Marie Curie

Marie Curie Nursing and Domiciliary Care Service, North East Region

Inspection report

Marie Curie Hospice
Marie Curie Drive
Newcastle Upon Tyne
Tyne And Wear
NE4 6SS

Tel: 01912191232
Website: www.mariecurie.org.uk

Date of inspection visit:
19 January 2017
20 January 2017
16 February 2017
28 February 2017

Date of publication:
27 April 2017

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 took place from 19 January to 28 February 2017 and was announced. Marie Curie Nursing and Domiciliary Care Service, North East Region is a well-established service that has previously been registered at a national level. In April 2016 the service was registered as a separate location and this was the first inspection.

The service specialises in providing nursing and personal care to people living with terminal illnesses in their own homes. At the time of our inspection services were being provided to 130 people across the North East 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.

We found the service was very effective in meeting its' aim of enabling people to be cared for at home at the end of their lives. Relatives we contacted spoke highly of the standards of care and treatment provided and their confidence in the staff. They described the service as being "outstanding in every way", "absolutely superb" and providing "brilliant support". Feedback received by the service and commissioners reflected these positive views, with many relatives wishing they had known about and been able to use the service sooner.

A range of planned and reactive services were provided by skilled and experienced nurses and healthcare assistants. The staff were proactively supported to develop their learning in line with current best practice and the needs of the people they cared for. A variety of methods were used to ensure staff were appropriately supervised, had their performance and clinical skills reviewed, and were competent in their roles.

Nurses contributed to accredited initiatives, delivered end of life training to other providers and were looking forward to supporting student nurses during their placements at the service. Very good links and joint working arrangements had been made with the NHS and other healthcare providers, promoting co-ordinated care for people.

The service equipped staff to understand the standards required of them and checked that they put person-centred care into practice. Staff were mindful of upholding people's rights to give their consent and direct how their care and support were given. Sufficient time was allowed for visits so that people's care was not rushed.

Relatives were consistent in their praise of the kindness and compassionate approach of the staff. They felt care was given very sensitively and that staff treated people with great dignity and respect. A relative, whose

family member had been cared for by the service, emphasised that, "The whole experience transformed my perspective of end of life care."

Many comments were received about relatives' appreciation of the comfort and emotional support that staff gave to families, including opportunities to rest and take breaks from their caring roles. The Marie Curie helper services were promoted to raise awareness of volunteers who could provide companionship and practical support.

Comprehensive information about the service, guidance and support on caring for people with terminal illnesses, and coping with bereavement was made available to people and their carers. People were encouraged to give their views and influence the service. Complaints were taken seriously and acted upon.

Care was taken to protect the safety and welfare of people using the service. Systems were in place to prevent risks and safeguard people from harm and abuse. There was enough staffing capacity to deliver the service and managers aimed to allocate regular staff for continuity, wherever possible. Support was provided with medicines by staff who were suitably trained.

Staff predominantly worked to care plans for people which had been devised by the district nursing service. Interim measures were taken to assess needs and risks when care documentation was not present or out of date. Good communication processes had also been implemented to provide staff with information about the care that people required.

Commissioners valued the different services provided and worked with managers to arrange care provision that was responsive to people's needs. They expressed satisfaction with the quality, performance and management of the services they contracted.

The service was well-managed and organised, with a structure that provided staff with leadership and support. Good governance arrangements were in place with clear lines of accountability and continuous measuring of the safety and effectiveness of the service provided. There was an open, inclusive culture where people's care experiences and standards of quality were actively monitored to further develop the service.

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.

Suitable systems had been established to safeguard people from harm and abuse.

Risks to personal safety were managed to ensure people received safe care and treatment.

There was sufficient staff employed to safely meet people's needs.

People received appropriate support, when necessary, with their prescribed 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 staff teams worked collaboratively with other professionals, ensuring people received high standards of co-ordinated health care.

Continuous learning, development and support enhanced staff skills and attributes in caring for people effectively.

The implications of mental capacity law were understood and put into practice to ensure people's rights were upheld.

Is the service caring?

Good

The service was caring.

