

Marie Curie

# Marie Curie Nursing and Domiciliary Care Service North West Region

## Inspection report

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## Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

# Summary of findings

## Overall summary

The inspection of Marie Curie Nursing and Domiciliary Care Services was announced and was carried out between 7 and 23 March 2017. This was the first inspection of this location following changes to the provider's registration. However, the service had been operating for several years and had previously been registered at a national level.

The service specialises in providing nursing and personal care to people living with terminal illnesses and life limiting conditions in their own homes. At the time of our inspection services were being provided to approximately 80 people across the North West region.

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

Everyone we spoke with told us they felt the service was safe. Relatives told us they had confidence in the service and felt their relatives were safe and secure with Marie Curie staff. Staff were trained to recognise and report any concerns about people's safety and welfare. All the required checks were done before new staff started work which helped to protect people from the risk of receiving care and support from staff unsuitable to work in a care setting. Newly appointed staff undertook a full programme of induction training and worked with more experienced colleagues until they were assessed as competent to work alone.

Risks to people's health, safety and welfare were identified and managed. The majority of the services provided were delivered overnight and there were clear procedures for staff to follow in the event of an incident, accident or emergency.

Where appropriate, people were supported safely with medicines.

People's consent was always obtained before any care or treatment was delivered. People were involved in decisions about their care and treatment and staff supported them in the least restrictive way possible. The policies and procedures in the service supported this practice.

People were supported by a team of staff who were trained and supported to understand and meet their needs. People were very complimentary about the staff and in addition to expressing confidence in their ability to provide safe and appropriate care, they described them as always being caring and compassionate. Relatives told us the service had been invaluable to them by providing the support they needed to fulfil people's wish to spend their last days of life in the comfort of their own home. People's privacy and dignity was respected.

People's needs were assessed and information about their needs and preferences was recorded. Relatives

told us staff were always attentive to people's individual needs and preferences.

People were given information about the service which explained how the service worked, what they should expect and what they should do if they had any concerns. We found people did not have any complaints or concerns about the service. There were systems in place for dealing with concerns and complaints and concerns. All concerns and complaints were dealt with and were seen as an opportunity to improve the service.

The services provided by Marie Curie in the North West were delivered as part of a package of care and therefore working with other agencies and professionals was an integral part of how the service was delivered. For example, in the case of the planned overnight packages of care the service worked with district nursing teams and the rapid response teams worked in conjunction with a local hospice and NHS hospital.

Staff had limited involvement in supporting people with eating and drinking. However, there was evidence staff were attentive to supporting people with drinks and to ensuring their comfort by carrying out mouth care.

The culture of the service was open and transparent. Everyone involved with the service was encouraged to share their views and have a say in how the service developed and improved. The management team were continuously focussed on improving the experiences of people who used the service.

There were effective systems in place to monitor and assess the quality and safety of the services provided.

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

We always ask the following five questions of services.

### Is the service safe?

Good ●

The service was safe.

There were systems in place to protect people from the risk of abuse. Staff were trained to recognise and report any concerns about people's safety and welfare.

The recruitment procedures were robust and helped to make sure only staff suitable to work with vulnerable people were employed.

Risks to people's health, safety and welfare were identified and managed.

Where it was part of the agreed package of care people received appropriate support with their medicines.

### Is the service effective?

Good ●

The service was effective.

The service provided very effective care and treatment that supported people at the end of their lives to remain at home.

The service worked closely with other professionals to ensure people received high standards of co-ordinated health care.

People received care, treatment and support from staff that were trained and supported to understand and meet their needs.

People's consent to care and treatment was always obtained before any care, treatment or support was delivered.

### Is the service caring?

Good ●

The service was caring.

Relatives and carers of people who used the service were very complimentary about the caring and compassionate way in which care and support was delivered.

People told us the support they received from the service meant

their relatives were able to spend their last days of life in the comfort of their own homes.

People, relatives and carers were fully involved in all decisions about care and their personal preferences were respected. People's privacy, dignity and autonomy was at the centre of every aspect of the service.

### **Is the service responsive?**

**Good** ●

The service was responsive.

People's needs were assessed and information about their needs and preferences was recorded. Staff were allocated on a daily basis and were matched to people's individual needs. Relatives told us staff were attentive to people's individual needs and preferences.

