Marie Curie

Marie Curie Hospice Community Services South West Region

Inspection report

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Date of inspection visit: 20 October 2021 to 22 October 2021
Date of publication: 20/12/2021

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

Ratings

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

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as good because:

The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service

Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to keep as healthy as they could, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

Staff treated patients with compassion and kindness and always respected their privacy and dignity. Staff recognised and respected individual needs. Staff helped patients and their families to understand their conditions. There was a strong, visible person-centred culture and staff provided emotional support to patients, families and carers in every way they could. Patients emotional and social needs were highly valued by staff and embedded in their care and treatment. The service considered itself as caring for the patient and those close to them and created systems to support care in this way.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Leaders ran services well and strived to motivate staff to succeed in enhancing their skills and improving care they delivered. The service had invested in information systems to improve the standard of care provided to patients. Staff felt respected, supported and valued. Staff were proud to work for the service, and their team. Staff were clear about their roles and accountabilities. The service engaged well with patients, staff and the community to plan and manage services.

However:

All staff we spoke with were unsure of how to access translation services and documentation around whether a patient or carer had any communication / information needs required improvement.

The service could not be assured that all staff had read policies and standing operating procedures.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Good 	Our rating of this service stayed the same. We rated it as good. See the overall summary for details.

Summary of findings

Contents

Summary of this inspection

Background to Marie Curie Hospice Community Services South West Region

Marie Curie is a registered charity which provides end of life care via nine hospices and community nursing across the country. Marie Curie Nursing Service (South West) (shortened to "MCNS") is a registered provider of palliative and end of life care services to adults with terminal illnesses across the South West. There was 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.

Marie Curie Nurses and Health Care Assistants work night and day in people's homes across the South West, providing hands on care and emotional support. They support people living with a terminal illness to stay in the place where they would be most comfortable. The nurses work closely with local district nurses, GP's and hospice teams to give flexible, 24-hour care. The service provides; planned overnight care, planned day care (over 3 hours and short visits), care home support service, fast track continuing health care co-ordination service and bereavement services.

Marie Curie staff at this location carried out 56,194 visits in the year 2020 to 2021.

How we carried out this inspection

This inspection was undertaken on 20 – 22nd October 2021 and was announced. The provider was given one weeks' notice as the service was geographically large. Notice was given in order that people who used the service could be told of our visit and asked if they would be happy to talk with us. The inspection was carried out by two hospital inspectors and a specialist advisor.

During this inspection we spoke with four patients and two relatives in their own homes who were receiving care at the end of their lives. We contacted three commissioners of care for feedback about the service. We spoke with 26 staff, the registered manager and had a meeting with a member of the HR department. We reviewed six sets of patient records.

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

Outstanding practice

We found the following outstanding practice:

The service pro-actively contacted recently bereaved patient family members across the South West area to help support them through a difficult time. The service called family members up to three times following the bereavement to provide support and listen as well as signpost them to other relevant services in the area. Other services provide bereavement support, but this relies on the individual contacting the service rather than the service contacting the bereaved.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Hospice services for adults

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

Are Hospice services for adults safe?

Good

Our rating of safe stayed the same. We rated it as good.

Mandatory training

The mandatory training was comprehensive and met the needs of patients and staff

Staff completed mandatory training every 3 years on a rolling basis or sooner if it was identified as necessary. Managers monitored mandatory training and alerted staff when they needed to update their training. Data given to us by the provider showed that by October 2021 mandatory training was at 85% or above compliance for all topics except manual handling at 78.3% . We were told by the provider this had been impacted by the COVID-19 pandemic, in that this is face to face training. The service was 100% compliant with Basic Life Support and Personal Safety and Mental Health Awareness / Conflict Management training. The service had an email alert system for staff when mandatory training was required.

Safeguarding

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

Clinical nurse managers were trained to level 3 in safeguarding for adults and children. Registered nurses and health care assistants were trained to level two in safeguarding for adults and children. Staff reported safeguarding issues via their electronic system. Clinical managers provided support for teams, including on call and out of hours to discuss any concerns raised by staff. The service had a head of safeguarding lead and conducted an audit of safeguarding incidents annually.