Staff developed very caring and supportive relationships with people and their families.

Relatives told us the staff were very caring and respectful in their approaches and provided sensitive, dignified care.

People and their families were encouraged to give feedback about their care experiences to influence the way the service was run.

Support to people at the end of their lives was focused on their comfort and dignity.

Is the service responsive?

Good

The service was responsive.

The range of services made available was responsive to people's urgent and longer term needs.

Staff provided care and treatment as planned by the district nursing service. Relatives reported the service gave care which was tailored to the individual's needs.

People were informed about the complaints procedure and the service responded promptly to any concerns received.

Is the service well-led?

Good

The service was well-led.

Leadership and support was provided by an experienced registered manager and a clearly defined management structure.

There was an open culture and the service worked inclusively with people, their representatives, staff and stakeholders.

The safety and quality of the service were continuously monitored to ensure standards were maintained and improved.

Marie Curie Nursing and Domiciliary Care Service, North East 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 was 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.

Our visits to the service were announced and took place on 19 and 20 January 2017. We gave short notice that we would be coming as we needed to be sure that someone would be in at the office. Telephone calls were made to relatives and staff on 16 and 28 February 2017. The inspection was carried out by an adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

We gathered information during the inspection using different methods. We judged it was not appropriate for us to speak directly with people being cared for at the end of their lives and contacted four relatives of people who were using or had used the service, with their permission. We looked at feedback gathered by the service from October to December 2016 with findings from 119 relatives and people using the service about their care experiences. We talked with the registered manager, the divisional manager and ten of the service's office and community-based staff. We contacted commissioners of the service from eight Clinical Commissioning Groups. During our visits to the office we looked at a range of records relating to the operation and management of the service.

Good

Is the service safe?

Our findings

The relatives we talked with were happy with the staffing arrangements, felt the service was reliable and told us their family members were provided with safe, consistent support.

Staff were introduced to the provider's safeguarding and whistle-blowing (exposing poor practice) policies during their induction. Thereafter, they were required to complete on-line safeguarding training at least every three years, refreshing their knowledge about different forms of abuse and the reporting procedure. Some staff had also undertaken multi-agency safeguarding training provided by local authorities. The service did not permit staff to have any involvement in handling people's money or to accept gifts, to ensure professional boundaries were adhered to.

The staff we talked with understood the vulnerabilities of the people they supported and knew how to report any incidents of suspected abuse or poor practice. Allegations of abuse had been reported to the local safeguarding authorities, the Care Quality Commission (CQC) and, where applicable, were thoroughly investigated. We noted, however, that some complaints received by the service included elements which could constitute safeguarding concerns. We clarified with the registered manager that allegations of neglect or omissions in care, arising from planned visits to people using the service being missed, needed to be notified to the CQC.

People and their carers were given an information pack when their services started which informed them about the measures taken by the service to keep them safe, how to make complaints and give feedback. The registered manager agreed this could be further enhanced by providing information that would promote understanding of safeguarding and people's rights to be protected from abuse.

Recruitment records showed all necessary checks had been carried out before new staff started working at the service. Proof of identification, application forms and health details were obtained and candidates were interviewed. Checks with the Disclosure and Barring Service (DBS), of nurses' registrations and reference requests were outsourced to an employment screening service. DBS checks support safe recruitment decisions by providing information to employers about an applicant's criminal record and whether they have been barred from working with vulnerable adults and children. Although references were always taken up from the last employer, in some instances the second references were character-based and supplied by former colleagues. We also found that although a risk assessment was carried out when employing anyone with a criminal conviction, the registered manager was not made aware of, or involved in the rationale for this. These issues were highlighted with the registered manager to take forward with the provider's human resources and senior management.

The service employed qualified nurses and healthcare assistants (HCAs) who worked in teams covering geographical areas across the North East region. At the time of the inspection there were 61 nurses and 144 HCAs, including bank staff, who covered visits according to their roles and availability. Each team was led by a clinical nurse manager (CNM) and senior nurses who organised staff in line with prioritising people's needs and the type of service they required.

