Marie Curie

Marie Curie Hospice Community Services Eastern Region

Inspection report

Unit 9
Mobbs Miller House, Ardington Road
Northampton
NN1 5LP
Tel: 02075997777

Date of inspection visit: 11 November 2021
Date of publication: 09/02/2022

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. They managed medicines well. The service managed safety incidents well and learned lessons from them.

Nurses provided good care and treatment and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, 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, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.

Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community end of life care	Good 	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. They managed medicines well. The service managed safety incidents well and learned lessons from them. Nurses provided good care and treatment and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, 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, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it. Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Contents

Summary of this inspection

Background to Marie Curie Hospice Community Services Eastern Region

Marie Curie Hospice Community Services Eastern Region is a registered provider of specialist palliative care services. They offer specialist palliative care across the Eastern Region, as well as providing support for family and friends. The Marie Curie Nursing Service staff work very closely with District Nurses and General Practitioners to ensure optimal care. The emphasis of care is community focused, enabling patients to be cared for and to die at home if this is their preferred choice. Marie Curie Hospice Community Services Eastern Region provide two services, a rapid response service where nurses would respond to urgent calls from families and an overnight nursing service, provided by healthcare assistants.

Marie Curie Hospice Community Services Eastern Region is registered with the CQC to carry out the following regulated activities:

Treatment of disease, disorder or injury

How we carried out this inspection

We carried out a comprehensive inspection of the service under our regulatory duties. The inspection team comprised of a lead CQC inspector and a specialist nurse advisor who specialises in end-of-life care. A CQC inspection manager was available for support offsite. We gave the service short notice of the inspection because we needed to be sure it would be in operation at the time we planned to visit.

We visited the office location on 11 November and made telephone calls to relatives and staff on 12 November 2021.

We undertook this inspection as part of a random selection of services rated Good and Outstanding to test the reliability of our new monitoring approach.

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:

Staff went above and beyond by staying with patients and families who needed their support longer than they were expected to and by finding a way to include all family members. Patients and their relatives told us they couldn't praise the service highly enough.

Staff demonstrated distinctive skills explaining patients' care and treatment. Staff took time to explain in a way patients and their relatives could understand, this included explaining very difficult topics around death to children.

Families described the sense of calm staff brought to situations when families were in distress.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community end of life care	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Community end of life care

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

Are Community end of life care safe?

Good

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

Mandatory training

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

Nursing staff received and kept up to date with their mandatory training. Staff told us the training they received gave them the skills for the work they did. Staff received training covering a range of topics, which included health and safety, infection prevention and control and food safety and hygiene. Staff training records showed all staff were up to date with their training, except for staff who were off sick long term. One member of staff described to us the support package to enable them to undertake their training.

Staff had access to wider training every three months with district nurses, GP's and hospice staff, through a group of health care professionals who worked in end-of-life care. This training reinforced staff learning around topics such as diabetes, deprivation of liberty and easy read care plans.

The mandatory training was comprehensive and met the needs of patients and staff. Staff told us if they asked for additional training, it would be provided if beneficial to their practice.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us they were emailed updates and they could access everything they needed easily.

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.

The registered manager and clinical nurse managers had a high level of understanding of their wider safeguarding responsibility to keep everyone safe from abuse and discrimination. All staff received safeguarding training for both

adults and children. The provider's safeguarding team received level four training; managers received level three training and nurses and healthcare assistants received level two training. We discussed this with the clinical nurse managers who explained their level two training also had additional bespoke training that reflected the needs of the patients the service cared for.

Nursing staff received training specific for their role on how to recognise and report abuse. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff completed training in equality and diversity.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. There was a safeguarding policy in place that included information about the protection of adults and children. The safeguarding policy listed types of abuse, and female genital mutilation (FGM) was included. The safeguarding policy also included guidance for staff who may be concerned about people who may be in danger of becoming radicalised; this guidance is known as Prevent.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients and caring for patients after death.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were bare below the elbows and wore masks, gloves and aprons while they were with patients. The service had updated their guidance for staff around the use of PPE. Staff always asked patients and their families if anyone had been in contact with COVID-19 and would wear a fluid resistant surgical mask if so. Staff were not exposed to any aerosol generating procedures, but managers told us specialist PPE would be ordered for them if they were. Guidance for staff included how to dispose of any PPE worn while they were with patients/relatives who were COVID-19 positive. Staff disposed of clinical waste in accordance with agreed protocols.

Staff told us they had enough PPE and could always replenish their stocks.

Environment and equipment

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

The service had enough suitable equipment to help them to safely care for patients. Staff were asked to complete questionnaires where they could comment on the equipment available to them. One question specifically asked staff if they had the equipment and resources they needed, to do their job well. One comment suggested there were additional items that would benefit them such as mouthcare gel, water for injections and red needles. We raised this with the registered manager who told us, "Patients have items they need prescribed for them, though we have supplies of stock such as red needles, syringes, dressings, syringe driver sets and other items". District nurses were responsible for providing equipment and arranging any maintenance required.

