Quality Account

2013/14

Marie Curie Cancer Care

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Who we are and what we do

Marie Curie Cancer Care provides end of life care to patients, regardless of their diagnosis, through our specialist palliative care teams in our hospices and our community nursing services.

We are a large national charity operating in England, Wales, Scotland and Northern Ireland. All Marie Curie Cancer Care services are registered with the appropriate regulatory bodies in each country of the UK.

Putting patients and families first

Our vision

Everyone with cancer and other 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

'We Put Patients and Families First' is Marie Curie Cancer Care's strategic plan for 2011-14. It sets out our plans to develop, expand and fund our work.

"A wonderful calm loving atmosphere where my patient friend felt very secure."

Carer

Our key objectives over the last three years have been:

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

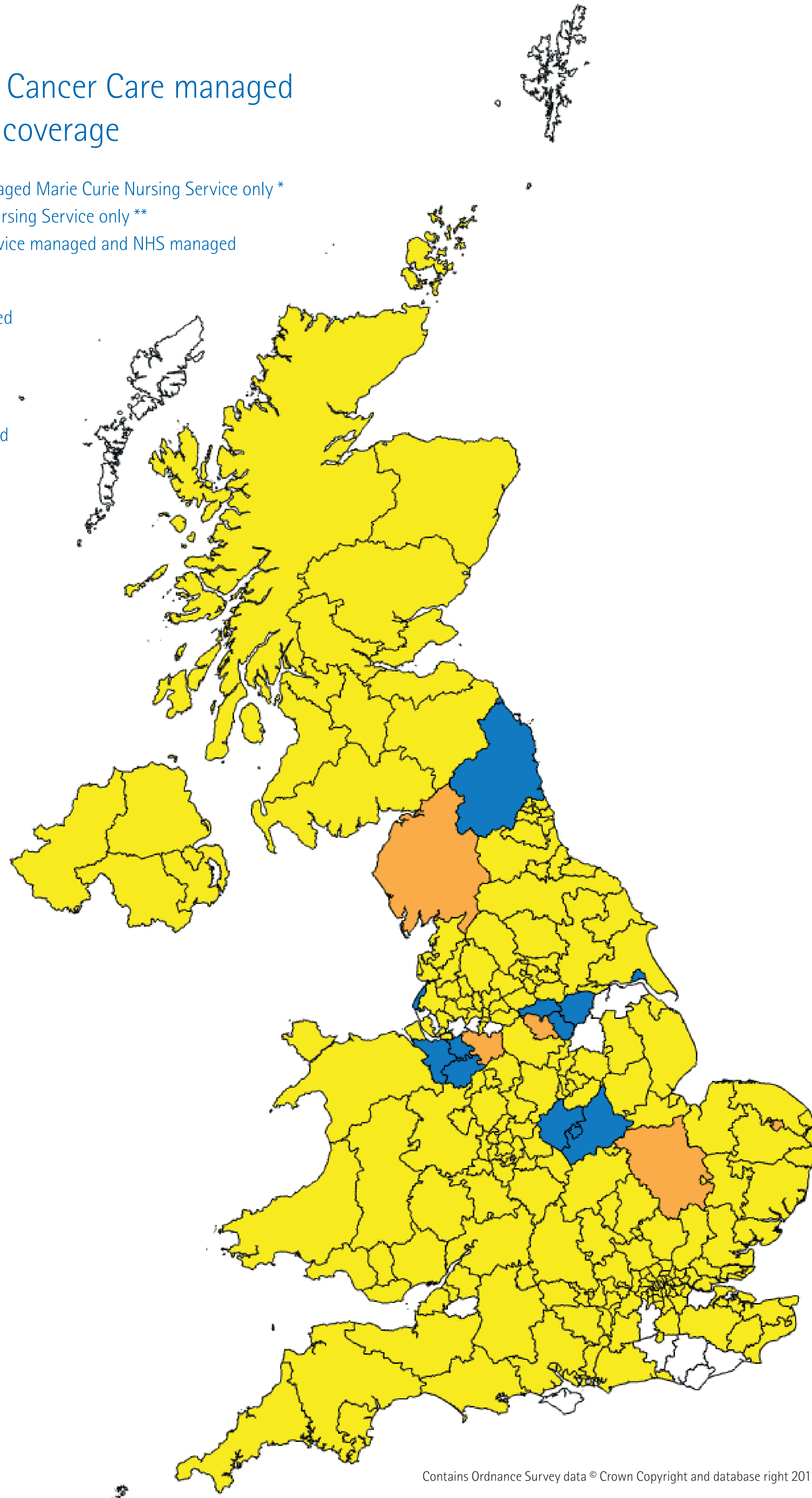
- Increasing the money we raise to fund our services
- Growing our volunteer support
- Improving our efficiency and effectiveness, always demonstrating value for money

This document, our 2013/14 Quality Account, demonstrates our commitment to the delivery of high quality, patient-centred care. It outlines our work on quality improvement over the last year and sets out our priorities for the year ahead as we move into the new strategic plan period.

Map 1: Marie Curie Cancer Care managed and NHS managed coverage

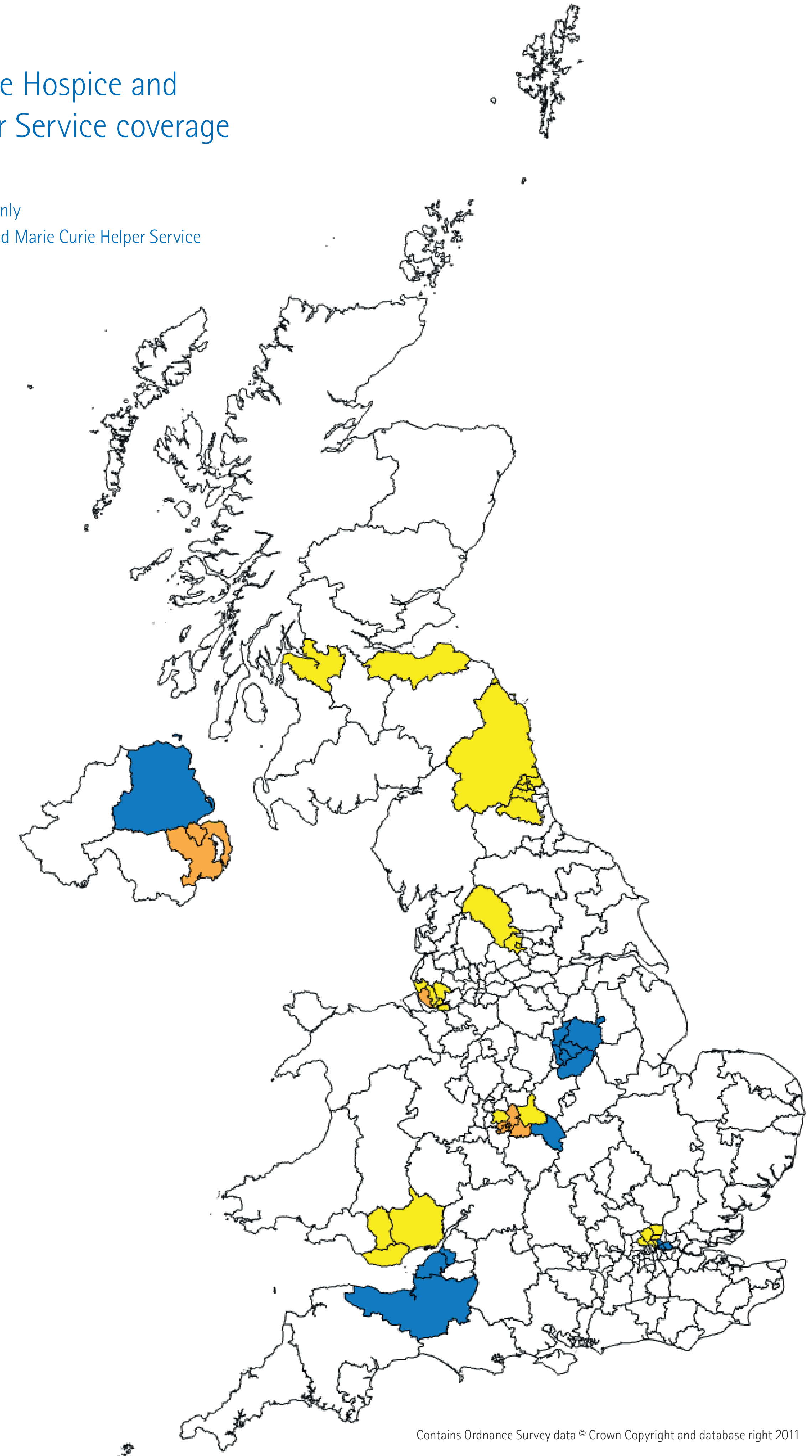
- Marie Curie Cancer Care managed Marie Curie Nursing Service only *
- NHS managed Marie Curie Nursing Service only **
- Both Marie Curie Nursing Service managed and NHS managed
- Neither service