Referrals were suitably managed, including allocation to urgent visits and forward planning of longer term services with regular staff for continuity, wherever this was feasible. Established communication systems kept people and their families informed about visits and the staff who provided their care. A nationwide, tiered on-call system was operated outside of office hours for staff to access advice, support or to escalate any emergencies to management.

Requests for the service were made by healthcare professionals, such as district nurses, to a central team in the Marie Curie referral centre. Initial information was gathered at this stage about the person including an overview of any risk factors associated with their care and aids/equipment used. This was then passed onto CNMs and the allocated staff, who mainly worked to the care plans devised by district nurses. Where no, or insufficient, care planning information was available in the home environment, staff were trained to assess and make sure actions were taken to reduce identified risks. The examples of assessments we saw demonstrated risks had been properly addressed to keep people safe during their care delivery. Lone working and consideration of other possible hazards which could affect staff were also assessed to ensure their safety was maintained.

Commissioners told us they regularly received performance information from the service, including reports of untoward incidents and any safeguarding concerns. A commissioner described the service as being transparent in its' reporting practices and said they were informed of safety issues implicating other professionals and care services.

A 'duty of candour' policy had been introduced and disseminated to staff teams to raise their awareness. This duty requires providers to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong.

The duty of candour was built into the service's incident reporting system where accidents, untoward incidents, 'near misses', complaints and safeguarding issues were logged. We were shown evidence that incidents were thoroughly investigated, including a root cause analysis to aim to prevent reoccurrence.

A risk register was kept which was updated monthly to monitor potential risks to the safe operation of the service. The measures in place included reviewing staffing capacity, the extent of training undertaken and checking key performance indicators were being met. A business continuity plan ensured all aspects of the service could be managed remotely in the event of emergency circumstances.

The service provided people with varying degrees of support with their medicines. Wherever possible, minimal support was offered and self-management or relatives administering medicines was encouraged. Staff involved in the handling of medicines were given relevant training and had their competency assessed annually. This included the use of specialist equipment for medicines which were not administered orally.

Details of current medicines prescribed for the person were documented during the initial referral and any changes were usually updated by the district nurses in their records. We were told staff would always check the care plans and administration records, if provided, prior to giving support, and where necessary, query any changes in medicines regimes. The registered manager said any support provided was accounted for in the district nurses records. Staff confirmed this, explaining they recorded the process thoroughly with the reason for administration, the medicine, dosage and time given, and whether the desired effect was achieved. Although limited documentation was available for us to examine, we saw evidence in visit records that verified what staff had described. A relative also told us they left 'as required' medicines out overnight for staff to give, if needed, and that they were diligent in informing them about and recording any support given with medicines.

Good

Is the service effective?

Our findings

Relatives told us their family members were given, or had received extremely good care and treatment from the service. Their comments included, "We'd been let down (by other health care professionals). The GP contacted Marie Curie and they saved us. My father had horrendous symptoms which they overcame. They were all very well-trained and committed. The service really was outstanding in every way"; "They've been absolutely fantastic. I have every confidence in them and they understand [relative's] confusion"; "It's brilliant support. I've nothing but praise for them" and "Absolutely superb - right from the start when the rapid response team came. They arranged for an electric bed with a special mattress within days. Everything is done expertly."

Commissioners of the service informed us there was positive feedback about the service from patient and carer experience reports. One commissioner told us, "We have found the Marie Curie service to be responsive and effective. The feedback that the community nurses receive from the patients is that the Marie Curie carers are trained to be able to manage their needs."

The service's main aims were to enable people to be cared for at the end of their lives in their own homes, where this was their preference, and to prevent avoidable admissions to hospital. These aims were monitored, with the latest information from April to December 2016 demonstrating around 89% of people whose preferences were known had been supported to die in the place they preferred. Rapid response teams consistently met stated targets of attending people with urgent needs within an hour of referrals being triaged.

New staff were given 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. Training aligned to the Care Certificate, a standardised approach to training for new staff working in health and social care, was provided for healthcare assistants (HCAs). Staff were provided with handbooks which set out the service's key policies and the standards and conduct expected of them as employees. They were also equipped 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 current statistics were between 91% and 100% compliance. The service had facilities for delivering training, a library of reading materials and subscribed to health and social care journals to assist staff in keeping up to date with practice developments.