People were given information about how to raise a concern or make a complaint. Concerns and complaints were taken seriously and viewed as opportunities to improve the service.

### **Is the service well-led?**

**Good** ●

The service was well led.

There was a clearly defined management structure. The management team understood their roles and responsibilities.

There was an open and transparent culture and a commitment to continuously improving the experiences of people who used the service.

People who used the service, their representatives and staff were encouraged to share their views and contribute to the continuous development and improvement of the service.

There were well established systems and processes in place to monitor and assess the quality and safety of the services provided.

# Marie Curie Nursing and Domiciliary Care Service North West Region

## **Detailed findings**

### **Background to this inspection**

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

The inspection started on 7 March 2017 and was announced at short notice. The inspection was announced because we needed to make sure there would be someone available at the office. On 8 March 2017 we visited the regional office again and we visited four people at home by prior arrangement accompanied by a senior nurse from the service. On 23 March 2017 we carried out telephone interviews with relatives of 12 people who used the service. The inspection was carried out by one adult social care inspector with the support of a bank inspector on 8 March 2017.

During the inspection we spoke with the registered manager, regional manager and five clinical nurse managers. We looked at a range of records relating to the operation and management of the service which included people's care records, staff records, meeting notes and audit reports.

Before the inspection we reviewed the information we hold about the service which included notifications submitted by the registered manager. We contacted ten commissioners (Clinical Commissioning Groups) to ask for their views of the service. The provider completed a Provider Information Return (PIR); this is a form which gives the provider the opportunity to tell us about their service and any planned improvements. We took account of all this information when reaching our judgements.

## Is the service safe?

### Our findings

People using the service told us their carers provided support in a way which made them feel safe. One person said, "I relax when my carer comes, I know I am in safe hands and it means my [relative] can get a good night's sleep."

People's relatives also told us they felt the service was safe. One relative said, "[They are] very good indeed and very pleasant and nice to have in the house, I feel safe with them."

All staff were required to complete mandatory safeguarding training of adults and children which incorporated mental capacity. The regional management team had also undertaken more advanced safeguarding training. There was a corporate national lead for policy and within the region there was a standard operating policy for dealing with safeguarding matters. Notifications were made to CQC (Care Quality Commission) about any safeguarding concerns. The registered manager told us the region had carried out a local safeguarding audit last year. The audit had focussed on staff understanding of safeguarding and their views on the e-learning training. One of the findings was that staff felt they would benefit from more face to face training where they could discuss scenarios they might encounter in their day to day work. At the time of our inspection the service was developing an action plan to address this.

The provider had national policies dealing with whistle blowing, bullying and harassment and staff grievances. The provider was in the process of recruiting 'Freedom to speak guardians' and was re launching the anti-bully champions initiative to provide staff with informal, confidential support.

This demonstrated the provider had suitable arrangements to protect people from abuse and to reduce the risk of any abuse which did take place being undetected.

The provider had robust recruitment procedures in place which also helped to protect people. Records showed all the required checks were carried out before new staff started work. This included two written references and DBS (Disclosure and Barring Service) checks. DBS checks are done to make sure prospective employees do not have a criminal conviction which would make them unsuitable to work with vulnerable people.

The provider had clear disciplinary procedures in place. During the inspection we saw examples of how these procedures had been used when staff performance or behaviour fell short of the required standards. This helped to ensure people experience safe and appropriate care.

The registered manager told us sufficient staff were employed to meet operational requirements and recruitment was on-going. They told us sickness levels had impacted on the service and there had been occasions when it had been necessary to cancel a planned visit or change the date. The allocation of staff was done by the referral centre and the clinical nurse managers told us they worked closely with the centre to make sure the correct staffing levels were put on the rotas. In addition, the provider was running two pilot schemes to look at different local coordination models for staffing. This work had not been completed at the

time of our inspection.

The numbers and skill mix of staff was determined by the contract service level agreement for each service. The majority of the planned overnight service was delivered by health care assistants and this group made up approximately 90% of the workforce. Staffing was monitored closely and the service submitted monthly reports to commissioners within the Clinical Commissioning Groups (CCGs) showing the number of people seen and the staff skill mix. Shortfalls, where Marie Curie Nursing Services (MCNS) had not been able to provide a service and the reasons for this were also monitored and reported on a monthly basis. Staff working in the planned overnight service were home based and required to work within a 25 mile radius. They were paid travel time and mileage from their home to the home of the person they were supporting.