Assessing and responding to patient risk

Good

Community end of life care

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

Staff completed risk assessments for each patient, and reviewed them regularly, including after any incident. Staff took time to explain any risks to patients. Staff knew about and dealt with any specific risk issues. Staff shared key information to keep patients safe when handing over their care to others. We observed staff completing assessments such as Treatment Escalation Plans (TEP's) and found the assessments to be thorough and fully recorded. Staff checked and followed the information in patient's ReSPECT forms. ReSPECT stands for Recommended Summary Plan for Emergency Care and Treatment. The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices. Staff worked collaboratively with other health care professionals, such as district nurses and GP's.

Shift changes and handovers included all necessary key information to keep patients safe. Staff kept full and informative records so other staff following had all the information they needed. Nurses told us if records hadn't been fully completed, this was raised as a concern and followed up with the member of staff to ensure it did not happen again.

Nurse staffing

The service had 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 if agency staff were used, gave them a full induction.

The service had enough nursing and support staff to keep patients referred to the service safe. Healthcare assistants provided overnight nursing services for patients and their families. The service had two clinical nurse managers, who were both responsible for distinct aspects of the service. One was the clinical nurse manager for Northamptonshire and was responsible for the rapid response and planned variable care (PVC). Another clinical nurse manager was responsible for a different geographical area and staff providing all night services.

Planned variable care (PVC) was provided for patients who required planned night care and were connected to GPs in Northamptonshire. Thirty-one patients were referred to this service, supported by four members of staff.

The overnight services were mostly provided by healthcare assistants although some nurses also worked in these areas. In the overnight nursing services, sixty-two staff altogether supported 130 active patients.

Advanced nurse practitioners, who were able to prescribe medicines, were senior nurses. Additional nurses were also employed.

Managers told us, "Everyone is incredibly flexible, they work incredibly hard but enjoy the work." Staff turnover was low.

The registered manager explained in order to offer the Marie Curie Rapid Response end of life service with the greatest flexibility, the service had several systems in place to manage the demand on clinical services, including flexible working. This included staff beginning their shift earlier than rostered to meet demand and taking time back during quieter periods. In addition, when demand was high the Rapid Response team could call on partner providers such as out of hours community nursing and district nursing services to ascertain who was best placed to reach a patient as quickly as possible.

A 'floating' nurse was available to cover any absenteeism such as sickness.

Managers told us they had vacancies for two healthcare assistants and were currently looking at staffing.

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.

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.

Electronic records were stored securely. Patients had their own set of records in their homes and staff also updated their electronic records. Patients had on-going care plans which were updated regularly according to patients' changing needs.

The service took appropriate and timely action when a potential data breach was identified.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely.

Processes were in place to ensure safe management of people's medicines and people told us they received their medicines as prescribed.

The patients' own medication was stored in their own homes. Nurses and health care assistants were responsible for checking and giving people their medicines, and we observed good practice in the preparation of medicines. All staff were trained to administer medicines. Healthcare assistants were trained to administer prescribed oral medication and followed the provider's policy. The rapid response trained nurses were trained to administer oral and injectable medicines. Advanced Nurse Practitioners, who could prescribe medicines, received training and underwent competency assessments before commencing single nurse dispensing and administration of drugs (SNAD), and a risk assessment had been completed to identify and mitigate the risks associated with SNAD.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Some people's medicines were given through a syringe pump. A syringe pump is a small portable pump that can be used to give a continuous dose of a painkiller and other medicines through a syringe. Advanced Nurse Practitioners followed a robust procedure if they were both prescribing and administering medicines.

Staff completed medicines records accurately and kept them up to date.

We observed a nurse following correct procedures for administering controlled medicines. These are medicines that require additional strict controls because they may cause harm or addiction. Correct processes were followed, and the nurse gave a good explanation of the care the patient required to other staff and the person's relatives.

Good

Community end of life care

Staff stored and managed all medicines and prescribing documents safely. Patients' medicines were stored in their own homes. Staff had access to stocks of medicines to dispense for patients out of hours if required. Patients' families were responsible for disposing of any unused medicines. The Marie Curie rapid response community nurses explained this to families and advised that unused medicines should be returned to any pharmacy.

Out of hours, the Rapid Response nurses could prescribe medicines which families could collect from a local pharmacy. If these medicines were not available at a local pharmacy, a request could be made for an out of hours GP to prescribe and dispense medication for the Rapid Response nurses to administer.

Staff learned from safety alerts and incidents to improve practice. Nurses benefitted from a weekly shared meeting based on the database used, where incidents were logged. This enabled them to share learning.