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. Training was also accessed from external sources, including courses on dementia awareness, defensible

documentation, and 'Sage and Thyme' (supporting staff to advance their communication skills with people who were distressed). Recent examples of training undertaken included a study day about Motor Neurone Disease and an interactive workshop on risk management.

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

The practice development facilitator told us, "The level of support for staff here is very good." They described how further training was planned with an emphasis on valuing staff and taking on board their ideas. This included training about specific medical conditions and building the resilience of staff. For example, the introduction of 'Schwartz rounds' which facilitated staff coming together to talk about the emotional challenges of caring for people. An action plan was also in progress following a 'care after death' audit to embed training in the provider's commitment to the five priorities for care of the dying person. The five priorities approach was developed by the Leadership Alliance for the Care of Dying People, which included representation from Marie Curie. The approach, 'One Chance to Get it Right', is focused on compassionate and individualised care in accordance with the needs and wishes of the person and those closest to them.

A delegated system ensured all managers and staff were appropriately supervised throughout the year. This took place in various forms through a series of individual face-to-face, by telephone and observational sessions, clinical supervision meetings and team briefings. The expectation was for all staff, including bank staff with other employment, to commit to participating in five sessions each year. We saw schedules were drawn up by the clinical nurse managers (CNMs) to meet these targets and attendance was monitored at monthly management meetings where staff performance was reviewed. A CNM explained that feedback from senior nurse surgeries had led to monitoring visits being introduced which encompassed on-site support for staff. Another CNM told us they felt these visits were proving to be productive and were appreciated by the staff.

Thorough assessments of clinical skills were carried out prior to annual appraisals. These addressed competency in areas including managing pain, nausea and vomiting, enteral feeding, suction techniques and non-invasive ventilation. Appraisals, 'my plan and review', measured the individual's success in meeting team and personal objectives and set out clear development plans. For example, developing a new skill through sourcing and attending a study day, reflecting on practice and applying learning by sharing their knowledge with other members of the team. We noted a HCA had received praise in the region's staff newsletter for their commitment to developing their skills and competence. Their portfolio of evidence had been used as an example of good practice and shared with new and existing staff.

Staff confirmed they were well supported in their personal development and had regular supervision with their managers. This included revalidation for qualified nurses to maintain their registrations with the Nursing and Midwifery Council. Comments from staff included, "Training is comprehensive and easy to access"; "I get clinical supervision and feel extremely well supported"; "We're a dynamic team" and "The training and support is really good. My manager is absolutely brilliant and I can ring them at any time if I have a problem."

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. The registered manager told us staff were not permitted to provide any care the person was reluctant to or refused to receive, unless a formal decision had been made in their best interests. Guidance and training on managing distressed and challenging behaviours was provided to prevent the need for any excessive control or use of restraint.

The service provided sensitive information to families about what to expect at the end of someone's life, including the potential for eating and drinking less and losing weight. People were given support with food and drinks and intake was monitored where this formed part of their planned care. The registered manager told us more staff were being trained in enteral feeding to address the demand for services where this was needed.

We found that services were provided by skilled and trained staff, with each person being designated nurses and HCAs according to the level of care and treatment they required. Close working relationships were routinely forged with district nurses and GPs to ensure people's health care was robustly co-ordinated. The service worked in collaboration with the NHS and other health and social care providers to ensure the needs of people receiving end of life care were effectively met.

A CNM and a senior nurse told us they were excited about the service being able to take on student nurses in the near future. Short term placements were planned, with one student per team and these were viewed as ideal opportunities to instil best practice in end of life care during the nurses' training.

A commissioner informed us that the service was fundamental to promoting best practice in end of life care in their area. They told us, "The staff attend the Gold Standard framework meetings and are seen as an integral part of the palliative and end of life services provided." The Gold Standard aims to improve the quality, co-ordination and outcomes of care for people at the end of their lives. Another commissioner described how the service was undertaking work with other providers as part of their contractual arrangement for meeting Commissioning for Quality and Innovation (CQUIN) targets. CQUIN encourages care providers to share and continually improve how care is delivered and make improvements in healthcare. This work entailed engaging with GP practices to increase the numbers of patients without cancer on the GP Palliative Care Registers and providing palliative care training into two local care homes.