* Marie Curie Cancer Care managed – staff providing care who are employed and managed by us.
** NHS managed – Marie Curie provides funding towards the service delivered by staff employed and managed by the NHS.



Map 2: Marie Curie Hospice and Marie Curie Helper Service coverage

- Marie Curie Hospice only
- Marie Curie Helper Service only
- Both Marie Curie Hospice and Marie Curie Helper Service
- Neither service



Section one – Chief Executive's statement

Welcome to our 2013/14 Quality Account, a summary of our performance against the most important aspects of care: patient safety, clinical effectiveness and patient experience.

I hope that you enjoy reading our report. My Executive Board colleagues and I are confident that the information set out here is a true reflection of the quality of our current care provision.

The Quality Account is one way that we can report to the public to show how we continually work to improve our services. This report sets out the progress against the targets we set ourselves for 2013/14 and what we hope to achieve for 2014/15, the first year of our new strategic plan.

We have nine hospices across the UK and also provide community nursing for those patients who wish to remain and die at home. All services are provided free of charge to all patients. Throughout 2013/14 we cared for around 39,000 patients. This figure does not include the many family members and carers that we also helped to support through an extremely difficult time for them.

We have tried hard to ensure we respond to carers' needs and acknowledge the incredible difficulties they often experience. We have developed mechanisms to make it easier for our patients and carers to contact us and tell us what they think about our services. We want to give all our patients and carers the best possible experience, and their feedback is invaluable in helping us to keep making improvements to the care we provide. More details about the various initiatives we have introduced or improved to enable people to feed back more easily can be found in section 2.

In 2013 Marie Curie Cancer Care joined the Carers Week consortium for the second time, along with Carers UK, Age UK, Macmillan Cancer Support, MS Society, Parkinson's UK and the Carers Trust.

There was significant media coverage of Carers Week (10-16 June), and several members of Marie Curie staff took part in radio interviews, as well as producing a series of posts about carers on the Marie Curie blog. We also took part in a 'speed networking' event and a 'Question Time'-type discussion with MPs, which provided an opportunity to highlight the unique pressures placed on those caring for someone at the end of their life.

We have continued to include our Expert Voices Group in as many decisions as possible, and they have provided us with invaluable guidance and advice on matters ranging from defining what we mean when we talk about spirituality to shaping our next strategic plan. The Expert Voices Group is made up of people who have first-hand experience of caring for someone at the end of their life. Members have also joined us on visits to our hospices when we check on the quality of care we are providing, to help us gather the views of our patients and their families. Their inclusion on the team has been extremely beneficial, and we have been able to gather some excellent informative feedback with their help. The Expert Voices Group has also helped shape the content and format of this report.

We also confirmed that we must demonstrate our commitment to Black, Asian and Minority Ethnic (BAME) patients and promote equality and diversity. Our Medical Adviser chaired a BAME consultation event in April 2013 to hear directly what the end of life needs of BAME patients and their families are, and this led to a commitment to report back in the next two years on progress made to address the issues they face.

Following the consultation, we established the Diversity and Inclusion Project Board. The board will take forward the actions from the event and the diversity work across the charity. The Equality Act 2010 provides a quality framework that will help us deliver care in an equitable manner, and we published a diversity statement on our website in July 2013.

We continue to monitor patient safety very closely. Last year we reported that we wanted to focus on the number of falls that occur in our hospices and find ways to reduce them. We have made some big strides in improving patient safety and we have introduced incident review panels to look at how well we manage and learn from serious clinical incidents.

We have also looked at pressure ulcers, which are all recorded as clinical incidents. We now record whether a patient was admitted with a pressure ulcer or whether the ulcer was acquired in the hospice during their admission. This early recording allowed us to undertake a baseline audit, and we developed a policy for pressure ulcer management to help ensure we follow best practice and reduce harm to patients.

We recognise that our frontline staff are essential in ensuring we provide high quality care and support to our patients and carers. We care for patients with increasingly complex needs and we are committed to further developing the skills within our workforce to meet that need, from expanding the role of Healthcare Assistants to the introduction of the PRIDE (Personal Responsibility in Delivering Excellence) campaign and a training academy. We have also introduced a People Board that will help us concentrate on the development of our workforce and ensure we remain focused on the right areas.

This report is divided into sections. Section two will provide progress against the targets we set ourselves last year and section three will set out our priorities for 2014/15. These two sections are divided into three domains of quality: patient experience, patient safety and clinical effectiveness.

Section four looks at information about the quality of our service. The information in this section is gathered from our own data, including analysis of our complaints and incidents, as well as the reports we receive following inspections undertaken by our regulators. The final section includes our legal requirements, mandatory statements and feedback from our stakeholders.

Next year will see the introduction of a new and very exciting strategic period. I look forward to reporting on our achievements over this coming year and setting out my vision for new and challenging targets to increase the number of people we help, either directly or indirectly, from 39,000 to 400,000 over the next five years.

To do this we will:

- establish an information and advice service
- increase the amount of partnership working we do
- increase the amount and range of research we fund and carry out
- support service redesign to improve services

I hope you find our Quality Account useful and I would welcome your comments on this report and suggestions for future accounts. If you would like to get in touch please drop an email to: quality.assurance@mariecurie.org.uk

The Quality Account has been reviewed through our internal governance structures as well as external scrutiny procedures in accordance with NHS England requirements.

Dr Jane Collins
Chief Executive

Section two – progress against last year's priorities

Priority 1 – Patient experience

- Patient and user engagement
- Becoming more accessible and providing better care

Last year we stated that it was our objective to listen to, analyse, learn from, act on and disseminate feedback from patients and carers, both quantitative and qualitative, through a variety of methods and use it to improve the quality of services, driven and led by patients, families and carers.

We said we would do this by focusing on two areas: patient and user engagement; and becoming more accessible and providing better care.

Patient and user engagement

We said we would	What we actually did
Increase by at least 20% the number of patients and carers feeding back in our yearly surveys.	The overall increase in the number of patients and carers giving feedback in the annual survey was 18%. A breakdown of the change from 2013 is: • Marie Curie Nursing Service +77% • Hospice in-patients -14% • Hospice day/outpatients +56% • Hospice community patients -32%
Provide regular analysis, learning and dissemination of feedback from the surveys and include this in our information packs and new digital surveys.	Analysis, learning, and dissemination of feedback is coordinated through the Patients and Families Feedback Review Group, which meets monthly.

