners and third-party providers. Contracts were reviewed on an annual basis, which included a review of quality indicators and feedback, where appropriate.

The director of care was the Caldicott Guardian for the service. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

Managing risks, issues and performance

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

There were robust arrangements for identifying, recording and managing risks, issues and mitigating actions. There was alignment between the recorded risks and what staff told us were concerns. The hospice had up-to-date risk management policies place such as the complaints policy and incident and near miss policy. The service had developed a significant event analysis framework to support the review of a potential or actual serious clinical incident.

The service had a corporate risk register where there were clear mitigations and review processes. These were reported to the board, reviewed regularly and acted on. There was an organisational risk log, environmental and clinical risk assessments and individual risk assessments which were monitored through the care governance and health and safety meetings. Minutes of meetings we reviewed confirmed this. The hospice did not have a site-specific risk register. However, senior managers undertook quarterly compliance visits to identify both hospice specific risks and organisation wide risks. We saw that all risks including hospice specific and generic risks were clearly identified and actions taken.

There were a broad range of policies and procedures that set out the hospice's expectations and approach to safety in key areas such as recruitment, risk assessment and management, medicines management, safeguarding and Mental Capacity Act and Deprivation of Liberty Safeguards. These were accessible electronically by all staff. Policies were reviewed to ensure they were in line with best practice, new legislation, national standards or latest guidance.

The clinical care assurance committee played a key role and function in the management of risks within the service. 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 themselves. The committee would look for themes and trends and scrutinise the actions taken to reduce the risk of recurrence.

The committee received several reports regarding different streams of risk including corporate risk, clinical risks and operational risks. Some of the reports received included complaints, medicine errors and information technology system issues. This gave the committee a broad and full picture of risk within the service.

The service and committee also took account of risks from external sources and worked to mitigate these. For example, they had a comprehensive action plan in place to address financial risks. This showed that the service was dynamic and proactive in their approach to managing risk.

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

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

The service had an up-to-date business continuity plan which was accessible to staff and detailed what action should be taken and by who, in the event of a critical incident involving loss of building, information technology or staff. Emergency contact numbers for managers and services, such as electricity, gas and water providers, was included.

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

Managing information

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

There was a holistic understanding of performance which sufficiently covered and integrated people's views with information on quality, operations and finances. Clear and robust service performance measures were reported and monitored. Staff had access to quality and performance data through the quarterly integrated quality and performance report. We saw these reports were detailed and included data on a range of performance and quality indicators, such as incidents, staffing, service user feedback, complaints and audit activity. Areas of good and poor performance were highlighted and used to challenge and drive forward improvements, where indicated. However, this did not include information about monthly inpatient stays, length of stay or bed occupancy. Reports including occupancy data, care assurance which incorporated the risk register, safeguarding, incidents and controlled drugs and compliance reports were presented at the monthly care assurance committee meeting.

The service had cross organisational policies and standard operating policies specifically for information governance. There were clear processes for reporting data breaches and recording breaches.

Staff had access to up-to-date and comprehensive information regarding children and young people's care and treatment. The service had implemented a new care database system that enabled all care documentation including clinical and patient information to be recorded in one place. The system was cloud-based and could be accessed both in the hospice and home settings. Staff have been issued with individual devices to access the care system. Staff told us the system was effective and enabled them to access up to date information when away from the hospice. There were arrangements to ensure confidentiality of patient information held electronically and staff were aware of how to use and store confidential information. Computers and laptops were encrypted, and password protected to prevent unauthorised persons from accessing confidential patient information. We saw that staff closed their computers when not using them to prevent unauthorised access. Quarterly reports were also generated for the CCG commissioned contract that was in place.

Management records were well organised, and records were detailed and kept up to date. Any paper-based care records were easy to follow and kept securely as were personnel records. We saw that these were stored securely in locked cabinets.

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

Engagement

Good ●

Hospice services for children

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

Children, young people and their families' views and experiences were gathered and acted on to shape and improve the service and culture. Children, young people and their families were encouraged to share their views to help improve services. Feedback was reviewed by staff and used to inform improvements and learning, where possible. Staff gathered real-time feedback through tablet devices, which generated a daily feedback report. Children, young people and their families were asked about their experience of care at the hospice, such as mealtimes and their experience of using the service and accessing groups and activities. By asking for feedback in this way, staff hoped issues would be raised soon after they arose and meant they could be acted upon quickly. We saw evidence of this during the inspection. For example, managers had analysed feedback from families about support groups and were developing an action plan to further develop the support groups. Additionally, there were plans in place to improve facilities in the cool room garden and parking arrangements.

The service had an open and transparent approach to sharing information. News and information for parents, staff and external professionals was available through the hospice website. Information included planned events, including fundraising and photographs of children and young people engaged in activities both internal and external to the service along with useful links to external resources.

There were high levels of engagement with children and young people, families and carers, partner organisations and the public. Engagement was open and transparent. For example, there was specific public engagement with views sought following the possible closure of a sister hospice and the impact on local services. All service users, staff, partners and, donors were informed of the difficulties and the potential impact on services before information was available in the wider public domain. A service user consultation was carried out to meet with and listen to families and staff views and to inform service development and planning. Additional consultation meetings were held with MP's, the Mayor, and an all-party parliamentary group for children's palliative care and the media. As a result, additional funding was secured in 2019 to enable the continuation of one of the hospices and lessen the impact on Acorns Hospice in the Three Counties.