Volunteers undertook safeguarding training. The service had identified the safeguarding training required to specific volunteer role groups and volunteers were able to move roles within this group. It was noted that volunteers required additional training if the role sat in a different group or banding.

The provider had a safeguarding assurance group which met regularly and any learning for services was shared with staff through the quality meeting process. We saw evidence of reflective practice following a safeguarding referral. There was an up to date safeguarding policy.

Cleanliness, infection control and hygiene

Staff mostly used infection control measures when visiting patients in homes.

Staff mostly followed infection control principles including the use of personal protective equipment ("PPE"). The service had reported two outbreaks of COVID 19 (an outbreak is where there are two or more tests confirmed cases of COVID-19). The service investigated the outbreaks and found there was no transmission of COVID-19 between staff to patients, however, policies around car sharing and infection prevention control measures were re-issued to all staff as an update and reminder.

The service carried out audits on hand hygiene and the wearing of PPE which found that mostly staff were compliant. Staff who were found non-compliant were given further education and training. There were COVID-19 screening questions for each patient at the initial assessment and on handover.

Staff had access to PPE and there were no issues for staff in obtaining enough supply. There were processes for staff to obtain PPE from local collection points.

Staff and volunteers were trained in infection control. As at October 2021 94.3% of staff had completed the training. Staff were trained in respect of this during their induction and then on a 3-yearly basis.

Staff were tested weekly for COVID-19 using polymerase chain reaction ("PCR") tests and twice a week using lateral flow tests. Staff were sent reminder emails to prompt them to carry out the test.

The service completed IPC audits and surveys in peoples own homes using a mixture of supervision and by obtaining feedback surveys from patients and family members. The audits showed staff were adhering to PPE guidelines.

In addition to the testing regime, the service had a policy where staff would isolate for ten days if contacted by track and trace whether they were COVID-19 positive or not. This decision was taken because patients were considered highly vulnerable individuals.

We saw infection control measures being taken in office areas. There was a regular cleaning regime, including frequent wiping down of touch points, and staff numbers were limited in rooms to comply with social distancing.

Assessing and responding to patient risk

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

The provider was not responsible for developing overarching risk assessments and management plans for its patient's. This was the responsibility of community and district nursing teams. Marie Curie staff helped with the implementation of the plans and communicated information regarding concerns and any new risks, as well as the progress of the patient to the community and district nursing teams.

Staff obtained patient information from the referral form completed on admission to the service. At the admission stage the service checked there was an advanced care plan and that a Do Not Attempt Cardiopulmonary resuscitation ("DNACPR") form had been completed, where appropriate, in consultation with the patient.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Patients were assessed into four categories; stable, unstable, deteriorating and dying. Prioritisation of care was based on the category of the patient. Staff would report against certain criterion daily and monitor patients for any change in their condition. The tool included a section to comment on the state of the patient's mental health.

Staffing

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

The service had enough nursing and support staff to keep patients safe. Managers monitored rates of sickness, staff turnover and vacancies, including reasons for any increases in rates. The service had identified staffing as an area of challenge and was actively running recruitment campaigns for all areas of the workforce except the clinical nurse manager position which was fully established. Vacancy rates varied from 11% for senior nurses to 28% for registered nurse positions. Whilst staffing was challenging, patients were kept safe as the service would only take on patient care if the level of staffing was available to meet the needs of patients.

There was a lack of career progression for health care assistants. The service had identified this as one of the reasons for the high turnover (25%) for this staff group. The service was developing a career progression framework to address the issue. This had not been introduced at the time of the inspection.

The managers could adjust staffing levels daily according to the needs of patients. Registered nurses were able to support health care assistants on visits if this was required. The service had access to Marie Curie bank nurses and health care assistants as a contingent workforce if needed.

Records

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

Patient notes were comprehensive, and all staff could access them easily. We reviewed six sets of patient records and saw that notes were clearly recorded. Staff were able to access patient notes via their password protected electronic devices. These had a process available which allowed them to continue to work in areas where there is no broadband access. This was used in the rural areas that staff visited.

Patient notes from other providers were not always available in the home setting. In instances when patient notes were not available, staff completed a dynamic risk assessment and completed a short episode of care document with the patient / or family member that included gathering information relevant to the patient's condition at that time. Staff received training in dynamic risk assessments and there was a standard template to complete. Staff completed an incident report for any missing records, and this was escalated to the clinical commissioning groups.