We said we would	What we actually did
There will be a section on the Marie Curie website to communicate 'you said, we did'.	'You said, we did' boards are at each of the hospices and on the website.

You said	We did	Outcome
"I have a big family and want lots of people to be able to visit at the same time."	We have developed some best practice to enable our hospices to accommodate large numbers of visitors where possible without causing disruption to other patients.	Families have told us that they feel able to treat the hospice as home and welcome their extended family and friends – who may have travelled some way to visit. Other patients have also told us that this has not disrupted them.
"There is a lack of Wi-Fi system for patients and relatives."	We have installed this in all of our hospices.	All nine of our hospices now have Wi-Fi access for patients and visitors.
"I want to be able to watch Sky Sports and Sky Movies in the hospice."	We have been working with Sky on this for some time and unfortunately the cost of supplying this is so high that we would have to sacrifice a great deal of money which we believe is better spent on care.	We are talking to other providers to see if there is a more viable option for us. We will continue to monitor this and will ask patients and families again how much of a priority this is for them and whether we can justify the cost.
"I want support as a whole person - for example, being asked about my beliefs, hopes, feelings of peace and sense of purpose, etc."	Offering spiritual support to patients and families is an important part of what we do. We asked our Expert Voices how we could improve this aspect of our care.	We have improved the way we monitor patient and family feedback about this aspect of care. We will continue to review the impact of the work we are doing in this area on patients and families.
"I'd like more of a variety of food to be available." "The canteen does not meet required needs of families out of hours."	In February and March we held a series of workshops with patients, carers, staff and volunteers to understand where the problems are and how we can improve them quickly.	We will continue to review this and make changes and improvements as necessary.

We said we would	What we actually did
Adopt the Friends and Family Test so that it can be applied in the end of life context. This will include families at an appropriate time after the death of the patient, and patients and families once Marie Curie services cease.	The Friends and Family Test is being rolled out with the implementation of a real-time feedback system. The test will become a standard question through the majority of our feedback channels (tablet devices in hospices, online, phone surveys) by 1 July 2014. The question will be added to our hospice comments card and patient pack surveys at the next print run. Early results from the pilot run in March in Scotland have shown: • 32 comments were received, which is a fivefold increase • 28 comments came directly from patients This is a significant number as previous feedback methods have attracted comments primarily from carers. The overall score for the Friends and Family Test was 94%. This compares to the NHS average of 73%. While this is limited data from a one-month pilot, we will continue to collect and analyse the data monthly.
Develop new methods for implementation within our services of real-time feedback, based on initiatives such as the pilots commissioned through the National End of Life Care Programme.	A new system to gather real-time feedback is currently being rolled out and will be operational throughout the organisation by 1 July 2014.
Implement the recommendations from the patient and family feedback programme to ensure that we are gathering, analysing and learning from the other significant methods of feedback. We will recruit a senior project manager who will lead the implementation.	A senior project manager was successfully recruited and is leading the implementation of the recommendations.

“I cannot see how my experience at the hospice could be improved upon. If only other medical professionals could see how it should be done.”

Patient

We said we would

What we actually did

Establish user-led measurements such as patient-reported assessments of symptoms including:

- breathlessness
- bladder and bowels
- pain
- patient preferences:
  - preferred place of death
  - preferred place of care

The development of symptom measures has not progressed as quickly as we would have hoped. However, the Marie Curie Hospice, Hampstead will run a pilot led by Kings College London to look at specific ways to assess symptoms to measure outcomes of quality including patient-reported assessments. The aim is to see if it makes a difference in the way we assess patients and the way the team operates.

Through patient surveys we continue to monitor and record how well patients feel their symptoms are managed. The development of clinical performance indicators is outstanding.

This work will be part of the **PRIDE** campaign:
Personal
Responsiblity
In
Delivering
Excellence
This project is being developed by our Director of Nursing.

Through our existing monitoring, patients have rated us on the following aspects of care:

	% responses 'very good'
Support for pain relief	83.1
Support for other symptoms (nausea, constipation, diarrhoea, breathlessness etc)	84.5
Emotional support	82.6
Spiritual support	83.1

Develop the Expert Voices programme so that they are involved in nine internal compliance visits and Patient Led Assessment of Care Environment (PLACE) audits.

Two Expert Voices Group members are routinely involved in internal compliance visits. More will join the team in 2014/15.

Expert Voices or local service users are involved in all Patient Led Assessment of Care Environment (PLACE) audits, which is a national initiative led by NHS England.

Include an Expert Voices Group member on the local clinical governance group.

Three Expert Voices Group members are now included in local clinical governance groups (two in the north of England and one in the south).

We have not yet implemented this initiative in Scotland, Northern Ireland or Wales.

Make information about the quality of our services readily available to the public via our website.

Our Annual Quality Account is published on the Marie Curie website.
mariecurie.org.uk/quality

Becoming more accessible and providing better care

We said we would	What we actually did
User involvement	
1. Ensure every hospice has a user involvement and patient experience group that feeds into local and national clinical governance groups.	1. The following hospices have a user involvement and patient experience group: • Belfast • Bradford • Cardiff and the Vale • Edinburgh • Glasgow • Liverpool • Newcastle • West Midlands Hampstead has yet to implement this initiative but has used focus groups of service users to input into specific local projects.
2. Develop user involvement groups within the Marie Cure Nursing Service.	2. A user group is being set up in the south of England (Kent and Surrey). Other groups are being developed.
3. Ensure common themes from the groups are reported to the National Clinical Governance Board.	3. Local user groups report to their local clinical governance boards, and these report to the Marie Curie Cancer Care National Clinical Governance Board.
Expert Voices Consult regularly with the Expert Voices Group. The group will be engaged in the development of the charity's strategy and will be involved in at least 10 pieces of work requiring consultation.	The Expert Voices Group has been engaged and consulted in developing the charity's new strategy. The Expert Voices Group has been involved in 54 pieces of work requiring consultation during this year including developing the content and format of the Quality Account.

We said we would	What we actually did
Engagement of Black, Asian and Minority Ethnic groups Build relationships with Black, Asian and Minority Ethnic (BAME) organisations and other stakeholders to achieve greater equality in end of life care. We will do this through two pilots in our hospices to raise awareness of nursing and hospice services. We will measure success by:	A BAME project group has been established that includes members from organisations such as the Race Equality Foundation, National End of Life Care Intelligence Network, Leicestershire Social Care Development Group, Help the Hospices and the National Council for Palliative Care. The project group has produced a research paper on end of life care needs of BAME people which was shared at a conference for BAME groups, providers and other stakeholders. The Marie Curie Hospices in Bradford and in Cardiff and the Vale have tested outreach work with BAME communities and raised their awareness of the hospice and end of life care.
1. Improved understanding of BAME patients and families through research and engagement activities	1. The Marie Curie Hospice, Cardiff and the Vale ran seven focus groups with around 70 people from organisations including the Apna Carers Groups, the African Caribbean Elders Society and the Hindu Community Centre, as well as people from community organisations, volunteers and other community members.
2. Identification of barriers to meeting needs	2. Barriers to access to care were identified, including lack of awareness of palliative care services and hospice care, and anxiety that dietary, religious, cultural and language needs will not be met.
3. Identification of priorities for policy and service delivery	3. Discussions identified the priorities for meeting BAME needs. These were included in the 'Next Steps' report launched at a parliamentary reception in January 2014.
4. More minority ethnic people accessing Marie Curie services	4. The number of BAME people accessing Marie Curie services in Bradford and Cardiff increased over the year. There were 44 more BAME service users in Cardiff and the Vale this year compared to the previous 12 months. This is an increase of 30%.

