Marie Curie Cancer Care

Quality Account Report 2010/11

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Marie Curie
Cancer Care

Contents

Statement on quality from the Chief Executive of the organisation

Welcome to our second Quality Account Report.

This report, as was last year's, is written to provide a balance to our financial reports and will focus on the quality of the care we provide to our patients.

The reporting period 2010/11 reflects the final year of our 2008/11 strategic plan.

The new 2011/14 strategic plan was developed to maintain our vision and our commitment to patients and families and has, therefore, kept the same title 'We Put Patients and Families First' as a demonstration that our vision and values are unchanged.

Putting patients and families first

Our vision for 2011/14

Everyone with cancer and other life limiting illnesses will have the high quality care and support they need at the end of their life, in the place of their choice.

Our core value

We put patients and families first.

Our strategic plan to deliver this throughout 2011/14 sets out our plans to develop, expand and fund our work.

Our key objectives over the next three years include:

Better care

- Delivering the right care, in the right place, at the right time
- Hospices being the hub of their communities
- Always improving quality

Wider reach

- Research and development to improve end of life care for everyone
- Being better known and understood

- Helping communities build better local care

Stronger foundations

- Increasing the money we raise to fund our services
- Growing our volunteer support
- Improving our efficiency and effectiveness, always demonstrating value for money

Providing care for terminally ill patients

Marie Curie Cancer Care was established in 1948 - the same year as the NHS.

More than 2,700 nurses, doctors and other healthcare professionals help provide care for terminally ill patients in the community and in our hospices, along with support for their families.

During 2010/11 we provided care through the Marie Curie Nursing Service and hospices to 29,057 people, and in 2011/12 we expect to provide care to more than 32,500 people with cancer and other terminal illnesses.

How do we decide what to include in this report?

The topics we have selected are those that patients and families have told us are important to them.

We regularly ask patients and families what they think about our services and what we can do to improve them and we have, to some extent, involved them in a limited number of focus groups in the hospices. This year we have appointed an important new post in the organisation, Head of Carer Services and Engagement, who will ensure that we are really involving patients and families as much as we can in improving services.

A major three year project has started to increase the amount of feedback we collect and the ways in which we do it, including a number of sources such as social media. The project will go on to establish the best ways to analyse and act on what we are being told. To ensure patients and families are involved as the project evolves, a carer is participating in the Project Board.

We will report next year on the progress of this strategically important work.

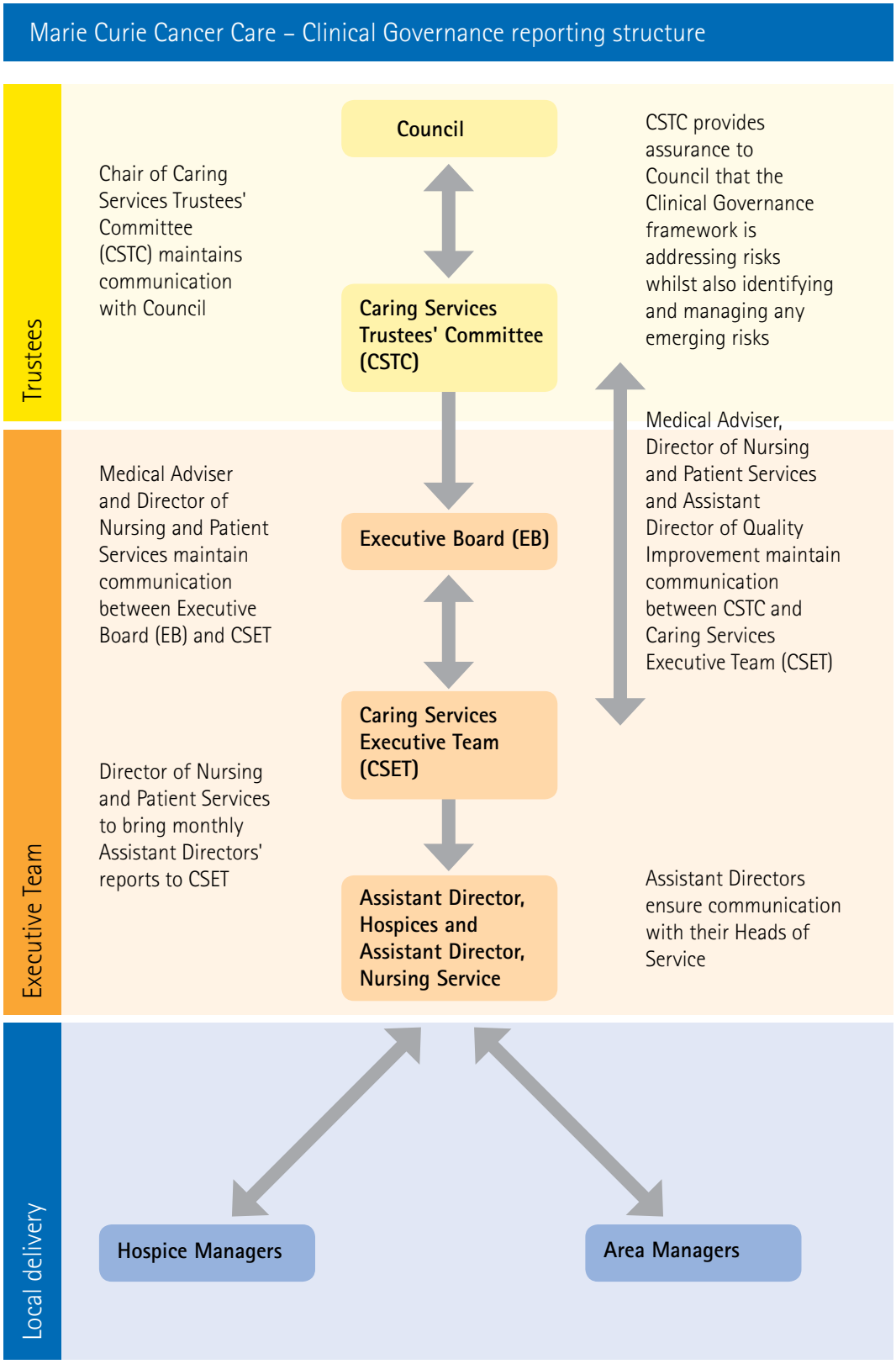
Measuring and demonstrating quality

Monitoring within Marie Curie Cancer Care

We know that it is not enough to simply say what we plan to do - we need to be able