Good

Hospice services for adults

Key information was shared when handing over patient's care to others. The service worked closely with district and community nursing teams. Patient care was shared across different organisations who used different information technology systems. The service had worked with partner organisations to create sharing information agreements to enable staff to view patient notes in the different systems. This was available for some but not all organisations. The service was working on the sharing agreements that weren't already established to ensure the best communication possible.

Medicines

The service is not responsible for any ordering, receiving, monitoring or disposal of medicines.

The service does not hold any medicine stock and none of the staff were qualified to prescribe medicines. Health Care Assistants (HCA) were trained in medicine management level 1. As at October 2021 87% of HCA staff had completed this training. The service required Registered Nurses to complete its medicines management training course to ensure continuing competence and professional development. As at October 2021 92% of nurses had completed this. This training was mandatory on a 3 three yearly rolling basis.

The service monitored medication incidents. It carried out a recent medication survey for health care assistants to check on their understanding of administering medication and highlight any issues in the service provided. Learning from this survey has driven improvements in the service such as highlighting that staff required awareness of the non-prescribed medication policy that was launched around the start of the pandemic.

Incidents

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

Staff knew what incidents to report and how to report them. Incident reporting for the region compared favourably with other regions of the service. However, staff reported they did not always receive feedback from incidents. This was identified in a recent local south west staff survey. The provider was intending to address this issue with an action plan which would be discussed and agreed with staff. The incident reporting system had been updated and included a box to tick to request feedback.

There was learning from incidents. We were told by staff that they received support from their line manager following incidents as well as offered additional training opportunities. Information from incidents occurring outside the locality were cascaded to all staff via team meetings and emails. All learning from serious incidents were shared with the whole organisation. We saw an example of learning from incidents with regards to falls. A review of falls across the organisation initiated as a result of incident reporting, resulted in a change to training. Falls training was previously included as part of the manual handling training but would now be a separate module giving staff the necessary skills to complete falls risk assessments. The falls risk assessment was the responsibility of the community nursing services. The number of incidents relating to falls is no higher in the South West than in other Marie Curie services across the UK.

Are Hospice services for adults effective?

Good

Hospice services for adults

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. National Institute for Health and Care Excellence ("NICE") guidance was reviewed centrally and cascaded to the different regions. Relevant guidance and changes to practice were added to the service action plan which was reviewed at quality meetings. Staff could access policies and guidance on the intranet system.

Managers used the "Ambitions for Palliative and End of Life Care" framework which outlined collective action on six fronts to ensure that in future everyone had the best possible experience of dying, and bereavement. This was used as part of the induction for new staff.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Psychological needs were documented and considered by staff at every contact. Staff understood how their condition could affect their mental wellbeing.

On handover and patient notes, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We observed a discussion regarding the psychological and emotional needs for two of the patients visited and staff knew to raise a concern if they were worried about these issues.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink. Staff regularly checked if patients were eating and drinking enough to stay healthy and help with their wellbeing. Health care assistants monitored and documented urine output in care records to ensure patients were not becoming dehydrated.

Pain relief

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

Staff asked patients about their pain levels and acted promptly. Health care assistants were trained in medicines management level 1. This means the patient self medicates with general help, for example, the health care assistant can act as an extension of the patient's arm. The registered nurses were able to administer 'just in case' medicines. Just in case medicines were also known as 'anticipatory medicines', these were prescribed medicines which were usually given by injection. They were kept in the home 'just in case' they were needed.

We saw staff assess and monitor patients during their visits to see if they were experiencing pain. Health care assistants raised any issues around pain with their immediate managers who would contact the district nursing service or GP surgery to address. Results from a patient and family survey from October 2020 to September 2021 stated that the support given to relieve pain was very good. However, the service is currently reviewing its pain assessment tool nationally and work was being carried out to further develop dementia awareness training for staff in order to equip them with the skills to deliver a more tailored approach to this aspect of the service. This would help staff better identify pain for patients who cannot communicate or who have a diagnosis of dementia. Pain management is important for patients with a diagnosis of dementia because it has been recognised that people with a diagnosis of dementia are not always able to recognise pain or manage it in the same way as someone who does not have a diagnosis of a dementia.