We said we would	What we actually did
Dementia care	
1. Improve provision of effective end of life care for people with dementia in Carmarthenshire by establishing three dementia end of life care case managers who will link with dementia care coordinators in the local area.	1. The Dementia Service in Carmarthenshire commenced in May 2013; care is provided by two staff who bring both community nursing and mental health experience to the service. The senior nurses have built strong links with the dementia coordinators to ensure that patients with dementia who are at the end of their lives have access to services that best meet their individual needs.
We will measure success by:	
2. Improved access and uptake of palliative and end of life services by patients with dementia.	2. Of the 46 patients cared for to date, the focus of support has been symptom management, psychological support and referral to appropriate services including the Marie Curie Nursing Service.

"On behalf of all the family, I would like to express my gratitude for the help and understanding shown by your nurses over the final week or so of my father's life. Your nurses showed a great kindness and understanding in their care of him and helped enormously in easing the burden which befalls a family whose loved one is approaching their final hours. Your wisdom and expertise were greatly valued and your professional approach was second to none."

Carer

We said we would	What we actually did
Care homes Reduce 'in crisis' admission to hospital from care homes for patients at end of life. Measure an increase in the use of integrated priorities on care in care homes across Hywel Dda Health Board which covers three counties: Carmarthenshire, Ceredigion and Pembrokeshire (Wales). Key performance indicators:	The Care Home service provides care to patients in care homes across the three counties covered by the Hywel Dda Health Board. The evidence shows that 100% of patients that have received care from Marie Curie Nurses have remained within the care home.
1. The target number of patients in the last weeks of life supported during the first 12 months of operation is 104.	1. 64 patients were cared for in 2013, lower than the target set. This was due to lack of referrals to the service rather than a lack of service capacity.
2. 90% of patients will be on the end of life care pathway. 3. 90% of patients will receive their end of life care using the end of life care pathway.	2. and 3. Exact data is not yet available but this information is collected by the health board. All patients cared for within this service are either cared for in line with the end of life care priorities or the Marie Curie Registered Nurses will initiate discussion around the implementation of the priorities.
4. 100% of patients cared for will remain in their permanent place of residence (care home).	4. Data for this is incomplete in some cases. Where the place of death is known, 100% of patients have died in their care home.
5. 90% of patients will be on the service case load for a maximum of seven working days. 6. 100% of patients who are on the case load for over seven working days will have Delayed Transfers of Care (DTOC) data kept.	5. and 6. Where intervention has been required prior to the last seven days of life, the patient has been discharged from the service, handing care back to the care home staff or community nursing teams. Patients have been re-referred to the service when necessary. We are now working with the health board to embed the service into the existing Marie Curie Nursing Service.

We said we would	What we actually did
Marie Curie Helper 1. Increase our overall engagement with a roll-out of the Helper service to three more sites across the UK, seeing a 75% increase on last year's achievements. 2. Conduct a series of in-depth case study interviews to continue to measure the impact the service is having.	The Helper service is now active in five different regions, and three further services are in development: • Somerset and Bristol • Nottinghamshire • Liverpool • East London • Northern Ireland • West Midlands (at set-up stage – expected service delivery from April 2014) • Fife (at set-up stage – expected service delivery from June 2014) • South Wales (in development stage) This meets our target to increase our Helper service by 75%. We obtained feedback from people who used the Helper service in a number of ways including several case studies. An example comment from a terminally ill person was: "I feel it has given me more of a positive outlook. Helped me to see that there are other things out there I can do even though my illness is restricting." One carer commented that the service "has allowed me to go out of the house and either meet up with 'neglected' friends and chat or go shopping or just escape for a few hours". This highlights the important role the service plays in enabling carers to have a break, ensuring they are able to cope. Promotional materials for the Helper service have been updated, taking into account feedback from our Expert Voices Group.
Choosing where to die Continue to follow the National Preferred Place of Death (PPOD) Audit: 1. The number of deaths recorded electronically per hospice in the year (April to April). 2. The number of patients with a preferred place of death entered electronically.	(see table below) These figures show that our recording of this data is not consistent across all sites. Some are recording PPOD for all patients, including day care and outpatients. More work is required before we can reliably draw conclusions about target achievement from this data.

Hospice	Number of deaths	Number of PPOD recorded
Belfast	170	107
Bradford	206	275
Cardiff and the Vale	304	244
Edinburgh	327	411
Glasgow	286	486
Hampstead	282	144
Liverpool	206	234
Newcastle	164	102
West Midlands	275	401

We said we would	What we actually did
Programme of work with the Royal College of General Practitioners (RCGP) Run a project with general practitioners to improve the care they provide to terminally ill people. The project will work across a number of domains, including their dementia, chronic obstructive pulmonary disease (COPD), cancer and care planning workstreams. It will embed end of life care principles and practices within the College's clinical priorities, eg elderly, dementia, COPD - for example by establishing a programme of work to improve pain management in end of life care. Measures will include: 1. Baseline survey of GPs 2. Development of training and resources 3. Dissemination of best practice 4. Collaborating on research	A three-year strategic partnership was announced in October 2013. Two GPs have been recruited as the national leads. In its first six months, the project has: • delivered a baseline survey of GPs on issues relating to end of life care and pain management, which will help shape the project's work programme • held five end of life care round table events with GPs and commissioners across England • published articles and opinion pieces in health-focussed media • contributed to the priority setting process for the charity's research programme • held a Twitter chat in partnership with the 'Health Service Journal'

> *"Having experienced different and various clinical/caring environments, Marie Curie is by far the friendliest and safest we have come across. Thank you."*
>
> Carer

Priority 2 – Patient safety

Last year we confirmed that it was our objective to provide 'zero harm' care, demonstrated through the development of a safety thermometer as an improvement tool for measuring, monitoring, analysing and reporting patient harm.

We said we would	What we actually did
Develop the Marie Curie Safety Thermometer. This will measure five potential patient safety issues or 'harms'.	This initiative has not progressed as far as it should have. To ensure progress is made, these patient safety measures will be captured in the PRIDE campaign mentioned on page 10.
Medicines management in hospices Undertake a baseline audit following publication of the Controlled Drug Management Policy. The preliminary audit will give a benchmark of practice versus standards.	A baseline audit of the medicines management policy was undertaken in May 2013. An external expert review of the medicines management policy will take place in the first quarter of 2014/15.
A second audit will check for progress in areas identified for improvement.	The second medicines management audit is being prepared in readiness for this.
Medicines management in the nursing service	
Undertake an audit of medicines management documentation in the Marie Curie Nursing Service.	This audit has not been possible as the clinical records for the Marie Curie Nursing Service are owned by the District Nurses. Consideration is being given as to how this assessment can be undertaken in a different way in 2014/15.
Falls Review and update the falls management policy. Undertake a baseline audit using national guidelines and best practice principles to: • demonstrate a reduction in incidents of falls • demonstrate 100% compliance with best practice	A falls audit was undertaken in October 2013 to establish current practice and areas for improvement. Results have paved the way for additional work by a physiotherapist-led working group to review: • policy • documentation • patient information leaflets • environmental issues A follow-up audit to monitor improvements took place in March 2014. Results are being analysed and will be reported to the National Clinical Governance Board.