to demonstrate that we really are delivering the best possible care to patients. In order to do this we assess and monitor a number of activities and outcomes across our care services using audit, service evaluations, patient and carer surveys and inspections, as well as analysing trends in complaints and incidents.

The results of these different monitoring activities are collated and reported internally through our governance framework which is set out below.



External monitoring

Each of our services is registered with the appropriate regulatory body as set out below:

England (hospices and nursing service)	Care Quality Commission
Scotland (hospices only)	Healthcare Improvement Scotland
Scotland (nursing service only)	Social Care and Social Work Improvement Scotland
Wales (hospice only)	Healthcare Inspectorate Wales
Wales (nursing service only)	Care and Social Services Inspectorate Wales
Northern Ireland (hospice and nursing service)	Regulation and Quality Improvement Authority

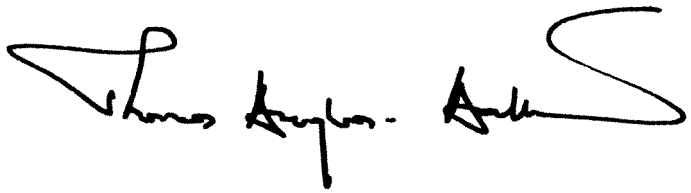
The regulators gather information about our services from a number of sources and use this to build a picture of the quality of services we provide. All our services are subject to announced or unannounced inspections at any time.

In addition, senior managers from the Caring Services Executive Team carry out unannounced visits to each of our hospices twice a year and the reports of these visits are sent to the regulators as well as our internal boards.

Whilst we believe that our structures are supporting the drive to improve quality, we want to be as sure of this as we are about our financial governance processes. In order to do this we are commissioning an external organisation to review and report on our processes. We believe this will be a valuable exercise that will establish our baseline and allow us to measure our effectiveness much more easily in the future. More importantly it will provide assurance that we are doing our absolute best to provide high quality care that patients and families can rely on.

In last year's report we set out some very clear aspirations for areas where we wanted to see improvements and our progress in these areas will be reported on in section three. We have also prioritised new areas for improvement in our new strategic plan which will form a new focus for us this year and these will be set out in section two.

My Executive Board colleagues and I are confident that the information set out in this report is a true reflection of quality in our current care provision.



Thomas Hughes-Hallett
Chief Executive

Priorities for improvement 2011/12

Community Nursing Service

Priority 1 Clinical Effectiveness

Maximising Efficiency

We want to make sure that we get the right care to the right patient at the time they need it, in the place of their choice.

In order to do this we need to ensure we have an effective, flexible workforce that can respond to rapidly changing needs and circumstances, not only of the patient, but of the healthcare environment within which we operate.

There are a number of issues we have identified that we need to address in order to achieve this.

Taking advantage of technological developments allows us to focus our energy where it is needed most – with our patients. Last year we implemented a new IT system called Patient Connect which enables us to match patients' needs to nurses' availability more easily. This means that we should reduce the number of times that we are unable to allocate a nurse to a patient when care has been requested. This number is described as "unmet need" and we are now specifically monitoring this to ensure that the changes we have introduced are improving access to care. We have targets in place to reduce unmet need in the next 12 months. Monitoring of how well we are doing takes place each month at the Caring Services Executive Team meeting.

"(Marie Curie Cancer Care could make my life easier) If I knew that I could get a regular amount of shifts each week. Sometimes I have one or two, sometimes more. It's not regular. If there is sickness (there's been a lot) then I get a last minute phone call."

Marie Curie Nursing Service patient, north east region

In addition, our nurses are providing their confirmed availability for work up to four weeks in advance which means that we are able to plan further ahead, again increasing reliability for patients.

"Suppose so (my needs are being met), local co-ordination centre left referring too late and no Marie Curie Nurses available this week."

Marie Curie Nursing Service patient, central region

Patient Connect enables us to be more flexible in the ways in which we allocate work to our staff. We can offer shorter episodes of care, allowing us to see more patients with the same number of staff and giving us the ability to respond urgently to patients during the day as well as at night.

We will monitor our progress against this target each month at the Caring Services Executive Team meeting and progress will also be reviewed by our Executive Board.

Priority 2 Patient Safety

Increasing effective partnership working

We know that we can not deliver all the care and support patients and families need during the course of a terminal illness and, therefore, we are increasingly working with other organisations to deliver seamless care to patients and families. Better continuity is a key theme we have identified from listening to our patients and their families.