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 raised concerns and reported incidents and near misses in line with the provider's policy. Staff had raised three serious incidents in the past year. The incidents were referred to a Marie Curie panel for discussion and the provider's policy and protocols were followed. Each incident was fully investigated by a clinical nurse manager, with the cause and any additional factors considered, and families were involved throughout. In all three incidents, learning was identified and shared with staff. Changes were also made as a result, for example staff have received further guidance around the use of PPE suitable for them to wear when patients use machines which help them to breathe better.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Relatives were fully involved throughout investigations so their voice could be heard. Relatives were also listened to if they wanted to make any changes to the service as a result.

The service had no never events. Managers shared learning with their staff about never events that happened elsewhere.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff told us about learning shared after incidents, for example when staff were concerned about an anxious family member.

Managers debriefed and supported staff after any serious incident. Members of staff who dealt with any incidents were able to debrief with the clinical nurse manager. Staff also had access to an employment assistance programme and other support if they wished.

Staff received feedback from investigation of incidents, both internal and external to the service. When managers had completed their investigations and identified learning, this was shared with staff during supervision and through emails.

Are Community end of life care effective?

Good

Community end of life care

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. We observed the process of taking a call for a rapid response nurse and followed this through to observing the patients' care and treatment. Relatives told us staff in the call centre provided excellent and accurate information and ensured the call was responded to as soon as possible. The nurse undertaking the visit followed correct procedures for administering medicines' and explained the situation to the family in a kind and supportive way.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. People's rights were respected because staff understood their responsibilities in relation to the Mental Capacity Act (MCA) 2005. When people lacked mental capacity, families and other professionals were appropriately consulted for decisions that needed to be made in the patient's best interests.

Effective management systems were in place to monitor the quality and safety of people's care. The service had a comprehensive programme for auditing and reporting to ensure a high-quality service delivery. The service benefitted from a business intelligence team, who reviewed and monitored data to produce reports for the service. For example, one recommendation from an audit of the service, which was taken nationally, included looking at how services audited documentation. Information on matters such as infection control, falls prevention, medicines incidents, staff recruitment/competencies, complaint management, safeguarding and finances were known about by those responsible and accountable within the organisation.

Nutrition and hydration

Staff helped to ensure patients had enough food and drink to meet their needs.

Nurses provided a rapid response service so were not involved in helping patients to eat or drink on a day-to-day basis. Staff providing the overnight nursing service were mostly supporting patients who were sleeping. Most staff were not directly involved with patients' nutrition and hydration, but staff told us they always monitored patients' records to ensure they had had enough to eat and drink. Overnight staff assisted patients to eat or drink if they wanted something.

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 observations and gave additional pain relief to ease pain.

Good

Community end of life care

Nurses undertook a full assessment of patients' needs and looked for signs and symptoms of pain. Some patients would show signs of pain even if they were unconscious. If patients were able to communicate nurses asked them if they had any pain; nurses would also note a patient's previous history of pain. A clinical nurse manager told us they had not found pain assessment tools very useful.

When patients deteriorated and couldn't swallow oral pain relief, nurses would set up a syringe pump so patients could receive the medicines they needed. Prescribing nurses prescribed, administered and recorded pain relief accurately. Staff had guidelines which detailed the processes to follow, which ensured the process of prescribing, administering and recording pain relief was safe. All staff involved with the administration of medicines had their competency assessed before they could administer medicines, and this was updated yearly. Nurses completed an annual syringe pump competency check. This meant people could receive essential treatment without the disturbance of having to travel to hospital, and there were no delays to receiving symptom control medicines because medicines could be given following an assessment of the patients' needs.

Rapid Response community nurses had access to essential supplies of medicines and batteries for syringe pumps. These were securely stored and accounted for.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to achieve the best outcomes for patients.

Surveys commissioned by the provider demonstrated the outcomes people wanted to achieve at the end of their lives was to have their pain managed and to die in a place of their choosing. People referred to the service, were thought to be in the last eight weeks of their lives. They were usually referred to the service by their healthcare professionals or were registered by hospital discharge nurses. If patients had difficult symptoms for nurses to manage, they could be referred to a hospice or the community palliative care team. The service had access to two hospices. The service provided monthly reports to the Clinical Commissioning Group (CCG) which showed most people who chose to die at home, did so.

The provider audited the patients' experiences and took action to improve results. For example, audits included monitoring how long it took for nurses to arrive at a patient's home and how well the patient's records were written. This was important to enable clear communication between district nurses and other professionals who visited the patient. When one instance of records not being fully written were identified, the member of staff received training and support to improve their record keeping. Nurses had a key performance indicator (KPI) to reach a patient's home within 60 minutes of time from when the call was received into the call centre. The expected KPI was 95% and audits showed this was fully achieved.