We said we would	What we actually did
Pressure ulcers Demonstrate a reduction in incidents and prevalence of pressure ulcers (10% reduction in year) by: • developing a pressure ulcer management policy • undertaking a baseline pressure ulcer management audit The first audit will benchmark prevalence in May 2013. Thereafter continuous monthly prevalence data will be provided per hospice against the benchmark.	A pressure ulcer audit was undertaken to establish current practice and inform the development of the policy. The pressure ulcer management policy has been written and ratified by the Clinical Governance Board. Additional work has been undertaken to improve recording and reporting of pressure ulcers to identify ulcers acquired in the hospice. A follow-up audit to review improvements will be undertaken in May 2014. We do not yet have sufficient data to report against the target set.
Patient Led Assessment of the Care Environment (PLACE) audit Participate in the national PLACE audits (April – June 2013) at all hospices. The set of audits most suited to the hospice environment includes: • general organisational questions • ward and community organisations • external and internal areas • facilities • food	All nine hospices took part in the first PLACE audit. Reports were received and actions were taken to address any areas for improvement. The PLACE audit will be undertaken again between March and June 2014 to monitor improvements.

We said we would	What we actually did
Infection control Review the current Infection Prevention Policy. We will use selected tools which have been accredited to audit current practice which will: • demonstrate a reduction in the number of hospice-acquired infections • Record and report all outbreaks of clostridium difficile and norovirus	The infection prevention and control policy was developed and is now being reviewed by an external expert. We will not undertake the audit until the policy has been ratified. The target for reduction has not been set yet. All clostridium difficile and norovirus infections are recorded as incidents which are reviewed every quarter by the Clinical Governance Board.

"The quick response from your team meant that my mum could rest at night knowing somebody was with her at all times. Thank you for helping my grandmother stay at home as her time came to an end."

Carer

Priority 3 – Clinical effectiveness

Last year we said we would deliver the right care, in the right place, at the right time.

We said we would	What we actually did
Implement and disseminate the most recent findings regarding carers from key research to ensure that learning is embedded in evidence-based practice.	Marie Curie Cancer Care funded a research study in 2010 to explore older carers' experiences of a loved one dying at home. (Professor Sheila Payne, Lancaster University, 'Unpacking the home: family carers' reflections on dying at home'). The study showed that carers would benefit from more information on a range of issues such as what to expect around the death and immediately afterwards and on financial help available. As a result of this and other research, we are developing more information resources for carers. The same research study also showed that the management of medications places a huge burden of responsibility on family carers. Marie Curie Cancer Care is now funding the development of an educational programme for carers that will enable them to better manage pain medication for a loved one with cancer at the end of their life.
Measure the application of the most recent evidence on effective interventions for the support of carers. This will be carried out as part of two carers pilots to be established in 2013.	Unfortunately, we were unable to secure funding for these pilots. However, a three-year project funded by People and Places is taking place in Wales to provide training to those caring for someone at the end of life. This will cover practical things like moving and handling, information provision about specific illnesses and signposting to bereavement support. The project started in October 2013, is being continuously reviewed by the Project Board and will be fully evaluated by our Analytics team.
Carers assessment Explore the use of the Carer Support Needs Assessment Tool developed by Cambridge and Manchester Universities as a consistent method of identifying the needs of carers.	The Marie Curie Hospice, West Midlands was one of the sites involved in the Carer Support Needs Assessment Tool (CSNAT) project, funded by the National Institute of Health Research. We have now completed the data collection from bereaved carers, as the sixth site on a multi-centre trial. The research team wanted to establish whether the CSNAT intervention would make a difference to carers and how. They did this by asking six Hospice Home Care services to use the CSNAT intervention with carers. Carers who had usual care were compared with those who had the intervention through a postal survey of carers to find out if those who had the intervention had better health, well-being, levels of grief and feelings of being supported. To establish what made the intervention successful, the views of the Hospice Home Care nurses and some of the carers who had the intervention were also sought. The learning from the study has been used to develop a training guide to enable services across the UK to use the CSNAT intervention. The tool has been trialled at the hospice since August 2013; and there is the desire to roll it out to the Day Hospice team in the future.

We said we would	What we actually did
Research from and into practice Develop the necessary methodology to translate research into practice, including: • the development of a suite of implementation tools for putting research into practice by the Research From and Into Practice group • linking the outputs from research into practice work with an audit and patient and carer feedback.	The Research From and Into Practice group was set up in 2013. Progress of implementation through the group was too slow so more efficient ways to implement practice are being explored, such as the working group approach used to improve falls management mentioned on page 17. Latest evidence-based guidance from the National Institute for Health and Care Excellence (NICE) states that numerical scoring of risk, such as high, medium or low, should not be used as part of falls risk assessment for patients. The falls prevention working group is incorporating this latest evidence into the new falls reduction package.

"I was overwhelmed by the professional yet very supportive and caring way in which you look after patients, and I know my husband appreciated this during his short stay with you. I cannot praise and thank you enough for your dedication and wonderful treatment during the one and a half weeks my husband was there."

Carer

Section three – priorities for next year

Our priorities for improvement for 2014/15

Priority 1 – Patient experience

Areas we will report on	What we will do	Who is accountable and responsible for this?
We will report on our continued commitment to engage with people who have experience of caring for someone at the end of their life and involve them in our service development.	We will increase national membership of the Expert Voices Group to more than 60, with at least two members in each of our nine regions. We will link them up with at least one local user group in every region to create an integrated network of user feedback on the charity's plans, materials, recruitment and projects.	**Accountable** Ruth Bravery, Director of Community Involvement **Responsible** Dean Cowley, Head of Patient and Family Engagement
We will report on the different mechanisms we use to increase the number of patients and carers we hear from and how successful those mechanisms are.	Feedback from recent users on their satisfaction with our service is currently being received from just 2.2% of those using our services. We will triple this percentage response across our three core services (Hospices, Marie Curie Nursing Service and Helper service) within a year.	**Accountable** Ruth Bravery, Director of Community Involvement **Responsible** Dean Cowley, Head of Patient and Family Engagement
We will report on the expansion of the Helper service.	Over the four years since the first pilot began the Helper service has supported 560 people with a terminal illness and/or their carers. By expanding in current locations and launching the service in new areas we will increase this figure to more than 1,000 within the next year.	**Accountable** Ruth Bravery, Director of Community Involvement **Responsible** Dean Cowley, Head of Patient and Family Engagement
We will report on the number of service improvements we have made as a direct result of patients and family feedback.	We will monitor the implementation of the changes to services through the Patient Services Board.	**Accountable** Caroline Hamblett, Director of Operations **Responsible** Dawn Tame-Battell, Assistant Director, Patient Services

Priority 2 – Patient safety

Areas we will report on	What we will do	Who is accountable and responsible for this?
We will report on the implementation and impact of the falls reduction strategy.	We will monitor the number of falls at each site as well as the impact each fall had on the patient.	**Accountable** Dee Sissons, Director of Nursing **Responsible** Anne Cleary, Assistant Director, Nursing
We will report on the implementation and impact of the pressure ulcer management policy.	We will monitor the number and grading of acquired pressure ulcers for our hospice patients.	**Accountable** Dee Sissons, Director of Nursing **Responsible** Anne Cleary, Assistant Director, Nursing
	We will audit the implementation of the pressure ulcer policy. We will carry out spot checks during our hospice visits. These will be reported quarterly to the Clinical Governance Board.	**Accountable** Dr Bill Noble, Executive Medical Director **Responsible** Ruth Liley, Assistant Director, Quality Assurance
We will continue to record and report on our infection control measures.	We will monitor the number and types of infections acquired by our hospice in-patients.	**Accountable** Dee Sissons, Director of Nursing **Responsible** Anne Cleary, Assistant Director, Nursing
	We will audit the implementation of the infection prevention and control policy. We will carry out spot checks during inspections. These will be reported quarterly to the Clinical Governance Board.	**Accountable** Dr Bill Noble, Executive Medical Director **Responsible** Ruth Liley, Assistant Director, Quality Assurance