The provider had lone working policies and procedures in place. There was a monitoring system in place whereby staff logged in when they left home and again when they arrived at the home of the person they were supporting. This procedure was reversed in the morning. The clinical nurse managers would be alerted if a member of staff failed to log in as expected. At the time of our inspection this system was not being used to monitor missed calls. The service relied on people who used the service and/or the case management team reporting missed calls. Missed calls were monitored and dealt with by way of the complaints procedures and if appropriate staff disciplinary procedures. The service had a low rate of missed calls.

Whilst care requirements and associated risk assessments were carried out by the district nursing service we saw carer staff recorded how they had participated in a risk aware manner. For example, we saw one person had bed-rails attached to their bed. Records described how the person had tried to climb over the bed-rail with the carer staff's response being to lower the rail and sit with the person until they fell asleep. We saw where the district nurse had identified tissue damage as a risk carer staff had ensured people were regularly repositioned and washed where necessary. Of the four people we saw, all spent most of each day in bed and had done so for a number of weeks. We found no evidence of tissue damage.

The registered manager told us all staff were trained and expected to carry out a dynamic risk assessment at each visit and escalate any concerns to a manager. Out of hours support for any management issues was provided by MCNS. Out of hours clinical support was provided by the local CCG.

Within the service managed by MCNS a full set of risk assessments were carried out by Marie Curie staff. They included risks associated with the environment, people's health and welfare such as the risk of falls.

The provider had a national policy for reporting and managing untoward incidents. Staff were required to record and report all accidents and incidents which were then logged on a national database. Accidents and incidents were analysed and reviewed at governance meetings. Where appropriate, action was taken to reduce the risk of recurrence.

The region maintained a risk register and there was a business contingency plan which was tested at specified intervals and in response to untoward events. For example, the plan had been reviewed and updated following the flooding of a hospice in the region last winter.

The majority of people we spoke with told us Marie Curie staff did not support them with their medicines. However, we did speak with one person whose partner received support with medicines and they told us, "[They are] very meticulous about checking medicines and filling in the medicine charts."

When we visited people at home we saw they self-medicated their regular prescribed medicines or received

'as necessary' (PRN) intra-muscular medicines from the district nursing service. People told us when they required additional pain relief through the night the carer would contact the Gold Line service. The Gold Line is a single point of contact for people or carer staff acting on their behalf. They can access help and advice 24 hours a day, 7 days a week. Care delivery records showed where this service had been accessed and actions of care staff to support people until professional help arrived.

The registered manager told us all staff were required to attend medicines management training for their role and follow the national policy and local standard operating procedures which were supported by the local clinical teams policies. Staff were required to follow care plans and medication sheets within people's records, usually provided by the district nurses. All staff were given a nursing handbook to carry with them which provided clinical information and advice.

There were infection prevention and control policies and procedures in place. All staff had tablet computers which meant they had easy access to infection control policies and procedures. Staff were provided with protective equipment to carry out their roles. The provider had a national infection control and prevention lead and the region had an infection control link nurse who provided staff with advice, training and updates from the national team.

## Is the service effective?

### Our findings

People spoke very positively about the support they received from staff and told us they were confident the staff were well trained. One relative told us, "The care my [relative] gets is excellent. The staff know what they are doing and without them we would be lost".

This was echoed in feedback the provider had received from people who used the service. One relative had commented, 'Their [staff] support, knowledge, experience, wisdom and sense of humour helped us during a very difficult time.' Another relative commented, 'We felt very secure and safe knowing he was in safe hands.'

Newly recruited staff received corporate and role specific induction training to prepare them for working in the service. This consisted of classroom based and e-learning training, undertaking mandatory courses, completion of a workbook and shadow shift(s) with set objectives. Staff were provided with handbooks which set out the service's key policies and the standards and conduct expected of them as employees. Staff were provided with tablet computers which meant they could access e-learning and the provider's policies and procedures at any time.

Staff completed training every two to three years in safe working practices including moving and handling, infection control, basic life support, oxygen therapy and the use of syringe pumps. This training was closely monitored and the service consistently achieved a compliance rate of 90% and above.