The service supported patients to die in a place of their choosing. For example, the contract between the CCG and the service stated a Key Performance Indicator (KPI) of 58 deaths each month to be in the patient's preferred place of care. Between April 2020 to March 2021 the Rapid Response Team supported 1668 patients to die out of acute hospital in their preferred place of care; the KPI was therefore exceeded by 972. Between April 2021 to September 2021 the Rapid Response Team supported 739 patients to die out of acute hospital in their preferred place of care, the KPI was therefore exceeded by 391.

Competent staff

Good

Community end of life care

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. The service had a recruitment policy, which provided a framework for the recruitment and selection of staff and volunteers. A range of checks were carried out including proof of identity, written references, and checks with the Disclosure and Barring Service (DBS). Further verification was undertaken for nurses through the Nursing and Midwifery Council (NMC). All staff had completed an application form and had been interviewed.

Nurses were supported to revalidate their training. Revalidation is required by the Nursing and Midwifery Council (NMC) to encourage a culture of learning, sharing and reflection. Managers observed nurses in practice.

Managers gave all new staff a full induction tailored to their role before they started work. All staff had an induction, including bank staff.

Managers supported staff to develop through yearly, constructive appraisals of their work.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Staff had access to supervision in groups mostly, although staff could have individual supervision if they wished.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Staff worked well with other health care professionals. When families called emergency services or the NHS helpline for their loved ones, staff working in these call centres would check if the patients were registered with Marie Curie. This was so the appropriate support could be arranged for the patient. The service was able to refer patients to other agencies, so if patients also needed a care package, this could be arranged.

Staff worked with other services to share their specialist knowledge. This was to enable patients to receive the specialised care and attention they needed at the very end of their lives by training staff what to expect and how to deal with it. Marie Curie nurses visited care homes and provided training to their staff.

We observed a nurse attending a patient with a district nurse. The nurse communicated effectively with the district nurse, the family and the patient, to explain the plan of care and the next steps.

Seven-day services

Good

Community end of life care

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

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

The provider had a contract to provide a rapid response service. There were six clinical nurses employed to provide a 24/7 service, one nurse on duty each day. This nurse responded to calls from the whole county. Patients called a dedicated telephone number which was covered 24 hours a day by staff in a call centre. Nurses attended to patients calling this service, then documented the care and treatment they received in patients' notes at home as well as completing an electronic record.

A dedicated hospital discharge service was available five days a week. The Marie Curie Primary Care Discharge Link Nurses based at Northampton General Hospital and Kettering General Hospital provided dedicated discharge support to help people who were in the last eight weeks of their life to get home quickly and safely from hospital. To organise a discharge, the link nurses worked with the dying person, their family or carer to assess their care and support needs. The nurses coordinated everything the patient needed for their discharge to happen smoothly, such as a care package, equipment, pre-emptive end of life medication and the DNACPR and special patient notes. The link nurses ensured everyone caring for the person in the community had up-to date information about their discharge plan and any care arrangements that had been made for them. They did so by working closely with the person's other care providers, including their district nurse, GP surgery, the out-of-hours service and Marie Curie's care coordination centre. When a person was discharged from hospital, they were given the contact details for the care coordination centre so they could access the community rapid response team.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff were observed seeking consent before carrying out tasks and explaining the procedures they were about to carry out.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. For example, staff discussed patients' wishes with their families and checked their notes for their end-of-life preferences. Families and other professionals were appropriately consulted to make decisions in patient's best interests.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. We observed staff checking patients' records and checking with relatives to ensure they were following the wishes of the patient. This was important because people at the end of their lives may not be able to say what they wanted.

Good

Community end of life care

All staff, nurses and healthcare assistants, received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff understood how people's capacity to consent to their care, could at times fluctuate when they were in pain or taking medicine which made them drowsy. They could describe how they would ensure when people had to make important decisions about their care, that discussions would take place at a time when people were best able to understand the information. The provider had a comprehensive policy in place.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. The provider's policy gave clear guidance for all staff.

Are Community end of life care caring?

Good

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

Compassionate care

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

Everyone we spoke with, relatives and patients, overwhelmingly described the service as excellent. Relatives told us, "If ever I need anything like that again, I'll be asking for them. They were just there, they said I could ring anytime, it was constant support. They made it easier. Staff said they'd come out even if he didn't need it."

Staff have received more than 70 compliments in the past year, where people expressed their heartfelt gratitude to staff for going above and beyond. Families told us they had been very fearful as their loved ones approached death, but had found the compassionate, enabling care they received from staff greatly reduced their anxiety.