Priority 3 – Clinical effectiveness

Areas we will report on	What we will do	Who is accountable and responsible for this?
We will report on the number of new interventions implemented as a result of new best practice evidence from research.	These will be monitored and reported quarterly to the Clinical Governance Board.	**Accountable** Dr Bill Noble, Executive Medical Director **Responsible** Dr Sabine Best, Head of Research
We will develop measures to monitor management of symptoms including pain; breathlessness; and nausea and vomiting.	We will continue to ask patients how well we are helping them to manage their symptoms. We will run a pilot at our Hampstead hospice in partnership with King's College London.	**Accountable** Dr Bill Noble, Executive Medical Director **Responsible** Ruth Liley, Assistant Director, Quality Assurance
We will report on the implementation and impact of the falls reduction package.	We will audit the implementation of the falls reduction package. We will spot check records during inspections. These will be reported quarterly to the clinical Governance Board.	**Accountable** Dr Bill Noble, Executive Medical Director **Responsible** Ruth Liley, Assistant Director, Quality Assurance

Section four – about the quality of our services

Complaints/incidents

The charity's complaints and incident management policies were reviewed updated, ratified and implemented during 2013/14. Details of the number and type of complaints received are outlined in this section.

Formal complaints

From 1 April 2013 to 31 March 2014 the Chief Executive received 15 written complaints.

The targets within the complaints policy are to acknowledge the complaint within two working days and to provide a full response within 20 working days. Where a response cannot be given within 20 working days due to the complexity of the complaint or staff availability, a revised timeframe is communicated to the complainant as soon as possible together with an explanation as to why.

In all cases where the complainant wrote to the Chief Executive, the complaint was handled centrally with the support of the local team. If complainants remain dissatisfied with the outcome of their complaint or the way it was handled they are able to contact the Ombudsman or the relevant regulatory body.

One complainant contacted the regulator in Scotland, Healthcare Improvement Scotland, and in conjunction with the regulator we worked to address the concerns raised by the complainant.

Safety

There were no incidents that resulted in the death of a service user in 2013/14.

There were 14 incidents that resulted in hospital visits of which three were fractured neck of femurs as the result of a fall. Each of these was investigated fully and reported to the relevant regulatory body at the time of the incident.

The table below indicates the number of serious incidents that related to medication errors in the hospices.

Hospice	Administration	Storage	Stock check	Total errors
Belfast	0	0	0	**0**
Bradford	0	0	0	**0**
Cardiff and the Vale	0	0	0	**0**
Edinburgh	0	0	0	**0**
Glasgow	0	0	0	**0**
Hampstead	0	0	0	**0**
Liverpool	1	2	0	**3**
Newcastle	4	0	2	**6**
West Midlands	1	0	0	**1**
Total	**6**	**2**	**2**	**10**

Only London and South East nursing region reported a serious drug administration error.

Effectiveness

The table below illustrates the number of Healthcare Acquired Infections that occurred in our services.

	Clostridium difficile			MRSA			Totals
	Acquired during admission	Known on admission	Not known when infection was acquired	Acquired during admission	Known on admission	Not known when infection was acquired	
Hospice in-patient	1	3	0	0	0	2	**6**

In the nursing service three patients were identified as having clostridium difficile.

Pressure ulcers

Since July 2013 we have recorded details of all pressure ulcers as incidents. The tables below show the number of pressure ulcers we recorded for hospice in-patients.

	Single pressure ulcer		Multiple pressure ulcers		Totals
Hospice	Admitted with pressure ulcer	Pressure ulcer acquired after admission	Admitted with pressure ulcer	Pressure ulcer acquired after admission	
Belfast	9	1	0	0	**10**
Bradford	9	1	5	1	**16**
Cardiff and the Vale	11	0	2	0	**13**
Edinburgh	7	9	2	3	**21**
Glasgow	17	8	1	0	**26**
Hampstead	39	13	7	2	**61**
Liverpool	23	14	9	1	**47**
Newcastle	15	2	2	0	**19**
West Midlands	22	8	1	2	**33**
Totals	**152**	**56**	**29**	**9**	**246**

The table below indicates incidents of pressure ulcers we recorded for patients in the Marie Curie Nursing Service.

	Single pressure ulcer	Multiple pressure ulcers
Nursing service region		
Central	1	0
North East	7	2
North West	12	6
South West	4	3
Wales	6	0
Totals	**30**	**11**

All ulcers identified in the community have been reported to the local District Nursing team.

Other quality indicators

Service users' experience – all services

Grading of services:

We measured the percentage of hospice service users in the sample who responded 'very good' to the following questions:

Responded 'very good'	
Welcome into the hospice	89%
Cleanliness of the hospice	88%
Quality of food and drink	75%
Quality of information	60%
Quality of care	87%

We also measured the percentage of hospice and Marie Curie Nursing Service users who responded 'always' to the following questions:

Responded 'always'	
Treated with dignity and respect	97%
Involved in decisions about care as much as you would like	91%
Have up to date information about you	91%
Provide enough support for family members and friends who care for you	91%

Next year we will be able to provide more detailed analysis by breaking this down between different services, and we will also be able to report on the Friends and Family Test.

> *"We received outstanding nursing care - professional, compassionate and caring."*
>
> Carer

Marie Curie Cancer Care compliance inspections

As part of our clinical governance process, the Quality Assurance team conducts compliance visits in all nine hospices. Visits are announced, giving the hospice two to three days' notice prior to the visit.

This year, healthcare regulators across the UK announced significant reviews of standards and their inspection processes. In light of this, a workshop was held in July 2013 which included members of the Quality Assurance team, the Assistant Director of Carer Engagement and members of the Expert Voices Group. The key messages from the workshop were distilled into two simple statements: 'quality should manifest itself in the patient experience' and 'we should share what we do well, learn from what we do badly'.

Work is underway to update the format of the compliance visits to reflect the regulators' new areas of focus and ensure the internal inspection process provides an in-depth and extensive picture of the quality of care.

In previous years we visited each hospice every six months. This year the programme of hospice visits was adjusted to visit each hospice once while developments were being made to the compliance visit process. The programme of two visits annually will continue once the new format has been finalised.

To reflect the outcomes the regulators had identified as areas of focus, broad headings for the inspections were reviewed:

- respecting and involving service users
- care and wellbeing of service users
- coordinating with other providers
- managing and supporting staff

Each outcome was reviewed with focus on three domains: patients and carers, staff and volunteers, and general observations including physical inspection. Each inspector focused on one domain to ensure a comprehensive overview. This included interviews with staff, volunteers, patients and families; observation and checking of documentation; and attendance at the multi-disciplinary team meeting or a routine handover meeting. The Expert Voices volunteers focussed primarily on seeking views from patients and families.

A spot-check medicines management survey was also introduced during this round of visits, and any issues requiring immediate rectification were highlighted to staff on the day of the visit.

The findings of the visit were reported in four key categories: areas of good practice, areas for improvement, key themes and recommendations.

All the hospices were found to be compliant with the areas of care reviewed but in each hospice the team made suggestions for improvements based on what they saw and heard on the day of the visit. There were no serious concerns identified during any of the visits.

There were five national themes identified for improvement:

1. **Care plans and documentation**
   Several of the care plans reviewed were incomplete or poorly structured and disjointed, while others were well completed but lacked elements of individualised care plans.

   Action: A national piece of work on care plans is planned for 2014/15 led by the Director of Nursing.

2. **Up-to-date documentation and patient information leaflets**
   Documentation and patient information leaflets available in several hospices were out of date.