Patient outcomes

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

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service had a plan of annual audits including falls and pressure damage which were reported to the executive team and commissioners. Action plans from any local audits fed into quality meetings and was shared with staff.

The service had a national rolling audit programme to inform quality and outcome information which included monitoring the preferred place of death. In 2020 /2021 the service helped 95.1% of its patients to identify and achieve their preferred place of care at the end of their lives. This was an increase on the 88.8% in 2019/2020.

Managers shared and made sure staff understood information from the audits. We saw information was presented to staff in formats which clearly showed audit results and where improvements were needed and action plans were developed to implement the improvements.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All new staff, including volunteers, completed a full induction tailored to their role, before they started work. Staff shadowed other staff as part of their induction and until they were competent and felt confident. Managers supported staff during their induction with one-to-one conversations to review progress and provide any further support needed.

Managers supported staff to develop through yearly, constructive appraisals of their work. Managers monitored staff appraisals and rates of completion. Most staff had received an appraisal or had an appraisal booked.

Staff had access to regular supervision. They had one to one meeting with their line managers on a regular basis as well as debrief opportunities following difficult situations. All staff reported they were satisfied with the level of support from their line managers. New staff had access to resilience-based supervision training and there was also training on how to become a resilience-based supervisor for staff who managed people. Staff told us there was always a manager or supervisor they could speak to on the phone. They were confident to call at any time of the day or night and get a helpful response.

Staff were supported to maintain and update their knowledge and skills. Staff attended additional training which supported their roles and specialties. Staff we spoke with said they were encouraged to develop new skills. Staff we spoke with told us they had access to a wide range of training courses, which could be accessed as required. Learning was available via the intranet and contained a variety of subjects, some extensive and some in shorter sessions to enable learning to happen in a variety of ways. Staff had received training in supporting people with dementia, and managers told us they had received very positive feedback on how this had improved the service staff provided. Staff also spoke positively about the resilience training they had received,

Clinical co-ordination staff in the south west were trained in managing challenging conversations. This was piloted in the south west region and was currently being rolled out nationally. This was developed as staff moved to home working as a result of the COVID-19 pandemic and staff didn't have access to the immediate support of a manager or colleagues.

The service was piloting a career framework, with defined understanding of roles, skills mix and levels of practice. The purpose would be to develop a career pathway to improve staff retention and ensure high quality standards of care.

Volunteers had the skills and knowledge to support patients and their families. Volunteers received supervision at regular intervals. There was a structured induction process which included mandatory training safeguarding, information management etc. Volunteers were recruited when required and they were trained and supported for the role they undertook. We spoke with a bereavement volunteer who said she was well supported and could contact her supervisor at any time. Volunteers have an induction and a training programme.

Multidisciplinary working

Doctors, nurses and other health care professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff reported that they had good working relationships with the community nursing teams and general practitioners (GP) services. Staff worked with external organisations to provide joint packages of care. Feedback from this service reported staff benefited from the learning and support available from other organisation's.

The service attended multi-disciplinary reviews and reassessment meetings for patients using its service for continuing health care needs.

Seven-day services

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

Good

Hospice services for adults

Services were available 24 hours, seven days a week, which comprised of multiple personal care visits, plus overnight personal care support.

Out of hours clinical support was provided by the district nursing out of hours team except in Cornwall where they used the out of hours doctor service. The service had out of hours support for staff to contact in case of incidents. For example, inability to gain access to the home of the patient, when a staff member was feeling unwell during shift or had injured themselves or if they were unable to attend visit for all other reasons except sickness. An on-call manager was available seven days a week between the hours of 17.30 and 08:00 to ensure staff had access to support if needed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions.

Staff understood their role and responsibility in ensuring patients consented to care. We observed staff obtaining consent to carry out personal care. Consent was clearly recorded in the patients' records.

When patients could not give consent, staff made decisions in their best interest in discussion with family members, considering patients' wishes, culture and traditions.