> *"We have four different services in our area and we do get mixed up between them all sometimes – we get a lot of phone calls telling us which service is coming that night and it's a pity that you can't just go to one place to get the service and save all the phone calls. But we are quite happy with the Marie Curie services and we think all the nurses are brilliant."*
>
> **Marie Curie Nursing Service patient, central region**

This year we will be testing several new services in partnership with other organisations including the NHS and other charitable providers. One example of this is the Greenwich project where we are working with an independent hospice and the NHS to deliver a combined service which offers planned in advance and urgent care 24/7. This partnership working will be evaluated to see if we have been able to achieve key outcomes for patients. These important patient focussed outcomes form part of the National End of Life Care Strategy set by the government and include avoidance of inappropriate hospital admissions, supported discharge to go home and delivery of care to the patient in the place of their choice.

A similar service has been started in Grampian where our staff are working with the NHS and GPs out of hours to ensure consistent around the clock care for patients.

One District Nurse told us:

"The Marie Curie Nurse visited the patient four times overnight and the man died peacefully about 8.15am with his family around him. I think this should be identified as an example of how good this service can be - if we did not have the Marie Curie Nurses this man would have been admitted to hospital - which would have undone lots of good work over many months - when the District Nurses were supporting this man to achieve his wish to die at home. A very well done to ALL involved is deserved."

Priority 3 Patient Experience

Becoming more accessible and providing better continuity of care

We know from research and our patient and family surveys that patients want better continuity of care. In order to provide this successfully we needed to know what this really means. Patients and families have told us that it means not having too many different staff caring for them, but also that it means having staff caring for them that have sufficient information about them so that they do not have to keep repeating their history over and over again.

"I have a 24 hour package and initially found the bureaucracy involved very frustrating, having to organise everything through the District Nurse. I know this is not Marie Curie's fault but the frustrations are still there. I really need continuity because sleeping with somebody else in the room is a very personal thing. One week I had four different carers from Marie Curie which is very difficult for my parents as well as me because they have to keep repeating themselves each time someone new comes."

Marie Curie Nursing Service patient, central region

We have three initiatives underway (set out below) that we will evaluate to see if the changes we have introduced improve access and continuity from the patient's perspective.

1) Marie Curie managed services

2) Self referral

3) Rapid response services

Marie Curie managed services

At present, when a patient is referred to our nursing service it is usually the District Nurse who assesses the patient's needs and decides how much care the patient can receive. Starting in Northern Ireland we have begun working in partnership with District Nurses to provide input in to the assessment of the patient's needs and advice on the best way they can be met. We will then ensure that the patient is given the most appropriate package of care from Marie Curie, including providing staff who have the ability to meet the patient's clinical need. The pilot is underway and will be thoroughly evaluated as it progresses. Further test sites have been identified and will begin this year.

Self referral

At the moment one of the barriers to patients accessing our services is the requirement for them to be referred to us by the District Nurse or another healthcare professional already involved in their care. This can be a barrier not only to access but also to patients being able to exercise their choice.

We have begun a small pilot in Derbyshire which will enable patients to contact us directly if they need our care. We will seek the patient's consent to work closely with the patient's primary care team to ensure that the care the patient receives is comprehensive and coordinated with the other healthcare professionals involved in their care.

As we will not be reliant on the District Nurse referring the patient to us, we will be changing the way we work. We will undertake the initial assessment of the patient's needs and determine the best level of care and support for them. We have ensured that the staff involved in the project have all received the necessary training and skills to do this effectively and efficiently.

Special publicity materials have been launched in Derbyshire in addition to a slot on local radio to raise the awareness in the area. Patients and families will be able to ring one contact number to receive an assessment within 24 hours.

The pilot will run for 24 months and will be evaluated to establish if it is appropriate to expand to other areas.

Rapid response services

We already have a number of rapid response services which can provide urgent short episodes of care to patients in the community. Generally these services form part of a more comprehensive out of hours' service involving doctors and other healthcare staff. All patients referred to our rapid response services are given a contact number to enable them to contact the care team directly as and when they need. A recent data review has shown that 50% of the care provided has been requested directly by patients and their families. We are increasing the number of rapid response type services around the country as they are commissioned and in the last year two new services were commissioned covering the regions of Grampian and County Durham.

Priorities for improvement 2011/12

Hospices

Priority 1 Clinical Effectiveness

Symptom Management

We know from our patients that if we can help them control their symptoms then their quality of life improves. Last year we focussed on improving the management of patients' pain and the improvements that have been achieved can be seen by our results in part three of this report.

"They are doing everything possible to keep my husband out of pain and keep him going as long as they can."

Carer of an in-patient at the Marie Curie Hospice, Solihull

This year we will focus on another common symptom; breathlessness. The clinical teams will establish and implement standards that will allow us to measure how well we are dealing with this troubling symptom and a national audit later in the year will give us an indication of how well we are doing. The audit will form part of our national audit programme so that we may monitor progress.

Priority 2 Patient Safety

Infection prevention and control

From a recent audit and review of our current infection control policies and procedures it was clear that we have inconsistencies in our practice across the nine hospices, including how patients are screened and the results recorded. These inconsistencies have not had any detrimental effect on the care we have delivered, but we want to be sure that the highest standards are being delivered across all our hospices at all times.

This year we will be producing and implementing standard policies, procedures and practice to allow us to compare performance across the hospices.

The Medical Adviser is our nominated Director of Infection Prevention and Control (DIPC) as required by the Department of Health and she will oversee this important area of work. Regular reports on progress against areas for improvement will be sent to the Executive Board.