   Action: A comprehensive project is underway to ensure only the most up-to-date policies and the most recent version of patient information leaflets are available. This is being led by the Policies and Publications Lead.

3. **Storage or disposal of confidential information**
   Disposal of confidential waste must be secure. There was one incident where papers for destruction were left in an insecure area.

   Action: This was immediately rectified when staff were notified. Further monitoring will be led by the Assistant Director of Patient Services and the Assistant Director of Quality Assurance.

4. **Communication with other providers**
   In a small number of cases communications with other providers could be improved, with more informative patient information shared to enable better partnership working. There was concern that not all GPs are aware of the services offered by hospices, and that there could be a better unity and integration between external providers and services before and after discharge.

   Action: New marketing material used to promote our services to GPs will increase the awareness of services we can deliver. This will be led by the Assistant Director of Patient Services.

5. **Maintenance**
   A lack of maintenance or complete cleanliness was noted in a small number of areas of the hospices.

   Action: The Head of Estates has received a report from each hospice on areas for improvement following the Patient Led Assessment of the Care Environment Audit. Action plans are being implemented to address any shortfalls and this work is being led by the Director of Services. The audit will be repeated in 2014/15.

The compliance inspections also noted a number of areas of good practice:

- Generally, patients, carers and families praised the high quality of care they received in all hospices, describing staff as friendly, welcoming and kind.
- Patients reported that they were treated with dignity and respect and were involved in decisions regarding their care.
- Use of a 'basic needs' checklist has been introduced in some hospices.
- Good practice regarding hand hygiene and the availability of hand gel and personal protective equipment such as gloves or aprons was observed.
- The introduction of a new initiative in Liverpool identifies the best staff regarding a particular area as 'champions', to encourage every member of staff to adopt responsibility as lead for a role in the hospice such as infection control.
- Special efforts such as giving all patients Easter eggs and decorating a patient's room for their children's birthdays were noted at Belfast.
- A dedicated community development officer to appropriately tailor the hospice to suit the needs of the local community was noted at Bradford.
- A patient at Cardiff and the Vale spoke highly of how staff liaised with external providers to arrange for him to leave the hospice to attend his daughter's wedding.

These areas of good practice have been disseminated to all hospice managers through the Quality Assurance team SharePoint site which is a Marie Curie virtual message board.

The July 2013 workshop with the Expert Voices Group and the Quality Assurance team discussed inspection improvements. As a result a new pre-visit pack has been developed containing documents and details that will form a hospice 'quality profile'. The team will meet to discuss the information prior to the inspection to focus the attention of the visit.

A new format for the inspections was proposed and implemented immediately. The team now visits the hospice over two days to enable inspectors to visit the hospice outside normal working hours, and to allow more time to undertake a more in-depth inspection. This was trialled at the Liverpool hospice visit in September and was deemed successful. Splitting the inspection over two days enabled the team to undertake a more thorough inspection, collect more data and observe out of hours practice.

The introduction of additional spot check surveys was agreed and implemented, for example falls management, PLACE follow up and medicines management. Work is also on track to develop report templates that are more tailored specifically to the standards of each country's regulator.

External inspections

All our services are subject to unannounced or announced inspections carried out by the regulator in that country. Where we have not listed a particular service, it has not been inspected in the last year but will have been asked to submit a self-assessment to its regulator.

Care Quality Commission

The table below summarises the outcomes that were inspected and the judgement made by the inspector. All standards inspected were met. The Care Quality Commission confirms that when they find standards are met they take no regulatory action but they may make comments that may be useful to the provider and to the public about minor improvements that could be made.

Outcome inspected	Bradford	Hampstead	Liverpool	Newcastle	West Midlands	Marie Curie Nursing Service
	14 January 2014	25 November 2013	19 September 2013	21 November 2013	12 July 2013	18 November 2013
Respecting and involving service users		✔ Standard met	✔ Standard met		✔ Standard met	✔ Standard met
Consent to care and treatment				✔ Standard met	✔ Standard met	✔ Standard met
Care and welfare of people who use services	✔ Standard met	✔ Standard met	✔ Standard met	✔ Standard met		
Meeting nutritional needs						
Cooperating with other providers						
Safeguarding people who use services from abuse	✔ Standard met		✔ Standard met	✔ Standard met		
Cleanliness and infection control	✔ Standard met					
Management of medicines						
Safety and suitability of premises	✔ Standard met					
Safety, availability and suitability of equipment		✔ Standard met				
Requirements relating to workers						
Staffing		✔ Standard met	✔ Standard met			
Supporting workers		✔ Standard met		✔ Standard met		✔ Standard met
Assessing and monitoring the quality of service provision	✔ Standard met	✔ Standard met				✔ Standard met
Complaints					✔ Standard met	
Records			✔ Standard met	✔ Standard met		

Regulation and Quality Improvement Authority – regulators for Northern Ireland

Hospice	Date of last inspection	Patient partnerships	Complaints	Breaking bad news	Management of records	Arrangements for palliative care	Bereavement care services	Staff qualifications
Belfast	20 November	The views of patients, carers and family members are obtained and acted on in the evaluation of treatment, information and care. A requirement was made to develop a Patient Guide as outlined in the legislation or amend the current patient booklet to include the information required by the regulations.	All complaints are taken seriously and dealt with.	Patients have bad news delivered by professionals who are well informed and in a manner that is sensitive and understanding of their needs.	Clear, documented systems are in place for the management of records in accordance with legislative requirements.	Patients, prospective patients, their families and carers are clear about the arrangements for the provision of palliative care. The needs of patients and carers are appropriately assessed and kept under review.	The patient's family and significant others have access to bereavement care services.	The hospice has procedures in place to ensure that all practitioners are appropriately trained, qualified and indemnified.

Healthcare Improvement Scotland – regulator for hospices in Scotland

Healthcare Improvement Scotland's grading key is:

6	Excellent
5	Very good
4	Good
3	Adequate – performance is acceptable but could be improved
2	Weak – concerns about the service and there are things that must be improved
1	Unsatisfactory – represents a more serious level of concern

Standards inspected	Edinburgh	Glasgow
	11 and 12 November 2013	16 April 2013
Quality of information		
Quality of care and support		5 – very good
Quality of environment		4 – good
Quality of staffing	4 – good	4 – good
Quality of leadership and management	4 – good	5 – very good

The Care Inspectorate Scotland – regulator for the Marie Curie Nursing Service in Scotland

The Marie Curie Nursing Service is registered as both a care at home service and a nurse agency. This simply means that, depending on the patient's needs, care can be provided by either a Healthcare Assistant or a Registered Nurse.

Standards inspected	Care at home	Nurse agency
	17 May 2013	17 May 2013
Quality of information		6 – excellent
Quality of care and support	5 – very good	5 – very good
Quality of environment		
Quality of staffing	6 – excellent	6 – excellent
Quality of leadership and management	6 - excellent	6 - excellent

Care and Social Services Inspectorate Wales – regulator for the Marie Curie Nursing Service in Wales

Service	Date of last inspection	Quality of life	Quality of staffing	Quality of leadership and management	Quality of environment
Marie Curie Cancer Care Domiciliary Care	14 August 2013	CSSIW found that people can be assured that specialist care will be provided to them in a sensitive manner. This is because staff make good use of information provided to them by NHS staff to deliver services and provide care in a friendly and professional manner.	People can be assured that arrangements are in place to ensure that they receive the services of suitably qualified, skilled and experienced staff. This is because the agency has a rigorous approach to training and staff support and has record systems in place to document this.	CSSIW did not consider it necessary to look at the quality of leadership and management in detail.	Quality of environment was not the focus of this inspection.