All staff had intranet access to a wide range of training topics offered through an e-learning programme. Where applicable, on-line training was linked to relevant policies, included tests or assessments and was certificated. Support from 'digital daffodils' (technology super users) was provided to staff if needed.

The registered manager told us the region had been without a practice development facilitator for some time and this had limited the amount of training and development opportunities available to staff. However, at the time of our inspection the post had been filled and the registered manager was confident that going forward staff would have more opportunities for training and development. For example, they told us the practice development facilitator had started to roll out 'Sage and Thyme' training which focussed on supporting staff in developing communication skills with people who were distressed.

Training in leadership, management and coaching skills was made available to staff in senior positions. Health care assistants were given opportunities through the provider's development programme to achieve qualifications in end of life care and health and social care.

The registered manager told us clinical supervision was no longer mandatory but staff were expected to attend a minimum of three clinical forums a year. Staff had opportunities to access support by means of face to face group meetings and individual meetings with their line manager. The managers within the service provided each other with supervision and support and used various methods such as action learning sets to facilitate this.

Annual appraisals were carried out and themes from appraisals were considered in the governance meetings and in the planning of future training. There were processes in place to support qualified nurses with the revalidation process which they were required to undertake to maintain the Nursing and Midwifery Council(NMC) registration.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

All staff were trained in the implications of the MCA and guided by the provider's policies on consent, mental capacity and advanced decisions on future treatment. Staff were instructed to empower people and their relatives to direct how their care and treatment was given and to gain and document consent wherever this was possible. Where the service worked in partnership with other care providers, jointly agreed care documentation prompted staff to check decision-making arrangements. This included whether the referral had been made with the person's consent, if lasting power of attorney arrangements were in place and obtaining consent to the care plan.

People's consent was sought by staff before any support was provided. Records of care delivery showed people were asked before any care was delivered. We asked one person if consent was gained before care was given and they answered, "Yes they are always asking, they even ask if I have said yes the night before." Records in relation to Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) were completed to a high standard, with the person's knowledge, participation and agreement.

The provider had a nutrition policy in place. The majority of the services provided were overnight care which meant staff had limited involvement in supporting people to eat and drink. Where appropriate, people's care records included information about special dietary needs; for example, thickened fluids or Percutaneous Endoscopic Gastrostomy (PEG) feeds. Within the care records we saw evidence staff encouraged people to drink when they were awake during the night. One person told us staff always made sure their partner had a drink within reach before they left in the morning. They said, "They always leave [person's name] with a drink nearby so they are not left waiting for me to come and give them a drink."

The service worked closely with other health care professionals to provide people with the support they needed to be cared for at home at the end of their lives. People and their relatives consistently remarked about the high level of effective communication between the district nursing service and the Marie Curie service. People said they knew two weeks in advance of when overnight support would be provided. They told us the service was reliable with the carer telephoning to confirm overnight support an hour before the period commenced. Relatives also commented about the reactive service provided. The reactive service is supplementary to the planned service and is designed to give additional support at times of high need. One relative said how they were concerned about their relative's condition one day. The district nurse told them they would arrange additional support which they did. The relative described the service as, "truly amazing."

We received feedback from one commissioner of the MCNS. They told us, 'My experience with Marie Curie has been an extremely positive one. I have an excellent relationship with the service manager and when required she is able to ensure that we have cover for patients, clinically assessed as a priority at short notice. Therefore, this is a very responsive service and is well led. This service places the patient at the centre of service delivery. Also, the requirement to support the both the patient and the families at this very emotional and stressful time. Any complaints/issues are dealt with in a timely manner and the outcomes are

communicated to me as the clinical manager, with the responsibility for the Marie Curie contract."

## Is the service caring?

### Our findings

Everyone we spoke with was very complimentary about the service and the caring nature of staff. One relative said, "I am always impressed with the carers; we are very grateful for these people who are second to none." Another relative said, "I can't fault them, they always ring and always arrive on time, we are very happy with the service, they know what they are doing."