The service did not have responsibility for completing Advanced Care Planning, Do Not Attempt Cardiopulmonary Resuscitation ("DNACPR") and Deprivation of Liberty Safeguarding decisions. This was completed when needed by the GPs or community nursing teams. The clinical nurse managers and quality team were available to support staff and provide advice relating to these issues.

Patients we saw had Do Not Attempt Cardiopulmonary Resuscitation ("DNACPR") decisions recorded. This was used to ensure the decisions for resuscitation had been discussed with the patient and an agreement had been reached and recorded. The service had a DNACPR policy and staff when questioned knew about the policy and its objectives and whether their patient had a decision recorded. A DNACPR decision was contained in all patient files reviewed and it was checked that this was completed at the point of referral to the service.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were not trained to restrain patients and would call emergency services if there was an urgent need. This was a rare occurrence.

Are Hospice services for adults caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Good

Hospice services for adults

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

Staff demonstrated genuine empathy and an understanding of both the patient's and relative's situation. We witnessed staff using a tone of voice which was tender, respectful and showed genuine compassion for the patient.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw care delivered in people's home and in all instances, we observed staff deliver care with skill and sensitivity. The patient's needs and wishes led the care that was provided. The personal care provided by staff was described as "second to none" and one relative described staff as being 'part of the family'. We saw a lot of positive feedback about the care provided had been received by the service from family members and survey results. When we observed care in people's home staff ensured that patients were asked about their dignity and privacy.

Patients and family members said staff treated them well and with kindness. We spoke with two relatives and four patients, and all told us staff were caring, kind and took the time to listen to the patient and the family. Staff supported families and those close to the patient and offered emotional support. Relatives told us how they appreciated the help provided and the interaction with the Marie Curie staff.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff considered the holistic needs of the patient and their family and used the "what matters to you?" approach to fully understand individual preferences.

Emotional support

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

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff gave patients and those close to them help, emotional support and advice when they needed it. They recognised when this was needed and did not wait to be asked. We saw staff sitting with and listening to patients and families. Staff supported patients and relatives and provided answers to questions wherever they could. Family members in the South West area had access to the Marie Curie bereavement support.

Staff undertook communication skills training and demonstrated empathy when having difficult conversations.

One member of staff told us they only had one chance to get the care right for their patients and families, so it was important to get everything right first time, and it was a privilege to do so. They told us that whatever happened in the patients last few days was what the family remembered, and they recognised the importance of this. A family member also told us staff had fully supported them emotionally. They could ask any question and if carers or managers did not know the answer, they would help them find the answers or support they needed.

The service also recognised the importance of emotional care to families and carers. They offered, where possible, respite to carers so they could take time to go for a walk, or a coffee.

Understanding and involvement of patients and those close to them

Good

Hospice services for adults

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

Staff made sure patients and those close to them understood their care and treatment. Staff talked through what they were going to do and asked patients whether they wanted this to happen. We saw staff take time to talk with family members. Feedback we saw stated staff always had time for patients and family members and care never felt rushed.

Staff supported patients to make advanced decisions about their care. In the Somerset area there was an advanced care planning service. There were trained volunteers that were able to help people to talk about their end of life preferences, wishes, beliefs and values, including their religious and spiritual beliefs. In other areas of the service, advanced care planning was offered by other services, however, we saw Marie Curie staff consulting with these services and being included in the care plans following the care that they had delivered.

Patients gave positive feedback about the service. One comment on the service received via a feedback survey stated 'my mum was treated like a person, not a patient'. All comments from this survey were positive. The surveys included measures for dignity and respect, emotional support (and family support) and a range of other measures.

We saw staff provide care to patients and saw they would ask permission to help the patient when moving them, took care to explain everything they were doing, and took the time to ensure patients understood what they were being told.

Are Hospice services for adults responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. The service ensured that patients most in need of its service were prioritised. The organisation attended local End of Life Care steering groups and worked with local providers and partners to ensure patients received appropriate levels of care.

The service worked closely with local providers and partners to ensure appropriate levels of care. Across the South West there was a pro-active bereavement service for patient family members following the loss of their loved ones. The service was run by trained volunteers who talked to family members by telephone to give them the opportunity to talk to an independent person about their loss. They could also signpost them to other organisations for help if required. In the last six months to August 2021 the service made a total of 478 calls and supported 329 people. Other services provide bereavement support, but this relies on the individual contacting the service rather than the service contacting the bereaved.