Good

Is the service caring?

Our findings

Relatives spoke very highly of the caring approaches and relationships with the nurses and healthcare assistants (HCAs) who were providing, or had provided care to their family members. They told us, "We get the same carers and they're fantastic. We know whose coming and they'll often get here early"; "The same group of four to five HCAs visit, so we've got know one another. They are all gentle, patient and caring" and "My father is so well cared for. The staff are great, they engage with him and he says they make him feel special. My mother tells everyone we've been spoilt with this service."

Relatives told us the staff were equally caring towards the needs of the family, providing support and comfort which they greatly appreciated. Their comments included, "They talked privately with my mother and took away her fears" and "The support to the family has been 100%. They are kindness itself and go the extra mile to help."

A number of relatives highlighted how invaluable it was to them to have services which meant they were able to take a break from their own caring roles. A relative, whose family member received overnight care, said, "I'm confident in their abilities and it mean I can get a good night's sleep." A staff member told us, "I encourage relatives to rest and reassure them I'll wake them if needed." Rapid response services were held in high regard, with one relative telling us, "They've worked miracles" and "Members of the team called to check how the family was coping (when the service ended)." They also felt comforted by the knowledge that the team was, "There in the background, if we need them."

The registered manager stressed the importance of recruiting and retaining the right calibre of staff, with caring attitudes. They told us this was implemented through questions and scenarios during interview, designed to ascertain the applicant's communication, empathy and values. Training was given that equipped staff to understand person-centred care and recognise the diversity of people's needs. The staff handbook set out standards for working in people's homes, respecting privacy, dignity and the ways in which people preferred to be supported.

We were informed that staff would be changed on request, or if any concerns were raised about their conduct or communication. This was confirmed by a relative who said a change had been made promptly, with no fuss, when their family member for no specific reason did not get on well with one of the staff who visited.

All staff we spoke with were very caring and respectful when talking about their work and the people and families they supported. For instance, a HCA told us, "We always try to keep consistency with patients. We form relationships, especially if we're visiting over a period of months. I never forget that they're opening their homes up to us and handing over the care of their relative to a stranger, initially. I find out what they need from me at different stages and adapt the support as the person deteriorates." A clinical nurse manager (CNM) said, "Our nurses are very passionate about getting it right."

Due to the nature of the service, it was rarely possible for staff to be introduced in person before they started

working with people. Requests for male or female staff were honoured and the nurses and HCAs telephoned people's homes an hour in advance of visiting to introduce themselves. They also left cards at each visit with their names, roles and contact details for the Marie Curie information line that would deal with any queries.

Planned visits during the day were never less than three hours duration, to allow sufficient time for people to be cared for in an unhurried way. Services provided by the rapid response teams were managed flexibly and visits had no time limit. This was confirmed by a CNM leading one of the teams who said, "The staff stay as long as they are needed." Another staff member told us about occasions when they had telephoned earlier before their visits in order to build in time to offer support to a relative who needed to talk.

Staff were given direction on promoting privacy and dignity, balanced with the need to deliver care. For example, during overnight care where a person shared a bed with their partner, they sat outside the bedroom and maintained checks as unobtrusively as possible. A staff member confirmed this, saying, "Privacy and dignity are so important, especially when you're caring for one of a couple. You have to get the balance right between keeping out of the way, if that's what they want, and checking on the person discreetly." A relative confirmed, "The staff are not intrusive at all and respect our privacy."

Relatives reported that staff treated people gently, with great care and dignity. One relative said, "It really is dignified care they give. The staff will sit and hold his hand and chat away to him." Another relative told us, "They looked after my father with the utmost care and dignity and delivered his wishes to die comfortably at home. When he died, they carried out the last offices (care given to the deceased person) and were talking to him, still treating him as a person."