Actions required include:

- Establish national standards and procedures
- Ensure Infection Control Lead Nurses in each hospice have a standard remit
- Ensure appropriate training is available to staff
- Develop a network of Infection Control Nurses to share information and best practice
- Formalise links with local NHS infection control teams into contracts or service level agreements
- Provide an annual report to Council on compliance

Priority 3 Patient Experience

Choosing where to die

> *"My life has been made easier by my spell on the (hospice) ward. (I) feel much safer – better than what I expected. Staff treat me like a real person. No worries about ever coming back in."*
>
> **In-patient at the Marie Curie Hospice, Glasgow**

Patients and families have told us how important it is to be able to have real choice about where they die. Research commissioned by Marie Curie Cancer Care shows that 65 per cent of people would choose to die at home. In reality, only 25 per cent achieve this. We recognise that patients can and do change their minds so we need to be sure we are capturing and updating information as their condition progresses. Last year we focused on recording the information about patients' preferences and our progress in this area can be seen in section three but this year we are going a stage further.

> *"Was apprehensive on going (to the hospice) but there was no need. A very welcome place to be (just what I need)."*
>
> **In-patient at the Marie Curie Hospice, Belfast**

This year we will further improve the recording of this important information to ensure that any changes expressed by the patient are captured. The next step is that we will undertake a review of where we have been unsuccessful in helping the patient achieve their choice to establish what the reasons were for this. By understanding the barriers to achieving choice we will then be able to identify how we can start to overcome them.

“Nothing at present but in the near future if anything changes it’s nice to know that they are there for you.”

Outpatient at the Marie Curie Hospice, Liverpool

Mandatory statements of assurance from the Board

The statements set out below are required by law; however numbers 2.1-2.4, 4,6,7 and 8 are not applicable to Marie Curie Cancer Care. There is no requirement to report on regulation of our services in Scotland, Northern Ireland and Wales although information on services across the UK form the basis for this report.

- **Review of services**

1) During 2010/11 Marie Curie Cancer Care provided services through nine hospices caring for in-patients, outpatients and day care in addition to the community nursing service across the UK.

1.1) Marie Curie Cancer Care's Executive Board has reviewed all data available to it in the quality of care in those services.

1.2) The income generated by the NHS services reviewed in 2010/11 represents 100% of the total income generated from the provision of NHS services by Marie Curie Cancer Care for 2010/11.

- **Participation in Clinical audits**

2) The following statement is **not applicable** to Marie Curie Cancer Care. Providers should complete the following statement:

During 2010/11 there were no national clinical audits or national confidential enquiries that covered NHS services that Marie Curie Cancer Care provides.

2.1) The following statement is **not applicable** to Marie Curie Cancer Care: During that period there were no national clinical audits or national confidential enquiries which Marie Curie Cancer Care was eligible to participate in.

2.2) The following statement is **not applicable** to Marie Curie Cancer Care: The national clinical audits and national confidential enquiries that Marie Curie Cancer Care was eligible to participate in during 2010/11 are as follows:

None

2.3) The following statement is **not applicable** to Marie Curie Cancer Care: The national clinical audits and national confidential enquires that Marie Curie Cancer Care participated in during 2010/11 are as follows:

None

2.4) The following statement is **not applicable** to Marie Curie Cancer Care: The national clinical audits and confidential enquiries that Marie Curie Cancer Care participated in, and for which data collection was completed during 2010/11, are listed below alongside that number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

None

2.5) - 2.7) The reports of 13 local clinical audits were reviewed by the provider in 2010/11. The actions being taken for the key audit outcomes are captured in section 2. For all these audits the clinical teams have produced local action plans for improvements where necessary and in general they will be re-audited within the next 12 months to check for improvements. However, where results were outside an acceptable level the hospice team will re audit within three months. The results will then be subject to review and approval by the Caring Services Executive Team.

Hospices

Audit topic	Data collection
Liverpool Care Pathway	April 2010
Records Management	May 2010, re audited January 2011
Do Not Attempt Cardio Pulmonary Resuscitation	June 2010
Admission and Discharge	July 2010
Pain Assessment	August 2010
Medicines Management	September 2010
Falls Prevention	October 2010
Bereavement	November 2010
Infection Control	December 2010
Preferred Place of Death	February 2011

Marie Curie Nursing Service

Audit topic	Data collection
Personal & Protective Equipment	July 2010
Falls Management	October 2010
Medicines Management	April 2011

The results of all these audits are reviewed by the Caring Services Executive Team and each local site has produced plans for improvements where necessary which are monitored by the Clinical Audit Group. Each topic is subject to re-audit within the audit programme to check progress.

- **Participation in clinical research**

Providers should complete the following statement:

The number of patients and carers receiving NHS services provided or sub-contracted by Marie Curie Cancer Care 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 92.

Hospice/Service	Number of patients
Belfast	48
Hampstead	29
Solihull	15
Total	**92**

Patients at our hospices were involved in the following studies:

Belfast hospice

Complementary Therapy Study
'An exploration of how older people with primary lung or colorectal cancer view registered complementary therapy services in Northern Ireland'.

EU Survey
'European Survey of Oncology Patients' experience of breakthrough pain.

INIS Instanyl Non- interventional Study (Nycomed)
A three month observational prospective patient cohort study of the treatment of breakthrough pain in cancer patients with Instanyl.

Hampstead hospice

An evaluation of a complex rehabilitative intervention for patients with advanced, progressive recurrent cancer.

Solihull hospice

Patients and carers were involved in a questionnaire-based study to consider whether health education in a hospice setting is acceptable and beneficial.

- **Use of CQUIN payment framework**

4) The following statement is **not applicable** to Marie Curie Cancer Care: Marie Curie Cancer Care income in 2010/11 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework. CQUINS are not currently being applied to our contracts.