Relatives told us how much they appreciated the service. They told us how getting a good night's sleep helped them to continue providing their relatives care at home. One person said, "[It is] a fantastic service, makes my life so much easier, I can go home and switch off knowing [relative's name] is getting first class care." Another relative said, "[They are] absolutely wonderful, I can rest and relax and get a proper night's sleep. [Relatives name] loves having them. They always leave a note if anything has happening during the night and that is very helpful to me. They are very, very caring." A third relative said, "[They are] my angels, I feel so much better since I have been able to get a good night's sleep knowing [relatives name] is in good hands. I hear them talking to him during the night, wonderful."

We saw similarly positive feedback had been received by the provider. One relative had commented, 'I was worried he might die and no one would be there, I could sleep knowing he wasn't alone.' Another relative commented, 'Special thanks to the MC nurses overnight, without them I don't know whether we would have coped.'

The provider told us people were sent an information pack before any visits were carried out. The pack contained information about the service, what people should expect and information about other advisory and support services. The people we spoke with confirmed they had been provided with written information about the service and told us they were happy with how staff communicated with them.

The provider told us the majority of the services they delivered were overnight care over a nine hour period to people in their own homes. They told us this gave staff (nurses and health care assistants) an ideal opportunity to provide 'patient centred' care which was not rushed and which was focused on supporting the person and their family.

People and relatives we spoke with told us they were fully involved in all decisions about care and their personal preferences were respected. A relative said, "[They are] absolutely lovely, perfect on everything. I can rest a bit easier knowing they are there. [Relative] feels safe with them, they write a report hour by hour and I know if anything did happen they would call me during the night."

The expected standards of caring for people with dignity and respect were reinforced through the provider's policies, training and materials provided for staff to refer to. The health care assistants were expected to follow the provider's code of conduct and registered nurses to follow the standards set out in their NMC (Nursing and Midwifery Council) code of conduct.

All people we spoke with commented upon the manner of care delivery with many describing carer staff as

being passionate about their role in supporting people. As part of our inspection we visited people in their homes in the company of a senior nurse. We witnessed the nurse establishing an immediate and compassionate relationship with each person. Our observations of the discussion between the nurse and people gave us great confidence the service was led by staff with significant empathy and understanding.

Information about people's individual needs and preferences was gathered at the time of referral by staff working in the referral centre. This information was used to match staff to people's individual needs thereby ensuring staff had the right skills to provide safe and appropriate care and support. Senior nursing staff carried out observational assessments of staff while on duty to check they were working to the required standards. The service always obtained permission from people using the service before these visits but staff were not always given prior notice.

In addition the provider used telephone calls and feedback from complaints and compliments to monitor the quality of the service and check people were always treated with respect and dignity.

The planned overnight services were delivered across a large geographical area and the provider worked with a number of different CCGs (Clinical Commissioning Groups). Staff working in this part of the service followed documentation in people's homes provided by the local key workers, usually the district nurses. The documentation included risk assessments, care plans, DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) forms and any other relevant information. If people's needs changed urgently during the night staff followed agreed local procedures. For example, if a person needed additional pain relief the Marie Curie staff contacted the on call district nursing service. Similarly there were clear guidelines for staff to follow if the person appeared to be in the last hours of life and if the person died during the night.

We spoke with the registered manager about the Equality Act 2010 and in particular how the service ensured people were not treated unfairly because of any characteristics that are protected under the legislation. We spoke about the protected characteristics of disability, race, religion and sexual orientation. Our discussion demonstrated the manager had a thorough understanding of how they needed to act to ensure discrimination was not a feature of the service.

The ethnic profile of people who used the service was recorded and monitored by the service and the CCGs who commissioned the service. The provider was looking at ways to increase the uptake of the service across the wider community. We saw an example of this whereby staff working within the region had developed a local initiative to raise awareness of the service among ethnic communities in Manchester. They had made changes to the services information leaflet, simplifying the text for people whose first language was not English and changing some of the photographs to represent families from ethnic communities. Staff had attended meetings in Kurdish, Sikh, Islamic and Afro Caribbean community centres to raise people's awareness of the services available to them. The registered manager told us it was early days but they had already started to see an increase in referrals from ethnic communities.

The provider also operated a befriending and volunteer support service. Although this was not part of the service regulated by CQC (Care Quality Commission) it provided an additional resource. Staff working within MCNS were able to refer people they felt might benefit from additional support.