An extensive range of information was made available to people and their families about what they could expect from using the service. Each person was given contact details for the service, the Marie Curie support line and website and an information pack. The pack contained informative booklets about nursing care, being cared for at home and supplementary leaflets on urgent care provision provided into particular areas.

A number of publications on practical and psychological support, aimed at people living with a terminal illness, for family and friends, and coping with bereavement could be accessed through the website or provided by staff. Guides could be ordered in different formats and languages and work was being undertaken to produce the information in an accessible, audio form. The registered manager told us they were able to signpost people and their families to advocacy and other external support services. The provider also had a 'patient and family team' that could be contacted for bereavement support.

People and their families were encouraged to express their views about the support they received. This could be done through direct contact with the service, the provider's website and in feedback forms left in people's homes. The latest feedback findings showed the service was highly rated in terms of people's care experiences. This included treating people with dignity and respect, involving them in decisions about their care, providing qualitative information, support with pain and other symptoms, and providing emotional support. At times bespoke feedback was prepared for commissioners, such as in relation to services provided by one of the rapid response teams. This again showed very positive findings about the high quality practical nursing care and emotional support, with many comments being made about the caring and compassionate staff.

Commissioners of the service also gave us positive feedback. Their comments included, "The planned overnight care is a valued service and complements the care provided by community services" and "The majority of patient feedback received is excellent in relation to the level of care and their actual experience."

Good

Is the service responsive?

Our findings

Relatives described the service as being individualised to their family member's needs. They told us there was good two-way communication and confirmed that staff recorded all care given in the care plans provided by the district nursing service. A relative commented, "I inform the office if there are any changes in medication or treatment. They're always very helpful."

The staff we talked with felt that on occasions not enough information was made available to them in people's homes. For example, one staff member said, "Sometimes the moving and handling plans are not up to date." Staff told us they contacted district nurses/other professionals directly, if there was any uncertainty about people's care and treatment. They also confirmed their peers and managers were good at exchanging information regarding people's current needs. A staff member commented, "We're able to quickly communicate by email."

The registered manager acknowledged the provision of sufficient care documentation was an on-going issue which they continued to raise with commissioners in an attempt to resolve. Staff were encouraged to report any absence of information and were trained to carry out assessments as interim measures. Whilst limited records were available for us to examine, those seen demonstrated that staff were responsive in adapting the care they gave in order to meet people's changing needs. When 'core' care plans with standardised interventions were used, these had been personalised to the individual's needs and circumstances. Examples of visit records showed that staff documented all care and treatment they provided, any contact with other professionals, and reported on the person's welfare.

A clinical nurse manager (CNM) showed us the measures in place to overcome the difficulties of other professionals being responsible for providing people's care plans. These included trackers for monitoring services from referral stage through to discharge or death, with details of all contact with families, district nurses and other professionals. District nurse handover forms were used to ensure significant information about the person was passed onto staff. The service's nurses and HCAs provided handovers following their initial visits and thereafter reported any important changes in people's needs to CNMs. The CNMs and senior nurses' observations of staff checked that they provided personalised care and accurately completed care documentation. The monitoring visits conducted also involved obtaining feedback from people, their relatives and staff, and reviewing records to validate the care being provided.

A range of planned and reactive services were provided, dependent upon the commissioning arrangements of the localities across the North East region. The CNMs arranged visits according to the priority of referrals and staffing availability. At times of high demand, when it was necessary to adjust the staffing, people and relatives with longer term support were asked if they would agree to their visits being flexibly arranged. This enabled care services for people with urgent needs to be accommodated.

Commissioners told us they worked closely with the management in securing services that were responsive to the needs of people across the region. Their comments included, "Following a successful evaluation of the pilot rapid response service that they were delivering, we agreed to fund such a service and Marie Curie

were successful at procurement for this" and "I am pleased with the overnight service. This is reflected in the additional funding given and the move to a three year contract." A commissioner also told us about one of the service's that had been recognised as no longer being required. They said, "I am assured by the way the transition and service withdrawal is being managed jointly with ourselves to minimise the impact on patients and staff."