Patients and their families told us how much they valued and appreciated the relationship they developed with staff, because staff went out of their way to provide the kindest care they possibly could. Staff demonstrated a commitment to providing the best quality of care and people told us staff took time to understand their preferences and needs. Staff supported the emotional wellbeing of patients' and their relatives and end of life care was provided with sensitivity. Staff from a care home, who used the services of the nurses, gave overwhelmingly positive feedback. They told us the Marie Curie nurses were a brilliant service; they were responsive, sympathetic and had empathy with their patients. Staff were respectful of people's cultural and spiritual needs. The provider supported staff to manage their emotional wellbeing.

Families told us the call centre was also responsive and let them know when the nurses would be with them. The care home staff told us they asked for Marie Curie nurses rather than other services they could access because they were so much more used to looking after patients requiring end of life care and would stay with the patient until the medicines had worked.

Good

Community end of life care

Staff were person-centred and provided exceptional support to both patients and their relatives. Patients and their relatives could not praise the service highly enough. Relatives told us how staff would take time to explain things to their children in a way they could understand. One relative said, “My daughter had lots of questions, staff sat with her and said she could ask anything.” One patient told us, “All Marie Curie staff are 200%, they’re fantastic.” One relative told us, “My relative was in so much pain, staff did everything they could and more.”

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. Relatives told us staff were able to maintain their loved one's dignity and always took time to give them the care they needed. Ninety eight percent of relatives who provided feedback in the national patient and carer feedback survey said staff treated their loved ones with dignity and respect.

Staff were motivated and demonstrated a commitment to providing the best quality end of life care in a compassionate way. Patients were overwhelmingly thankful for the service they received. Relatives we spoke with intensely expressed their appreciation and high regard for the services their loved ones had received.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. For example, staff were aware that following a Muslim man’s death, his religious beliefs meant his body could not be touched by a woman and would make appropriate arrangements to respect this. The provider’s national report analysed the feedback provided and summarised patients’ experiences. The report stated, “People with experience of our services often tell us that we “go the extra mile” to treat them with dignity and respect, adding personal touches to our care and treating people as individuals rather than patients.”

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff were exceptionally compassionate and cared for the relatives of the person who was dying with empathy and understanding. One relative said, “The nurse was like an angel at the foot of the bed, she added an amazingly calming presence to what was the saddest night of our lives.”

Another relative wrote a compliment after their loved one died that said, “I am certain that [the help I received] bolstered me emotionally and made the rest of the day easier to copy with.

Relatives told us, “I've found them excellent from the minute they contacted us, nothing but excellent service” and, “Staff were unbelievable, we’ve never used the service before, so it was all new, we didn't know what to expect.”

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. One relative told us how incredible staff were and said, “They went more than the extra mile and enabled me to get some rest, which I had not managed to do.”. One relative praised staff for the information they provided about what to expect and who to contact when their loved one died; they said it made it so much easier for them to cope with when it happened later that day.

Good

Community end of life care

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. Relatives asked to speak with us so they could share everything that made staff so special. Comments included, "They were unbelievable, I didn't know what to expect but they were brilliant" and, "They were just there, they said I could ring anytime, it was constant support. They made it easier. They said they'd come out even if he didn't need it."

One compliment described how a nurse stayed past her official leaving time to not only give practical help and advice, but to stay with the family until the community nursing team arrived, despite having no sleep and their own family waiting for them. The relative said, "The offer to stay with me showed such kindness and sacrifice.". Another relative said, "Staff worked tirelessly. On the final night they were amazing and such a comfort to us all."

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff demonstrated distinctive skills explaining patients' care and treatment. For example, we observed staff giving a very clear explanation to relatives about how a syringe pump worked and the benefits to the patient.

People's wishes for their final days were respected. Information about people's personal preferences were recorded so staff attending the patient ensured that people received end of life care that met their wishes.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Many families provided feedback through the friends and family test, which is widely used in the NHS. The overall experience of care was reported to staff in the annual report. The friends and family test asks patients/families how their overall experience of the service was and gives the options 'Very Good or Good' or 'Poor or Very Poor.' There were 1,842 responses, 98.4%, which rated the service very good/good. Although eight responses rated the service as poor/very poor, none of these negative responses were from the eastern region. Patients and relatives could also provide feedback through a national patient and carer feedback survey, which was overwhelmingly positive.

Staff supported patients to make informed decisions about their care. Most patients had chosen to die at home but there were occasions when patients wanted to explore other options. Patients told us how staff explored different options for extra support with them, and how staff made referrals on their behalf.

One relative provided the following compliment, "Staff went above and beyond to get my relative home. The nurse was amazing, found a magic wand and made it happen so my relative could spend their remaining time at home. My family and I appreciate you making this happen for me."

Are Community end of life care responsive?

Good

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

Service delivery to meet the needs of local people

Good

Community end of life care

The service planned and provided care in a way that met the needs of local people and the communities served, although this was limited to the services commissioned. 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. Managers worked with Clinical Commissioning Groups who funded the services' nurses. Patients were either registered with the service when they were discharged from hospital, or by their GP or other healthcare professional.