## Is the service responsive?

### Our findings

MCNS in the North West provided three different types of service. The majority of the services delivered were nine hour overnight packages of care to people living in their own homes. The primary focus of this service was to support the relatives and carers of people receiving end of life care and care for life limiting conditions. We saw MCNS provided much needed respite to carers and relatives which in turn supported and enabled them to carry on caring for their loved ones at home.

MCNS provided a local rapid response service. This service was delivered in conjunction with the local hospice and community health care professionals. The rapid response team provided telephone support and if needed visited people at home to deliver additional care or treatment. The main focus of this service was to provide the right support to people who had expressed a wish to spend their last days of life at home. The rapid response team also supported staff working in the community by verifying expected deaths.

The third aspect of the service was another local initiative whereby MCNS managed end of life care in conjunction with the local CCG. The main difference with this part of the service was that MCNS carried out the assessments, developed the packages of care and allocated staff to deliver the service. As in other areas, the services provided by MCNS were mainly overnight packages of care with day care packages being delivered by a carers (relatives/friends of people using services) trust.

Referrals to the planned overnight service were received by a national referral centre. Referrals were received from community health care professionals, usually district nurses. The referral centre gathered information relating to people's demographics, needs and risk assessments, care requirements and preferences. This information was given to staff on the daily allocation of care which was also done by the referral centre. If there were particular requirements or risks the clinical nurse managers would be alerted and they would discuss them with staff before the visit.

People and their families told us they were involved in making decisions about future care provision. One relative told us their relative was very independent and had a strong desire to die at home. They told us without the support from the Marie Curie team that would not be possible. People and their relatives told us at the beginning of each period of overnight support the care staff asked about the person's day and whether any aspect of care need had changed. One person said, "They never presume they know what I want, even if they came the night before."

In the majority of cases the care plans were written by the district nursing service. The records we reviewed contained the necessary plans which clearly outlined people's wishes for end of life care. Records of care delivery carried out by the Marie Curie carer staff showed people's wishes were being respected. For example, one person had requested their main need was to have access to fluids and to be kept comfortable in bed. We saw records of encouragement to drink and regular attention to positioning in bed. Delivery of care was recorded at the time rather than at the end of a period of duty.

A relative told us their relative was supported to access the care most appropriate to their needs. They had

recently been in hospital for respite care and without the package of care being given they would have found it difficult to return home. The relative described the overnight service as being of equal benefit to the person and the family. This was a view shared by other people. Another relative told us, "Last night [name of care worker] was a God send, they were really attentive, provided mouth care all night and they assured us they would contact us if anything changed which meant we were able to get some rest." Another relative in feedback to the provider commented, 'You (MCNS) were very observant to [relatives] needs and this was very reassuring.'

People we spoke with did not have any concerns or complaints about the service. The expression 'can't fault them' was used by almost everyone we spoke with. People told us the only thing that could make the service better would be if it was available seven nights a week. This was not within the provider's control as the level of service was determined by the contract they had with each CCG.

All concerns were treated formally, fully investigated and recorded. In the case of serious complaints a root cause analysis was carried out to identify future learning and help prevent a recurrence.

Complaints and feedback were received in a variety of ways and people who used the service were made aware of by means of the 'patient handbook' and a feedback leaflet. Within the North West service the local team had carried out telephone follow up calls and postal surveys to encourage further feedback regarding the care received.

A national patient and carer feedback report was produced by the provider's quality team using the 'Friends and Family' test (The number of people who would recommend the service), the Marie Curie website and telephone and paper survey responses. The report included a 'You said, We did' section and a section reviewing themes nationally. This was looked at within the local governance meetings to identify themes, learning and any action needed, for example, staff training.

The organisation had a duty of candour policy and staff were provided with training on this. This showed people were supported to raise any concerns about the service and their feedback was taken seriously and acted on.

## Is the service well-led?

### Our findings

The registered manager who had managed the service for several years had recently moved to take on the role of registered manager for the Marie Curie in-patient hospice service in Bradford. At the time of our inspection they were the registered manager for both services. The regional manager was also present during the inspection; they had taken over the day to day running of the MCNS and were in the process of applying for registration with the CQC.

There was a clearly defined management structure and at the time of inspection the management team for the North West was fully staffed. The registered manager was supported by clinical nurse managers, senior nurses, service managers and regional office administrators. The operational management team was supported by national teams, for example the Human Resources, quality and business teams. The clinical nurse managers and senior nurses were all qualified nurses with experience in palliative care.