- **Statements from the Care Quality Commission**

5) Marie Curie Cancer Care is required to register its services in England with the Care Quality Commission and its current registration status is fully registered. Marie Curie Cancer Care has the following conditions on registration:

Marie Curie Hospices are registered to provide the following regulated activity:

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Diagnostic and screening procedures

The Marie Curie Nursing Service England is registered to provide the following regulated activity:

Personal care

Nursing care

Treatment of disease, disorder or injury

Diagnostic and screening procedures

The Care Quality Commission has not taken enforcement action against Marie Curie Cancer Care during 2010/11.

Marie Curie Cancer Care has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

- **Data Quality**

6) The following statement is **not applicable** to Marie Curie Cancer Care. Providers should complete the following statement on relevance of data quality and your actions to improve your Data Quality:

Marie Curie Cancer Care is not required to submit records during 2010/11 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published area.

- **Information Governance Toolkit attainment levels**

7) The following statement is **not applicable** to Marie Curie Cancer Care. The following statement is required under the Data quality section:

[Name of provider] Information Governance Assessment Report overall score for [reporting period] was [percentage] and was graded [insert colour from IGT Grading Scheme].

- **Clinical coding error rate**

8) The following statement is **not applicable** to Marie Curie Cancer Care. The following statement is required under the Data quality section:

Marie Curie Cancer Care was not subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission.

Review of quality performance

In last year's report we set out three priorities for improvements for our hospices and our community nursing service. All the areas identified were specifically selected as they would impact directly on the care our patients received, either through improving patient safety, clinical effectiveness or the patient's experience. We will now look at how well we have met our aims.

Last year's priorities – Marie Curie Hospices

Patient safety

Priority 1 – Every in-patient in our hospices has a falls prevention plan completed within 12 hours of admission

We routinely monitor the number of incidents and accidents that occur in all our services and, by analysing this data regularly, we know that patient falls remains the main theme. Whilst we recognise that patient falls are caused by multiple factors, including the patient's condition and that it is, therefore, not possible to eliminate falls completely, we are actively working to reduce them to a minimum.

We have set standards of assessment and care which we have included in our clinical audit programme.

In 2009/10 we audited each of the hospices against the standards and it was the result of this audit which led us to identify this as a key area for improvement. Whilst the results from the audit demonstrated good compliance with our core standards, it also showed that there was considerable variation in the documentation used. Recommendations from the audit included the need to review the methods used.

This year the audit was repeated and it demonstrated that improvements had been made in three out of the four key standards, but also that further improvements were required in one. The one which requires further improvement relates to the availability of written information for patients and carers.

	2009	2010
Standard 1: 100% of in-patients will have a falls risk assessment completed within 12 hours of admission.	91%	91%
Standard 2: Falls risk assessment should be reviewed as the patient's condition changes.	85%	100%
Standard 3: 100% of patients identified with risk of falling should have a falls care plan completed.	86%	74%
Standard 4: 100% of patients and/ or carers will be offered information on reducing risk of falls.	45%	61%

(Green = 76 – 100%, Orange = 51 – 75%, Red = 0 -50%)

The results of the audit have been distributed to the nine hospices. We recognise the result of the audit against Standard 3 has fallen and therefore a review of falls care planning will take place. The hospice manager at Bradford is now leading a team of physiotherapists and occupational therapists to carry out a comprehensive review of how we assess patients and more importantly how that information is used in planning their care. When the optimum assessment method is agreed it will be implemented across all hospices. To ensure the improvements have had a positive impact on patient care it will be audited again next year.

Clinical Effectiveness

Priority 2 – Every in-patient will have a pain assessment within 24 hours of admission with a daily review, where necessary, to monitor how effectively their symptoms are being managed

We know that for many of our patients having good symptom control is a key part of their care. If their pain is controlled then their quality of life is dramatically improved.

In order to monitor the effectiveness of our care, one of our Medical Directors led a national piece of work to set core standards of patient pain assessment and documentation across our nine hospices. These standards were then audited as part of our ongoing national clinical audit programme. Following the audit the standards are reviewed to ensure they continue to reflect best practice.

	2009	2010
Standard 1: A detailed initial formal pain assessment will be carried out for every inpatient within 24 hours of their admission to a hospice. • Is there documented evidence that an initial pain assessment has been carried out?	73%	95%
Standard 2: Patients will have an ongoing assessment of their pain in accordance with the needs of the individual patient (at least daily if not controlled). •Has a daily pain score been recorded, or if not, has an alternative method of daily pain assessment been recorded?	62%	81%
Standard 3: Each member of the clinical ward team with responsibility for symptom control and pain monitoring understands their role and responsibilities. • Are you satisfied that the member of the ward clinical team has an understanding of the following?	93% overall	88% overall
- completion of pain assessment on admission		100%
- pain scoring system used in the hospice		82%
- use of pain monitoring charts		82%

(Green = 76 – 100%, Orange = 51 – 75%, Red = 0 -50%)

For the last two years three of the key standards have remained the same, allowing us to directly compare the results. In 2009/10 we only included in-patients in the audit criteria but for 2010/11 we audited in-patients, out reach community patients and day care patients.

"The very reason I'm in a Marie Curie Centre is for them to make my life easier by controlling my pain for me. That is all I ask of them."

In-patient at the Marie Curie Hospice, Newcastle

Compliance with standards one and two has improved significantly but the result for standard three has shown a slight reduction. In order to understand where the change has occurred the results have been further analysed to allow remedial actions to be taken where they will have most effect. This audit will be repeated again next year to ensure that improvement is maintained and enhanced.

"All needs are met. Pain almost under control – getting there – (it's a) big improvement."

In-patient at the Marie Curie Hospice, Bradford

Patient experience

Priority 3 - Every patient who expresses a preference about where they want to be cared for and die will have this noted and communicated to all staff involved in their care

We know from listening to our patients and their carers that choice and control in their care are extremely important. Helping patients achieve these important choices is a central part of our patient care.