Patient's care was planned and delivered to meet their health, social, emotional, and spiritual needs. People received holistic care because staff understood the importance of working together as a team to provide seamless care for people. A plan of care was agreed which reflected patient's views about how they wished to receive their end-of-life care and support.

The registered manager told us, "We provide a lot of care to patients with a dementia in their own homes; it may be the main disease but quite often it's not the only disease. All staff do dementia training in the 'understanding the needs of people' programme."

Marie Curie hospital discharge teams discharged patients, including those living with dementia, to their own home, nursing homes and to residential homes whichever was the preferred place of care and death. The Marie Curie discharge service was therefore equitable for all patients regardless of their diagnosis. The rapid response community teams also provided an unscheduled service to people in their own homes and residential homes so everyone with a dementia had access to the service across the county.

The registered manager acknowledged most patients and families seeking support from the service were from a white British background, although people from other cultures did access the service. The registered manager explained how patients were registered/referred to all services either by community health care professionals or the Marie Curie hospital discharge nurses at Northampton and Kettering General Hospitals. The provider supplied a detailed monthly report to commissioners and regularly pointed out the service delivery was not equitable. The registered manager was actively working to include everyone from a range of backgrounds and cultures. The registered manager shared a goal known as the North Star, which states, "Everyone will be affected by dying, death and bereavement and deserves the best possible experience, reflecting what's most important to them. Marie Curie will lead in end-of-life experience to make this happen." To achieve this, the service recognised they needed to reach out to people such as those living with a disability, people who were homeless, people with a range of religions or beliefs and others. The registered manager told us, "The charity is very committed to inclusivity and the latest strategy and internal restructure will facilitate this work to be developed over the next 18 months."

The provider commissioned a report, "A Place for Everyone - what stops people from choosing where they die." This report found people with an Asia/Pacific background indicated strong preferences for being in hospital. In 2020, Marie Curie researchers were awarded a grant to determine whether people from South Asian communities were able to have equitable access to palliative care. The study is looking at patterns in referral by GP surgeries to palliative care by ethnicity and will include interviews and focus groups investigating how to improve access. The study will run until January 2022. Other projects have been undertaken to understand the difficulties experienced by 'hard-to-reach' groups, as defined by the service. These included "Including people with learning difficulties in end-of-life care", "How our nurses care for people with different religious beliefs" and, "LGBT people face discrimination as they die – Marie Curie's LGBT Report." The service was proactively trying to engage with these groups.

Good

Community end of life care

The service had systems to help care for patients in need of additional support or specialist intervention. A service user using the service told us the service was responsive to their needs. They told us," They were just there, they said I could ring anytime, we had constant support."

Meeting people's individual needs

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

Staff told us they always listened to patients to understand what was important to them and gave us some examples of how they did this. For example, when patients' preferences around how they wanted their care delivered meant they did not want staff sitting in the same room, staff found a way of sitting outside but still be able to monitor the patient.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff told us they could access communication aids, if necessary, but patients with a disability or sensory loss usually had family members with them who could communicate between staff and the patient. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Nurses visited patients who lived in care homes as well as patients living in their own home. Nurses did not visit patients in nursing homes because there were trained nurses on site, however they supported staff in nursing homes by providing advice over the phone when requested.

Access and flow

Most patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

Patients referred to the service were expected to be within eight weeks of their death and had chosen to die at home.

Managers recognised while patients and families expressed gratitude for the service they received, a common request was that more frequent support would make a big difference. Some people said as well as receiving more care, they would like support sooner and would like more care provision during the day as well as nights. The provider recognised the care they could deliver was restricted by the hours they were commissioned to provide.

The service worked closely with partner specialist community palliative care providers. Where a need was identified a rapid response nurses could make direct referrals to community palliative care nurse specialists, palliative care consultants, community palliative care occupational therapy and physiotherapy teams and hospice at home. They could also arrange for a person to be admitted to hospice for complex symptom management or when a person had identified their preferred place of care when they were in the last days of life was a hospice, or for day care hospice services. The team also had 24-hour access to an on-call palliative care consultant/registrar who they could contact for advice and support regarding symptom management and prescribing.

Data showed the demand for the service exceeded the hours commissioned. Nurses told us about the pressures they faced on days when they responded to lots of calls from patients and their families, and sometimes had to travel long distances to reach patients. The service provided monthly data to each CCG, which demonstrated demand exceeded capacity each month. This was discussed at contract review meetings.

Good

Community end of life care

We discussed staffing with the clinical nurse managers, who explained they are contracted to provide a set number of nurses and had to work within the budget set. Although the service was providing a contracted service, this meant staffing levels were not related to patient dependency. Staff explained there were days when they were very busy and other days when they were not. When two separate family members raised concerns that there was only one nurse to cover the whole of the county, and the impact this had on patients struggling with pain levels, the registered manager escalated these concerns to the Clinical Commissioning Group who contracted the service.