The service recognised the importance of preventing social isolation and wherever possible enabled families and informal carers to take breaks away from the home. Staff also promoted the local Marie Curie 'helper services' to people and their families. The helper services provide volunteers who befriend and provide companionship, emotional support and practical help.

The relatives we talked with had no concerns about the care their family members received or the service in general. People and their families were informed about the complaints procedure and any complaints raised were logged on a database and had been responded to. We were shown an example of a complaint that had been thoroughly investigated, including a detailed written response to the complainant and learning requirements made clear to the staff member involved. The outcome to another complaint was less clear and the registered manager gave us assurance this would be revisited with the investigating officer and complaints manager. They also confirmed changes were planned to the database which would identify where the nature of complaints prompted the safeguarding procedure to be invoked.

We saw complaints were subject to analysis and action was taken on emerging themes. The practice development facilitator took a proactive role in supporting and retraining staff, following any complaints implicating individuals or when disciplinary action was taken. A CNM told us all compliments and thanks received were shared with the staff teams to make sure they were made aware of positive feedback. Commissioners also told us the service routinely brought complaints and compliments to their attention. A commissioner commented, "I have no concerns with the Marie Curie service. I believe we communicate regularly so that issues can be addressed in a timely manner."

Good

Is the service well-led?

Our findings

The service's registered manager was an experienced, qualified nurse who had many years of working in and managing palliative and end of life care services. They were clear about their responsibilities and registration requirements and were well supported in their role. This included managerial support, clinical supervision, attending governance meetings with peers, a national clinical reference group and management meetings. The operation of the service was also assisted by human resources, information technology and finance teams, the practice development facilitator and administrative support.

A defined management structure supported the running of the service. Clinical nurse managers (CNMs) and senior nurses had devolved accountability for managing the services provided into each area across the North East region. The registered manager maintained close contact with the CNMs, including those who were not based within the service offices, to ensure they kept themselves fully appraised of all aspects of the service. They held monthly group and individual meetings with the CNMs to discuss operational and quality issues and supervise their practice. The registered manager also at times took part in daily teleconferences where the CNMs and senior nurses communicated with one another about the day to day operation of the service.

There was inclusive work with people, their relatives and staff that enabled them to influence the way the service was developed. Improvement leads at divisional and service levels led on methods of obtaining and analysing feedback about the service. Feedback from people and their families was consistently positive and was relayed to staff to ensure they felt appreciated and valued. The main theme arising from relatives' feedback was that they wished they had known about and been able to receive the service earlier. Action taken in response to this included further advertising and a senior nurse setting up a service promotion with district nurses, into nursing homes and during meetings with GPs.

The relatives we talked with told us they would or had already recommended the service to others. They praised the service, felt it was well-managed and could not think of any ways in which it could be improved. A relative told us they were so pleased with the service that they were planning to take part in fundraising during the forthcoming Marie Curie 'Great Daffodil Appeal'.

Staff told us they had opportunities to meet with their peers and managers, felt they were listened to and that suggestions for improvements were welcomed. Each of the staff we talked with had good morale, appeared motivated and were happy with the leadership and support they received. Their comments included, "It's a really good organisation, a pleasure to work for and very well-managed", "The group meetings are very important to me. I can't fault the support overall", "There is always someone we can contact by phone or email. We communicate well with one another" and "It's the most supportive team I've ever worked in."

During 2016, a national survey had been carried out with staff to get their views on engagement. The report specific to the responses from staff working in the service contained a number of highlights. These included 97% of the team believing a high quality service was delivered to people with terminal illnesses, their

families and carers and that their work gave them a feeling of personal achievement. An action plan for 2017 had been drafted to address those areas the service would continue and those that needed to be developed to further improve staff satisfaction.

We found the service responded well to the challenges of supporting and communicating with staff who worked remotely in the community. For example, nurses and healthcare assistants were provided with mobile telephones linked to 'CommuniCare', a system for logging their safe arrivals and departures to and from visits to people's homes. A CNM told us the service had flexible working policies and that they tried to accommodate individual requests, wherever possible, to enable staff to maintain a good work/life balance.