"Quite honestly, very little else (can be done to make my life easier). In 89 years I have never spent a more comfortable recovery period and if I am unfortunate enough to need your services again I hope I can be readmitted. Long may you continue. Thank you."

In-patient at the Marie Curie Hospice, Liverpool

We have set four key standards to measure how effective we are in firstly understanding our patients' needs and wishes, but also how well we are helping them to achieve their choices. One important aspect of the outcome is to further understand what the barriers are that would prevent a patient achieving their goals which is now one of our key priorities for this year.

	Dec 2009	Feb 2010
Standard 1: 100% of patients should have recorded Preferred Place of Death or a record of variance in their notes.	64%	85%
Standard 2: 100% of patients with an expressed Preferred Place of Death should (with the patient's consent) have that information shared with other relevant healthcare professionals if they were discharged home or, for day and community patients, if they were living at home.	96%	97%
Standard 3: 100% of patients with an expressed Preferred Place of Death should have this information recorded on PalCare/ SystemOne.information on reducing risk of falls.	55%	72%
Standard 4: Patients who express a preference should achieve their Preferred Place of Death.	63%	76%

These results show improvements against each of the four key standards that would have an impact on patients' care.

Some patients identified they would prefer to die at home but their second choice would be the hospice if a home death was not possible. For those whose preference was home but was not achieved this was often due to circumstances beyond the control of the hospice staff. Some examples include the patient who was waiting for a nursing home bed but none was available, several patients whose condition deteriorated rapidly and others whose families could not cope with the patient at home or where the patients had no family to look after them.

This year we will be looking at the reasons given for any instance where we were not able to help a patient die in the place of their choice. This goes further than simply recording and communicating the information as we are striving to understand and then breakdown the barriers that prevent us achieving the patients' choice. Only by understanding why we have not met the patient's wishes will we be able to improve our rate of success. This will be audited again in 12 months to ensure that progress is maintained and further improvements made.

Continued improvement

Priority 4 – To continue to benchmark care in the nine hospices to ensure consistent high standards and a system for shared learning

As our hospices have been working more closely together we have been able to improve the consistency of care provision across all the hospices, ensuring that identified best practice is the same whether in England, Northern Ireland, Scotland or Wales. National standards have been developed and implemented in a number of topics; some of these are clinical standards, for example for symptom relief and others are about professional practice, for example how well our staff meet the professional standards for record keeping.

We now undertake audits against these national standards across the UK every month with a rolling programme of subjects. The results for each hospice are then collated into a report which gives a traffic light score to each hospice. These traffic light scores highlight in red where improvements are needed, in amber where practice is acceptable and green where it is good. The hospice managers are then able to share these results with their teams so they can see how well they are performing in comparison to their peers. The hospice managers are also encouraged to share their methods and practices with each other where they are better than their colleagues. An example of one of the summary tables is below. This summary chart represents the results from the audit on records management.

	Standard 1	Standard 2	Standard 3	Standard 4	Standard 5
BELFAST	0%	94%	❶ N/A	100%	89%
BRADFORD	100%	68%	6%	20%	83%
EDINBURGH	100%	87%	33%	50%	86%
GLASGOW	40%	67%	16%	0%	74%
HAMPSTEAD	45%	78%	42%	❷ N/A	❸ N/A
LIVERPOOL	100%	79%	69%	❷ N/A	93%
NEWCASTLE	100%	87%	❶ N/A	❷ N/A	93%
PENARTH	100%	94%	❶ N/A	❷ N/A	86%
SOLIHULL	100%	97%	33%	❷ N/A	100%

(Green = 76 – 100%, Orange = 51 – 75%, Red = 0 -50%)

❶ no alternations were found in the notes audited

❷ no retrospective recording was found in the notes audited

❸ no entries relating to contact with other professionals and/ or agencies found in the notes audited

Where standards have not been met the hospice manager is responsible for taking action to improve compliance which is monitored by the Caring Services Executive Team.

The five standards for records management are

Standard 1: The charity's agreed form for multi disciplinary chronological record keeping should be used at all times.

Standard 2: All (100%) original entries in the notes should contain time (24 hour clock), date, signature, printed name, job title and clear handwriting/ legible entries.

Standard 3: All (100%) alterations made are clear and there is an audit trail of changes.

Standard 4: All (100%) retrospective recordings should state at the beginning that the recording is retrospective and the reasons as to why.

Standard 5: All (100%) entries relating to contact with other professional and/or agencies should be clearly recorded.

Last year's priorities – Marie Curie Nursing Service

Priority 1 – Audit Plan for the Marie Curie Nursing Service

The Marie Curie Nursing Service is UK wide and managed through 13 areas. Whilst each area has been undertaking local audits it is important that national standards are set for specific aspects of care and monitoring to improve performance in key areas of patients' care. A national audit programme has been introduced in the Marie Curie Nursing Service and has been designed to closely match the topics audited within the hospices to ensure that they work together to result in a robust audit programme for Marie Curie Cancer Care. The audits in the nursing service are carried out simultaneously in each of the 13 nursing areas.

Three audits were completed in 2010/11, the topics being:

- Availability of personal protective equipment (PPE) in patients' homes (gloves, aprons and hand gel)
- Moving and handling assessment for falls management
- Medicines management in the home

Key outcomes from the PPE audit

Marie Curie Nursing Staff are reliant on PPE (personal protective equipment) being supplied in patients' homes by the District Nurses. In the audit sample no gloves were available in the patient's home in 26% of the visits and no aprons were available in 55.1% of visits. Clearly this is unacceptable for both patients and our staff, so the Director of Nursing and Patient Services authorised the purchase and direct provision of PPE to our staff, all of whom now carry a supply of gloves, aprons and hand gel so we can be sure of offering the best infection control standards we can when working in patients' homes.