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. The service took complaints seriously and used them as an opportunity to identify learning. The most common complaints in the nursing service nationally were to do with communication with patients and relatives. There were no complaints escalated to the relevant ombudsman or regulatory body from the nursing service. All complaints were analysed, and changes made. Learning was then shared nationally. For example, all services nationally have been made aware to make sure families understand the separate roles of nurses and healthcare assistants, so they know which service they need to book.

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. Staff received quarterly updates about feedback and engagement from patients and their relatives through a patient and carer experience report. This report gave a national picture and gave managers the opportunity to benchmark their services against national expectations. For example, key findings from the national report included the number of people rating services as “Very Good” or “Good” was better than their expectation. The registered manager confirmed they had responded to complaints in line with the provider’s policy.

Staff could give examples of how they used patient feedback to improve daily practice. The registered manager made changes and informed all staff about new procedures where necessary. For example, where a member of staff did not attend an overnight stay due to confusion about the rota, a flow chart was designed to clearly show staff what the process for arranging the rota was. This meant all staff were able to follow the same procedures when work was booked. This incident only happened once and was reported as an incident.

Are Community end of life care 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.

Good

Community end of life care

There was a clear management structure with senior staff allocated lead roles. The board of trustees delegated the day-to-day management of Marie Curie to the chief executive, who appointed the executive team, made up of the charity's most senior managers.

Throughout the organisation staff understood their lines of responsibility and accountability for decision making about the management, operation and direction of the service. The management team demonstrated a strong commitment to providing people and those closest to them with a safe, high quality and caring service and promoted high standards. The clinical nurse managers and the registered manager were experienced managers with knowledge and understanding of the sector. All the staff we spoke with were enthusiastic about their work and shared the values and aims of the service.

Throughout our visit we found the provider valued the importance of quality, improvement and learning. Each member of staff had a personal development plan and were supported through supervisions and appraisals to identify opportunities for shared education and learning. The provider also promoted learning and development within the wider community and offered training for care home staff.

Staff told us their managers were knowledgeable and supportive. Staff told us they could raise any concerns and they would be listened to. Staff were able to request training if this would enhance their role.

Vision and Strategy

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

The registered manager had a clear strategy, developed with input from staff, patients and their families. This set out what they were working towards to meet the needs of their local population. The registered manager was working with other Marie Curie managers and directors to develop a business plan to detail how their aims for the service would be achieved. This included providing:

Care Home Training

Hospice at Home

Hospice at home digital/virtual ward

GP list identification

Training for families to take on higher level caring skills

Death Cafes – to encourage people with lived experience to share their stories and provide support for people currently going through it. For the end-of-life patients also if they wanted to share and work towards planning their own end of life experiences.

Death Doulas – to attempt to reach hard-to-reach groups also with the more spiritual side of this work

Good

Community end of life care

Community tree planting

Social prescribing in end of life

Mixed housing development

Rapid Bereavement support.

The registered manager said, “We will incorporate the fundraising and learning and development aspects of Marie Curie to achieve and resource some of the aims.”

Staff delivered a night nursing service and rapid response nursing service and worked in close partnership with key organisations, such as clinical commissioning groups and other care providers to care for people in the last six to eight weeks of their lives.

Patients and their families consistently told us they received care and treatment that reflected the services’ values. Marie Curie values included always being compassionate, making things happen, leading their field and making people at the heart of everything they did. One member of staff said, “We get emails to update us and we’ve just had a new update; we get the core values, all on our laptops.”

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.

The management team fostered a culture of openness, respect, and transparency. Staff were encouraged to raise concerns openly and without fear of recrimination. We saw examples of this in the implementation of the accident, incident, safeguarding and complaints procedures. Where appropriate, staff had been enabled through closer support and offer of additional training to ensure consistent high-quality care for people using the service.

When asked if their manager communicated openly and honestly with them in a survey, one staff member wrote, “She is the best clinical nurse manager, she has mutual respect. Nothing is ever too much trouble; she will put herself out to help you.”

Staff knew how to follow whistleblowing procedures and raise concerns anonymously if required and were confident that any issues raised would be addressed to keep people safe and to improve the service people received.

Staff completed equality and diversity training, this included enabling staff to challenge inappropriate behaviour. The provider acknowledged the ethnicity of the workforce did not reflect national statistics. Work was in progress to address this, this included using an external body to assist with shortlisting for senior roles, creating apprenticeship opportunities specifically for diverse communities and reviewing staff training. The provider was actively recruiting new staff from diverse backgrounds and had working groups to support staff with protected characteristics.