There were well established lines of communication at national and regional level to help facilitate the flow of information between management and staff. The registered manager attended divisional meetings and from this information was cascaded to the regional management team. The regional management team held bi-monthly meetings to cascade and share information. The clinical nurse managers had a monthly meeting with time set aside for peer supervision, support and learning. Senior nurses attended network meetings where the topics covered included ways to support staff with training and development. Clinical forums and staff meetings were held within the local areas and combined the cascading of information with opportunities for support, reflection and learning.

The provider's strategic plan and values had been cascaded to staff and formed part of the discussions in team meeting and staff forums. There was a regional staff forum and representatives from this group attended a national staff forum. This helped to ensure the flow of information within the organisation was a two way process and gave staff an opportunity to contribute to the development of the service. In addition staff views were obtained through an annual survey.

The provider had a national governance structure and governance meetings were held within the region. The governance groups looked at monitoring standards of quality and safety and ways to improve the service. The region followed a national and local audit plan, audit findings were reviewed and actions plans were agreed and reviewed by the governance group. In addition the service provided quarterly quality report to the commissioners (CCGs).

The management team worked to performance targets which were set nationally. These were monitored by means of monthly reports and action plans to address any required improvements. We saw the action plans showed who was responsible for implementation, had timescales for completion and progress updates were recorded.

The provider obtained feedback from people who used the service in a variety of ways. The information pack given to people who used the service included information about how to comment on the service. This

information was also available on the provider's website. For example, people could telephone the support line, use the on-line chat service or complete a survey on-line. Any concerns or reports of negative experiences were passed to a member of management team for immediate follow up. The registered manager told us they were working with local CCGs to look at ways of improving local feedback.

In addition the service used telephone and postal surveys. For example, in December 2016 over 300 surveys had been sent to people who had accessed the service in the preceding eight months. The results of this survey were being collated at the time of our inspection.

Incidents, complaints and compliments were monitored and reported on weekly and this was monitored by the central quality team.

At corporate level the quality team produced a 'Patient and Carer Experience Report'. This covered all the provider's services and showed the results at both national and local level. The report was based on feedback from the Friends and Family Test, postal, telephone and on line surveys. The report showed a high level of satisfaction with the services provided and included comments from people who had experienced the service. One person had commented, 'The lady who came to support my Dad during his partner's final days was incredible. I only wish every family going through this terrible ordeal had access to a Marie Curie Nurse. Thank you.' Another person had commented, 'After quite a few days and nights caring the Marie Curie night nurse just gave me the respite I needed to deal with my mother dying on the following days. It is an excellent and very valuable service.'

The provider also had an 'Expert Voices' group. The group was made up of volunteers who had experience of living with or caring for someone with a terminal illness. They donated their time, knowledge and experience to help Marie Curie improve future care and were involved in variety of roles. For example, in the January 2017 'Patient and Carer Experience Report' we saw one member of the Expert Voices group had spoken at the providers marketing and communications department meeting and another had represented Marie Curie at the National Voices annual conference.

Throughout the inspection we found management and staff were open and transparent about the service. We were assured the service had a strong culture of seeking to continuously improve the quality of care and support people experienced.

There were arrangements in place to help ensure the service kept up to date with current good practice. The managers and senior staff were linked to End of Life strategy groups and quality groups within their local areas. Information was cascaded through the local networks about good practice, research and up to date practice. National Institute of Clinical Excellence (NICE) guidance was reviewed and cascaded by the quality team within the organisation. The service was involved with Dying Matters (Dying Matters is a coalition of 32,000 members across England and Wales which aims to help people talk more openly about dying, death and bereavement, and to make plans for the end of life) events and going into schools. In addition there were links with local hospices for networking and sharing good practice. For example, MCNS staff had attending training on advanced care planning at a local hospice. Nationally the provider had links with the Royal College of Nursing (RCN) which meant they had access to their training and learning materials. The service had also participated in Dementia Friends awareness training and commissioned a company to put on a play for staff to help raise awareness of the challenges faced by people living with dementia. The provider also held an annual research conference for the sharing of good practice. This demonstrated the provider's commitment to the continuous improvement and development of the service.