Key outcomes of the falls management audit

Marie Curie Nurses care for patients on a one to one basis and, therefore, it is important that we understand the patient's mobility limitations and their risk of falling to be able to provide appropriate and safe care to them. At present the risk assessment is carried out by the referring District Nurse.

Our audit looked at a number of aspects of the assessment and the availability of accurate, up to date information.

The content of the District Nurse's assessment varied considerably between each of the 13 regions and the accuracy with which each was completed varied across and within the regions. In some cases the assessment had not been updated despite significant changes in the patient's condition and in a significant number of cases, even where a risk had been identified, there was no plan in place to address this. This lack of information increases the risk to our staff but also impacts on the care to the patient.

Overall, in 98% of patients their condition had changed since the initial falls assessment, and only 50% of that total had a documented re-assessment in their care plan.

We have concluded from this audit that it is important that our staff carry out a further comprehensive and nationally consistent risk assessment at specified intervals. Steps are now being taken to develop an appropriate assessment document.

In order to implement this effectively we also needed to understand what training our staff would need. A further question was asked in the audit to establish any gaps in the training that had previously been developed and delivered locally within the regions.

The results of this identified that although 98% of staff had attended moving and handling training within the previous 12 months, the content of the training varied. These variations are now being addressed through changes to the way in which training is developed, coordinated and delivered.

The data for the medicines management audit is currently being analysed and recommendations will be taken to the Caring Services Executive Team.

The audit programme is a rolling programme for 12 months, but this is regularly reviewed to make sure that there is sufficient flexibility in the plan to allow us to look at any aspects of care if we have any concerns or if new guidance is published that may affect the way in which we deliver care to patients.

Priority 2 – Caring for patients and looking after staff

In order to provide the best care to patients we need to have accurate up to date and complete information about the patient's condition and clinical needs before we allocate a nurse to visit them.

The Patient Connect database has helped us to capture more accurate information about the patient which is then used to allocate an appropriately skilled member of staff who is then given all the information they need to look after the patient safely including the District Nurse clinical and manual handling assessment.

In addition, the database records the additional training that staff have undertaken to ensure that the patient's needs are matched to the staff's skills.

To improve staff training a number of online training modules have been developed which staff can access at any time. Some of these have been specifically designed as a result of feedback we have received from patients and families.

Assisting with medication training

This training is provided to all new Healthcare Assistants during induction. Currently 89% have completed the training. The outstanding 11% were employed before the training was declared compulsory and a programme is now in place to ensure these staff complete the training. The 100% training target will be met within six months.

Assisting with oxygen therapy training

At present this training is only being implemented in specific regions where we care for a high percentage of patients with breathing problems who are receiving oxygen therapy at home but it is being considered for future core training for staff where commissioned services have requested those skills.

The North West region identified this as a priority last year and now 99% of the Healthcare Assistants in the region have completed the training and have been assessed as competent.

Administration of medicines for Healthcare Assistants

This training will be provided to some Healthcare Assistants depending on local service needs. A pilot of the training is taking place in Yorkshire and the Southwest region with the agreement and support of the local Primary Care Trust. To date 55% of staff have received training and progress is being monitored through the Practice Educator team.

By training Healthcare Assistants in these additional skills it enables us to provide a more flexible and responsive workforce enabling us to provide more care to more patients.

Priority 3 – Keeping staff safe

Most of our community staff work alone and primarily at night. The safety of our staff is paramount and, therefore, we commissioned an external audit of our methods of working to better understand where the greatest risks are. This audit was carried out in two stages over several months and the resulting report highlighted some key areas for improvement.

All staff will be receiving a leaflet reminding them of the important aspects of personal safety for when they are travelling and working alone at night. This will highlight the importance of using CommuniCare, a mobile phone based tracking system that ensures that we know when a member of staff is in transit and when they have safely arrived at their destination. It also has a built in emergency button staff can use to access emergency services' help if necessary. Staff will also be reminded that we have a comprehensive 24/7 on call manager to help and support them if necessary. The information leaflet provided in the short term will be supported by further face to face training. The lead Area Manager is reviewing what training is already available in the community such as the Suzy Lamplugh Trust training package that our staff can access and, if necessary, a tailored training package will be developed.

We recognise that working alone with patients near the end of life and their families can be stressful. We offer support to staff through our occupational health scheme and we have recently introduced an annual night worker assessment to identify, as early as possible, if staff have any health issues we can help to address. In addition the occupational health team offers a welfare support service which is open to staff to access directly or for a manager to refer staff to for support and counselling if necessary. Early anecdotal evidence suggests that this is having a positive impact on reducing sickness rates and this will be monitored in the next 12 months. All nurses are encouraged to attend clinical supervision, a one to one or group meeting, to enable them to reflect on their practice and identify what support and development they need to continue to deliver a high standard of patient care.

We know that if we want to continue to deliver high quality care to our patients and support to their families then we need to maintain our focus on quality improvement. Quality covers a range of areas but as we have stated in this report, focus on patient safety, clinical effectiveness and the patient experience will continue to drive what we do.