In the Somerset area there was an advanced care planning service. There were trained volunteers that were able to help people to talk about their end of life preferences, wishes, beliefs and values, including their religious and spiritual beliefs. This was in addition to services in the Somerset area that provided planned overnight care.

The service was commissioned by clinical commissioning groups in some areas. Feedback from these groups was generally positive.

Meeting people's individual needs

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

The service tailored care around patient's individual needs and preferences. Staff we spoke with said care after death was provided sensitively and in accordance with any cultural or religious beliefs. A compliment received by the service stated, 'even after my husband had passed the Marie Curie nurse bathed and dressed him and supported the undertaker, allowing us to compose ourselves and remember him as the strong, wonderful man he was'.

The service provided easy read booklets via its website. In specific cases where there was a language barrier the service translated its written information into the language that was required. Staff we spoke with explained how they would meet the needs of people with a disability or sensory loss, they also talked about signposting patients to other services and providers as relevant. We were told of an example where a patient had deteriorating eyesight and the staff member facilitated contact with the local Royal National Institute for Blind people to see if they could provide help and support.

Patients who were not able to use or have difficulties with technology could access the service by calling its support line which was a freephone number and open to everyone and not just people who Marie Curie support.

Documentation around whether a patient or carer had any communication / information needs required improvement. This was identified by the provider in a February 2021 audit. The service had an action plan to address this issue and plans to re-audit the information in 2022.

Staff were aware about the differences in providing care for people from different cultural and religious backgrounds. They told us there was information they could easily access on their intranet site. The organisation also had an Equality, Diversity and Inclusion group who provided guidance and support.

Staff did not know about accessing interpreters to help with language barriers. The service did have a standard operating procedure for information / inclusive communication which included numbers for interpretation services in each county, however staff were not all aware of how to access this service. We raised this with the provider who stated they would re-share the standard operating procedure with staff.

Access and flow

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to care delivery were in line with good practice.

Clinical coordination and work with partner organisations ensured high-risk patients were identified and prioritised. In Cornwall and Dorset area clinical co-ordination staff and nurses assessed patients who required 'fast track' referrals for patients who required continuing health care in their home. This meant that patients requiring Marie Curie packages received them quickly. Care packages that could not be provided, due to staffing constraints, were referred to other providers.

Good

Hospice services for adults

The clinical co-ordination and nursing staff accepted and managed patient referrals from the community (from patients, families and health care professionals). The team monitored referrals and ensured patients met the referral criteria and had consented to care. Staff told us patient care packages could be responded to in a timely way and this was monitored by the organisation. The use of bank staff enabled some flexibility in providing additional packages of care when needed or required.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. They received information about how to make a complaint in a booklet provided at the beginning of care from Marie Curie. The booklet also provided detailed information about what to do if they were unhappy about the way their complaint was dealt with. Patients and relatives could also access information on how to complain via the Marie Curie website. The registered manager told us they were continuously striving to improve the service by looking at complaints and learning from people's experiences. We reviewed how the service responded to complaints and saw detailed investigations were carried out and actions such as additional learning for staff was used to improve the service. We reviewed the tool used to analyse complaints in order to look for any trends or themes. This showed during the period April 2020 to September 2021 Marie Curie South West received 18 complaints and there were no themes or trends identified but some corrective action required. Where corrective action was required, this was undertaken as part of the complaint handling process.

Are Hospice services for adults well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

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

There was a clearly defined management structure. The registered manager was supported by a head of operations and quality, 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 and quality and business teams.

Staff told us on numerous occasions that the regional leadership team was visible and approachable. We were told and could see, there were strong channels of communication from board to operational levels which ensured the voices of patients, carers, volunteers and staff were heard, listened to and acted upon.

The leadership team understood the challenges that the service faced. The issues identified by the inspection were challenges which the leadership were aware of and had plans to improve or manage the risk.

Staff told us they felt well supported by the management. Staff told us there was strong leadership, who were a cohesive and friendly and approachable team. Staff felt confident in approaching them regarding issues to do with their professional or personal life.