All staff were sent brochures to make them aware of new training courses and learning and development opportunities. 'Team briefs' cascaded national and regional updates, patient and carer feedback and learning lessons from local complaints, clinical issues and incidents. Trackers were also kept to ensure that staff were made aware of any revisions in the provider's policies and procedures.

An on-line survey had been conducted with staff to get their views about the frequency and content of meetings. Actions taken as a result included staff having more input into agendas and CNMs arranging guest speakers. In addition to regular meetings and supervisions, staff were issued with 'North News' newsletters, giving them updated information about services within the northern division. The latest edition included news of developments, planned work with the Newcastle hospice, and recognition of the contributions of staff in sharing best practice, delivering training, and fundraising in aid of the charity.

Celebration events had been held for each staff team, with awards for long service and small gifts being given to everyone. Marie Curie fundraisers had attended and photographs had been posted on social media. The events were well received, raised the profile of the service and events of a similar nature were being considered for the coming year.

A range of methods were used to assess and evaluate the quality of the service provided. Quarterly quality and safety reports were produced, based on a number of indicators that included patient experience, staff training, incidents, complaints, audits and actions taken in response. A programme of national clinical audits was planned each year. During 2017 these included audits of infection control, professional standards, and management of medicines and records. Information was routinely gathered to check the extent to which the service met people's preferences for being supported at home until death and prevented hospital admissions. Work was on-going within the service to look into the reasons behind why a minority of people had been admitted to hospital in order to learn lessons and, if necessary, improve practice.

A thorough internal compliance review had taken place in June 2016, led by the provider's quality assurance team. This had measured the service against the Care Quality Commission's (CQC) standards of quality and safety. The team had included the registered manager and CNMs, managers of other regional nursing and domiciliary care services, and a member of the Marie Curie 'Expert Voices Group', which represents the views of people and their carers.

A varied methodology had been used during the review to gather evidence, incorporating patient, carer, staff and stakeholder feedback, observations and analysis of incidents, complaints and training. We saw the review report detailed the team's findings, which were predominantly positive, and set out required and recommended actions for further developing the service. The registered manager had devised an action plan with each area of improvement that was updated on a monthly basis. The plan showed some remedial actions had been promptly completed, such as making clinical supervision accessible to a particular team

and reinforcing the safeguarding policy with staff. It was evident that progress with on-going issues was monitored, for example working with district nursing teams to reduce the incidence of missing or insufficient care documentation. The service was also looking towards community based staff having access to care information that was held electronically. A CNM told us, "This won't be a quick fix and will take time and the right technology."

The registered manager felt the service had benefitted from the review and told us efforts continued to be made in embedding the CQC standards into the service. CNMs and the registered manager had lead roles for collating and promoting best evidence in each of the five key question areas, to demonstrate the service was safe, effective, caring, responsive and well-led. The key questions were now also routinely built into meeting agendas to hold discussions and obtain the views of staff.

The service worked in partnership with Clinical Commissioning Groups, district nursing services and GPs. Joint working arrangements had also been developed with the NHS and hospice at home services which promoted the delivery of co-ordinated care to people with terminal illnesses.

Commissioners confirmed the management met regularly with them and supplied contract and quality performance reports in line with their contractual arrangements. They told us, "I find the registered manager for the service to be experienced in her field and responsive to any queries I raise. Likewise, I find the divisional business and service development manager responsive and helpful", "They are always well prepared for our meetings and provide us with detailed reports which have been adapted over time to provide more information" and "(At our last meeting) we were satisfied with their compliance with the various performance and quality measures we discussed."

We were informed that localised co-ordination was being piloted in one of the Marie Curie nursing and domiciliary care services in another region. A CNM said they felt this might prove to be beneficial in practical terms and in enhancing the quality of person-centred care. The registered manager's vision over the coming months was to implement more integrated work between staff in the service and the Marie Curie Newcastle hospice. A transformation programme was currently in progress across the provider's care services. The registered manager told us they would be supporting their teams in transitioning to any changes identified in the model of care and working practices for the nursing and domiciliary care service.