The hospice engaged well to meet the needs and requirements of their children, young people and families and they celebrated the good working relationships with the families they cared for. The hospice considered feedback from the local community and service users as invaluable in informing of the service of what was working well and areas to be enhanced. The service had developed the role of young ambassadors. These roles were undertaken by either young people or their siblings who had used the service. The role involved providing information, attending events and giving talks in schools and to a variety of agencies about the work of the hospice.

Feedback from children, young people and their families identified the positive impact the hospice had on their wellbeing. The hospice provided a range of activities and therapies for children, young people and their families accessing the hospice. These included coffee mornings, bereavement, sibling and grandparents' groups, under five play groups and the provision of complementary therapies such as acupressure. Support groups and events were held in the hospice and at venues in the community. This enabled access to those who had difficulty getting to the hospice.

Following the financial difficulties experienced, the role of the adolescent worker was lost. The wider care team supported by volunteers worked to ensure that they made each child and young person's stay as fun and engaging as possible. An adapted vehicle had been donated to the service. This had enabled the care team to take children and young people who were wheel chair users, out on trips when they stayed for palliative care short breaks.

The hospice worked in partnership with other services providing end of life care to ensure children and young people's individual needs were effectively met. For example, they worked closely with local NHS trusts, local commissioners and local authorities to ensure the charities services were aligned with the local health and social care economy to ensure it was best meeting the needs of children, young people and their families. Staff worked in partnership with other local children's hospices. Staff also attended local palliative care network groups for the West Midlands, Worcester, and Gloucester. Additionally, staff attended safeguarding and support meetings with local authorities, other health and educational professionals. For example, they supported the development of team around the child, health education plans with and transition to adult services plans. Consultants who worked with the service provided training for GP's on end of life and palliative care. The service hosted and provided administrative support for the local palliative care network and hosted the child death overview panel for the Worcester area.

The service valued the input provided by volunteers. Volunteers worked in all areas of the service. These included supporting the catering staff, care staff and working in the reception area. Some volunteers had been trained to support the outreach workers and family team staff. They supported siblings or parents while the child was cared for. This enabled some of more rurally isolated children and families to access the service. Volunteers who provided outreach services told us that they really enjoyed the role and developing good relationships with families.

The views of staff were sought and acted on. Staff were invited to participate in the annual staff survey. Staff were not surveyed in 2018 or 2019 due to the change management programmes that were being implemented and the financial issues experienced. A further survey was planned for 2020 to focus on staff engagement and well-being.

Following a formal consultation with all care nursing and health care assistant staff, changes to shift patterns were piloted to provide safe cover 24 hours a day. Following a successful pilot and positive staff feedback, the new rotas were to continue.

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

The service had established links with local universities and offered regular placements at the hospice for nursing, physiotherapy and medical students. Feedback received from students identified that they had found this to be a positive experience, had been well supported by their mentors and had gained considerable clinical experience.

Acorns group was a registered charity and fund raising was crucial to enable the service to continue to provide care to children and young people. The hospice had arranged a variety of fundraising activities. These included whole family events such as a “bubble run”. Families and staff participated in a day of “foamy fundraising” and ran, jogged or walked through colourful bubble stations along a five kilometre route. Staff and families, we spoke to told us how much they had enjoyed this activity. Opportunities were available for corporate fundraising as well as smaller events. During our inspection we financial donations delivered to the hospice following a local fundraising event.

Acorns hospice produced a group magazine for children, young people and their families. This included information about fundraising events and activities. The service had also launched a 360-degree virtual reality tour to provide an introduction to the facilities for potential service users and professionals.

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

Learning, continuous improvement and innovation

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

Good ●

Hospice services for children

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

Managers and educators were working with the sepsis trust to develop an assessment tool that was more appropriate for children with palliative care needs as this does not currently exist.

The clinical educator was to attend a sepsis train the trainer course in January 2020.

The service had won a Diversity Award for the last 5 years due work in supporting equality and inclusion for all.

In 2018 the service was the winner of the Downtown Business Social Media Presence of the year.

In 2018 the service was the winner of the Great Birmingham Chamber of Commerce; Excellence in Contributing to the Community.

In 2018 the service was a finalist in the Birmingham Post Business Award. The service was a finalist for best not for profit organisation of the year 2018.

The service had achieved the UNICEF - Rights Respecting Award (Rights of the Child) and was working towards the bronze award.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should have a consultant medical director with oversight at executive level.
- The provider should ensure all staff are aware of feedback and learning from incidents. (Regulation 17 (2)(a))
- The provider should ensure all staff have an annual appraisal. (Regulation 18 (2)(a))
- The provider should ensure that all audit processes are robust and actions are identified to improve performance. (Regulation 17 (2)(a)
- The provider should ensure all staff received feedback from complaints. (Regulation 17 (2)(a)
- The provider should ensure audit data is included in team meeting minutes. (Regulation 17 (2)(a))