All staff felt valued and told us they enjoyed working for the service. We were told 'they were proud to work for the service and felt the service provided a high level of care to patients'.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

The service strategy and vision were going through a period of change to align with the wider health economy. Most staff we spoke with were aware of the change in vision. The leadership team were working with staff to make sure they were aware of the changes and the vision.

Culture

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

All staff we spoke with felt positive and proud to work in the organisation. Staff were passionate about their patients having the best end of life experience possible and providing patient centred care for patients and family members.

The provider supported staff with their wellbeing. All staff had access to a wellbeing hub on the intranet with a variety of links to relevant resources as well as external links to organisations for mental health and wellbeing. All staff had access to an employee assistance programme which included counselling. Staff we spoke with said access to external support was facilitated through the provider and made easier to access. Staff had access to supportive supervision.

The service had undertaken a COVID 19 risk assessment to identify vulnerable staff to ensure that both staff and patients remained safe, for example, someone who was assessed as vulnerable would not be required to care for a patient who had COVID 19.

All staff who had a period of absence had a return to work interview to ensure they were fit for work and to identify any necessary adjustments that may be required.

The provider had processes to support lone workers. All staff had an electronic device and logged in to the system when they arrived and departed from a patients home. If the staff member did not log in and out, then an alarm was triggered. Staff also had a system if there was any sign of danger. Information on the patient referral form identified any patient risks associated with environmental or behavioural issues. We saw staff use these tools during patient visits.

Staff were able to raise concerns without fear and retribution. Staff had access to freedom to speak up guardians and there was evidence of learning and action taken following a freedom to speak up complaint. All staff we spoke with understood the duty of candour and reported incidents. A recent survey enabled staff to feedback anonymously.

There were some mechanisms for providing staff with development opportunities, however this was mainly for registered nurse level and above. The provider had recognised that there was limited career progression for Health Care Assistants and was looking at introducing development opportunities in the future.

Governance

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

The provider held monthly management meetings which focused on performance and operational issues. The service had mechanisms to feed information up and down to its national management. We observed one team meeting and reviewed minutes from these meetings which showed how key messages were shared across the organisation.

The provider held monthly team meeting for each county. This was added to staff rosters and staff were expected to attend eight out of ten meetings. Minutes were provided from the team meetings and circulated to staff to provide feedback to all staff. The team meetings discussed any learning from incidents that had happened in the region as well as any national learning incidents that were relevant to its service.

The provider had policies and standing operating procedures which were available to staff on its intranet system. The provider shared updates to policies and standing operating procedures via email and through team meetings. However, the provider did not have assurance staff had read these updated policies. We raised this with the provider who stated they were going to implement an electronic sign off system which would provide this assurance.

The service met with commissioners of the service at regular intervals to discuss any issues about the service provision.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Leaders were aware of the areas of challenge to the service and had a local risk register for identifying, recording and managing risks which was updated and reviewed monthly and fed into the corporate risk register. Staff recruitment was the main risk identified by the service and we saw plans on a national and regional level for a recruitment drive.

The service had business continuity plans for each area / department of the South West service. The plan was developed to ensure core activities were able to be fulfilled in event of an emergency or incident. We were told by staff that the service responded quickly to unexpected events and were given examples of how the service supported staff during the recent September fuel crisis.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The service had introduced new information technology systems to improve the way it collected data and analysed it. Staff reported that the new systems were an improvement and helped to improve patient care. The new systems had only recently been introduced and old systems were currently still being maintained, resulting in staff having to input data several times. This route was chosen by the leadership team to ensure that the new systems were fully operational and patient care was maintained before the old system was shut down.

There were effective arrangements to ensure that data or notifications were submitted to external bodies as required.

Engagement

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

There were high levels of satisfaction across all staff. Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed.

The service engaged well with patients, staff, volunteers and the public and local organisations to plan and manage appropriate services and collaborated with partner agencies effectively.

Patient experience stories were embedded in the service as an opportunity to share learning, create improvements and shine a light on good practice. Staff shared patient stories at board meetings, staff and team meetings and staff forum meetings to highlight patient views and feedback. Feedback from patient and family members was positive.

Staff surveys were undertaken at regular intervals. We saw evidence the management team took actions from these surveys to improve the service for staff and patients.