The provider had a lone working policy to help keep staff safe. Staff worked alone much of the time, so the provider's 24-hour call centre always knew where staff were and the route they were taking. The environment staff worked in was also risk assessed, such as if there were steps, poor lighting or dogs in the house. Staff carried torches with them. If necessary, an out of hours nurse would attend a patient with staff.

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 registered manager understood the improvements that needed to be made across the service. For example, the provider was working to improve participation of hard-to-reach groups by raising awareness of the services they provided. Reports had been commissioned to identify why some people in "hard to reach groups", such as people with a learning disability, were not being referred to the service.

Audits were benchmarked against a series of measures structured around national directives on end-of-life standards as well as the organisations own goals. This enabled the service to measure progress against agreed standards, monitor quality in a systematic way and share best practice. Where improvements were needed, we saw that action plans with agreed timescales were put in place. For example, staff equality and diversity training had been changed to include empowering staff to challenge inappropriate behaviours, such as challenging any racist comments.

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. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The provider worked with a fixed maximum budget to deliver commissioned services. The provider's reports showed demand always exceeded capacity in every service. The challenge for the service was to provide care in a way that had the greatest impact for the most patients. When the service increased their charge rates for 2021/22, most commissioners chose to have less care rather than provide additional funding to maintain service levels. Managers managed this by negotiating with the referrer to ensure the service was not overwhelmed.

The organisation had systems to manage risk and monitor performance. The service had a risk register, which was a live document. All senior managers had access to the risk register. The board and the executive had monthly reports about risks, and these were followed up. The registered manager had weekly meetings with staff to update the risk register and fortnightly meetings with a senior manager to review, prior to reporting to the board.

The registered manager also reported risks to the national quality team, which meant the provider had oversight of risks across the organisation. The registered manager met with the team monthly or when anything arose, to review the risk register. The provider had appointed a new risk manager who had made some changes which improved the risk register by identifying themes. Staff had also been encouraged to report incidents better. The clinical nurse managers had a line management responsibility for advanced nurse practitioners and nurses who visited people in care homes and in their own homes.

Good

Community end of life care

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected data such as the number of patients who have been supported to die in a place of their choosing. This information was recorded monthly and reported to the CCG. The service exceeded the Key Performance Indicator (KPI) every month for patients dying in their preferred place of care. The provider produced reports summarising the service's performance which were available to all staff.

Clear reporting procedures and monitoring arrangements were followed in the event of serious accidents and incidents relating to people's care. Records showed that incidents were analysed, and the results communicated to staff along with any required actions. There were effective arrangements to ensure that data or notifications were submitted to external bodies. Appropriate notifications were submitted to CQC.

The provider recognised families and patients sometimes did not always know the right thing to ask or they lacked information when they needed it. The provider acknowledged they had a wealth of information they could provide, and they needed to ensure people received this information in a timely way. Quality Improvement work was underway to ensure people received information such as the Marie Curie Nursing Services patient packs when they needed them. The provider also recognised some face-to-face communication needed to be improved and was looking at ways of achieving this.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

Staff told us how they worked with GP's, district nurses and care home staff to provide the support patients needed at the end of their lives. Staff had regular newsletters to keep them informed about developments within the organisation. Staff were also given the opportunity to complete surveys where they were asked their opinions on a range of topics. The registered manager was able to see the comments and discussed anything staff raised during 'virtual drop-in' meetings. The registered manager told us that where possible, they implemented suggestions from staff. For example, staff asked for extra pieces of equipment which helped them move patients easier; these should have been provided by district nurses but were not always available. A clinical nurse manager explained staff could access resources they needed either from the stores the service held, or by placing an order with NHS supplies service.

The organisation was working towards better communication between patients, relatives and staff. This is governed by legislation called The Accessible Information Standard. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. Staff were encouraged to document whether the patient and/or carer were asked if they had any communication /information needs relating to a disability or sensory loss, and what they were if applicable. The service could provide people with the support they needed once this was identified, for example by producing documents using large print.

Learning, continuous improvement and innovation

Good

Community end of life care

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

The provider commissioned reports which looked at the performance of the various aspects of their services. The reports were based on evidence gained from a variety of audits and statistics. The reports gave the provider and other organisations an overview of what the services had achieved and reported their progress against identified targets.

The service was committed to developing an excellent service and identified ways to further improve through research and reflective practice. For example, the service was undertaking a collaborative dementia related research study.

The registered manager wanted to develop the service to provide facilities such as death cafés and death doulas. Death cafés will be a place where people with lived experiences will be encouraged to share their stories and provide support for people currently going through it. Death cafés will also help people who may be reaching the end of the lives to share and work towards planning their own end of life experiences. In the same way a midwife would support at the start of our lives, a death doula is a person who will support people at the end of their lives. The death doula would be aware of spiritual and cultural needs, and this would help the service appeal to minority groups. People would be able to have someone who would support them through the bereavement process and have discussions about death, grief, and loss.