What others say about our Quality Account

Statements from Local Involvement Networks (LINk), Overview and Scrutiny Committees and (OSC) and PCTs

NHS Lincolnshire Commentary for Marie Curie Quality Account 2010/11

In terms of performance against the 2010/11 contract there are a number of issues worthy of note. For example in relation to home deaths during 2010/11, the home death rate was 21.9% on average which demonstrates that more patients are achieving their preferred place of death. NHS Lincolnshire continues to work with Marie Curie and other providers of end of life care to develop partnership relationships ensuring that providers work collaboratively to support patient choice in this area.

NHS Lincolnshire notes Marie Curie's evidence and acknowledges the excellent feedback from patients and carers alike. NHS Lincolnshire supports the ongoing work to improve the patient experience and the focus on treating all patients with dignity and respect and notes the progress across a range of initiatives to raise standards. In particular, the continued focus on achieving optimum pain control for patients is welcomed.

NHS Lincolnshire also commends the organisation on supporting partnership working with other providers to enhance the range and quality of palliative care services.

Examples given within the Quality Account highlighted areas of service that demonstrate high quality care using the three key areas of effectiveness, safety and patient experience. NHS Lincolnshire particularly welcomes the focus placed on falls prevention and that this work will continue to be embedded in practice across the services.

Marie Curie Cancer Care income in 2010/11 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework. CQUIN payments are not currently being applied to this contract.

NHS Lincolnshire notes that the Trust's current registration status with the Care Quality Commission is fully registered. Marie Curie Cancer Care has the following conditions on registration:

Marie Curie Hospices registered to provide the following regulated activity:

- Accommodation for persons who require nursing or personal care
- Treatment of disease, disorder or injury
- Diagnostic and screening procedures

Marie Curie Nursing Service England is registered to provide the following regulated activity:

- Personal care
- Nursing care
- Treatment of disease, disorder or injury
- Diagnostic and screening procedures

Further, NHS Lincolnshire notes that Marie Curie Cancer Care has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Areas for Improvement 2011/12

NHS Lincolnshire endorses the areas identified for improvement for 2011/12 and the associated initiatives as detailed within the Marie Curie Quality Account as:

Marie Curie Hospices

Priority one: Clinical Effectiveness

Symptom management

To help patients to control their symptoms to improve quality of life. This year the focus will be on breathlessness.

Priority two: Patient Safety

Infection prevention and control

From a recent audit and review of the organisation's current infection control policies and procedures it was clear that there are inconsistencies in practice across the nine hospices including how patients are screened and the results recorded. These inconsistencies have not had any detrimental effect on the care delivered but it is important to ensure that the highest standards are being delivered across all hospices at all times.

Priority three: Patient Experience

Choosing where to die

To further improve the recording of this important information to ensure that any changes expressed by the patient are captured.

Marie Curie Nursing Services

Priority one: Clinical Effectiveness

Maximising efficiency

To make sure that the patient gets the right care at the right time they need it, in the place of their choice.

Priority two: Patient Safety

Increasing effective partnership working

This year it is intended to test several new services in partnership with other organisations including the NHS and other charitable providers. One example of this is the Greenwich project where the organisation will work with an independent hospice and the NHS to deliver a combined service which offers planned in advance and urgent care 24/7.

Priority three: Patient Experience

Becoming more accessible and providing better continuity of care

There are three initiatives underway (set out below) that will be evaluated to see if the changes introduced improve access and continuity from the patient's perspective:

1) Marie Curie Managed Services

2) Self referral

3) Rapid response service

Whilst NHS Lincolnshire does not commission Marie Curie Hospice services, NHS Lincolnshire does commission the Marie Curie Nursing Service and the Rapid Response Service. Commissioning high quality, safe patient services is our highest priority and the areas identified will enhance the patient experience and improve patient safety and clinical outcomes.

NHS Lincolnshire has yet to agree a contract indicator for home deaths in 2011/12 which will be based upon the Department of Health's revised methodology for measurement of home deaths for 2011/12.

NHS Lincolnshire endorses the accuracy of the information presented within the Marie Curie Quality Account and the overall quality programme performance will be reviewed through the formal contract quality review process and triangulation through patient experience surveys.

E Butterworth – Director of Quality & Involvement, NHS Lincolnshire

Thank you for the invitation to comment on the Marie Curie Cancer Care Quality Account. We note that you are required to submit this to the Lambeth Health Overview and Scrutiny Committee as your principal offices are based in the borough. However, we further note that the QA refers to services provided across the UK and particularly at the nine Marie Curie hospices (none of which are in Lambeth).

We believe that there should be some form of national oversight of the QAs of national organisations. However we feel it is questionable whether a health OSC is best placed to comment on the merits of a QA solely on the basis of head office location (rather than experience and knowledge of a provider); nor do we consider it appropriate that you should be required to potentially make your QA reflective of (Lambeth) local priorities or locally meaningful when your work is on a national basis.

This submission also reflects our position on receiving the QA last year and subsequent representations to, and discussions with, the Department of Health following experience of the first year of Quality Account.

Elaine Carter, Lead Scrutiny Officer, London Borough of Lambeth

LINk Southwark would like to express our appreciation to the Marie Curie Cancer Care Quality Improvement Team who organised a meeting with the Department of Health to review last year's Quality Account process and the production of the 2010/11 Quality Account. However, we are unable to provide a comment on this year's Account due to the LINk prioritising the submission of comments on our three local hospitals' Quality Account.

A Kinch – Team Leader – LINk Southwark

Do you have any comments or questions?

Marie Curie Cancer Care is always keen to receive feedback about our services. If you have any comments or questions about this report please do not hesitate to contact us using the details below:

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Marie Curie Cancer Care provides high quality nursing, totally free, to give people with terminal cancer and other illnesses the choice of dying at home, supported by their families.

www.mariecurie.org.uk

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Marie Curie Cancer Care