Where necessary, action plans have been put in place by the local senior management teams to ensure we address areas for potential improvement.

Section five – legal requirements

Mandatory and legal statements

We have a legal requirement to report on this section.

- During the period of this report (1 April 2013 to 31 March 2014) Marie Curie Cancer Care provided end of life care through part NHS funded services through its nine hospices and national community nursing service.
- Marie Curie Cancer Care has reviewed all the data available to it on the quality of care in all of the services detailed in the preceding section.
- The percentage of NHS funding is variable depending on the services commissioned but on average is in the region of 50%. The rest is provided by Marie Curie Cancer Care charitable contribution.
- The income generated by the NHS services reviewed in the period 1 April 2103 to 31 March 2014 represents 100% of the total income generated from the provision of NHS services by Marie Curie Cancer Care for the period 1 April 2013 to 31 March 2014.
- During the period 1 April 2013 to 31 March 2014 there were no national clinical audits or national confidential enquiries covering the NHS services that Marie Curie Cancer Care provides.

  Marie Curie Cancer Care sets an annual core audit programme that runs for this report period. The core audit programme is risk based and includes:

  - management of sharps
  - hand hygiene
  - falls prevention
  - pressure ulcer prevalence
  - use of personal protective equipment

- The monitoring, reporting and actions following these audits ensure care delivery is safe and effective. Each service reports audit findings through its local clinical governance group. Oversight of these results and actions is provided by the Marie Curie Cancer Care national Clinical Governance Board which meets quarterly.
- From 1 April 2013 to 31 March 2014 Marie Curie Cancer Care was not eligible to participate in national clinical audits.
- The number of patients receiving NHS services provided by Marie Curie Cancer Care from 1 April 2013 to 31 March 2014 that were recruited during that period to participate in research approved by a research ethics committee was 184 patients.
- A proportion of Marie Curie Cancer Care income in 2013/14 was conditional on achieving Commissioning for Quality and Innovation. These were subject to the discretion of Clinical Commissioning Groups.
- Marie Curie Cancer Care's English hospices and Community Nursing Services are registered with the Care Quality Commission. Marie Curie Cancer Care's registration is subject to conditions. These conditions include the registered provider and the number of beds at our hospices for the following:

  - accommodation for persons who require nursing or personal care
  - diagnostic and screening procedures
  - nursing care
  - personal care
  - treatment of disease, disorder or injury

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

- Marie Curie Cancer Care did not submit records during the reporting period from 1 April 2013 to 31 March 2014 to the Secondary Uses service for inclusion in the Hospital Episodes Statistics.
- Marie Curie Cancer Care's Information Governance Assessment Report overall score for 2012/13 Information Governance Toolkit Version 10 was 82% and was graded GREEN: satisfactory.
- Marie Curie Cancer Care will be taking appropriate steps to improve data quality. We will do this by:
  - increasing the awareness of the importance of reporting
  - training, including how to name data stored in governance systems
  - identifying trends through data analysis
  - auditing data flows

> *"The nurse from Marie Curie was alongside my family the night my dad peacefully passed. She bought nothing but comfort and made me feel calm. I have nothing but admiration and respect for these wonderful nurses."*

Carer

Statements from stakeholders

Clinical Commissioning Group

Commissioning high quality, safe patient services is Lincolnshire West Clinical Commissioning Group's (LWCCG) highest priority. It is anticipated that the priority areas identified within the Marie Curie Quality Account will continue to enhance both the patient's experience of health care, and improve patient safety and clinical outcomes throughout 2014/15. There is much good work highlighted for 2013/14 that evidences this continuous quality improvement approach.

Marie Curie has divided the UK into seven Regions. Lincolnshire is part of East and Central Region along with 15 other counties. Activity is generally reported at County level but reflects more the information for the counties with hospices (two counties). It is therefore difficult from the information provided to determine Lincolnshire activities. The Quality Account relies heavily on the activities that take place in the nine Hospices across the UK and only provides LWCCG with limited detail regarding the activity that is commissioned within Lincolnshire in respect of the Nursing Service and the Rapid Response Service.

In respect of the progress against last year's priorities, LWCCG welcomed the focus on improvement of patient and user engagement and improved accessibility and care. Positive examples of this include an increased response rate to the annual survey of patients and carers and also the information about how patients and public can comment, compliment or complain about their treatment or service publicised via the Marie Curie Nursing Service patient information packs and the Marie Curie website. However there does seem to be some difficulty in providing analysis of issues received and actions taken on a county level and further development of this level of detail to enable assurance in respect of Lincolnshire patients would be helpful in future reports.

The Marie Curie Helper Service has recorded an increase on the roll-out of the Helper Service on the previous year and raising the number of counties that have access to the service and meeting their target to increase the service by 75%. The CCG acknowledges and supports the achievement appreciating some of these services are just starting. We therefore note and approve plans to expand the service in current locations and launch this service in new areas. The CCG will look forward to receiving information on these future developments.

The CCG notes that Marie Curie has established Local Clinical Governing Groups. However despite this improved governance, an annual Audit Plan for 2013-14 was not provided. However a number of audits that have taken place are described: Medicines Management, falls audit, pressure ulcer audit, and PLACE (all 9 hospices took part). For LWCCG the Quality Account would have been further enhanced with audit plans/results in respect of the Nursing Service and Rapid Response Service (in Lincolnshire).

Lincolnshire West CCG are encouraged to see the establishment of a Black, Asian and Minority Ethnic groups (BAME) project group and the pilots that have taken place in two (Cardiff and Bradford) hospices. The CCG is also pleased to note the establishment of a Diversity and Inclusion Project Board and the publication of a diversity statement on the Marie Curie website in July 2013. However, Lincolnshire West CCG would like to see the continuation of this work in the priorities for 2014/15 along with plans to develop further the monitoring of protected characteristics. Collection of this data is part of the quality schedule requirements for 2014/15.

Lincolnshire West CCG endorses the areas identified for improvement by Marie Curie in 2014/15 and the associated initiatives as detailed within the Quality Account around the broad Quality parameters of Patient Experience, Patient Safety and Clinical Effectiveness. Lincolnshire West CCG will continue to monitor Marie Curie's overall quality programme performance through the ongoing formal contract quality review process.

Wendy Martin, Executive Lead: Nurse/Midwife & Quality, Lincolnshire West CCG

Healthwatch

Thank you for the invitation to comment on the Marie Curie Cancer Care Quality Account.

Unfortunately we will not be able to comment on the Marie Curie Account as we are currently in the process of commenting on our three Acute Providers. Furthermore, although we appreciate you are required by the Department of Health to seek our commentary, we feel that we are not appropriate stakeholders to comment due to your status as a national provider with no services based in Southwark.

Sec-Chan Hoong, Healthwatch Development Officer, London Borough of Southwark

Lambeth Council – Health and Adult Services Scrutiny Committee

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 reflects our position on receiving the QA in previous years and subsequent letters to, and discussions with, the Department of Health on the process.

Notwithstanding this response in relation to the QA, Lambeth Council's Health and Adult Services Scrutiny Sub Committee would wish to acknowledge and extend thanks to Marie Curie Cancer Care for the valuable work undertaken by the organisation.

Elaine Carter, Lead Scrutiny Officer, London Borough of Lambeth

Marie Curie Cancer Care Expert Voices Group

I am delighted to have been invited to contribute to this quality report on behalf of the Expert Voices Group.

First of all, a little about me and Marie Curie Cancer Care.

My first real knowledge of the charity was in summer 2010 when my 78-year-old neighbour was nursed at home by Marie Curie Nurses in the final days of her terminal cancer.

Little did I know that less than six short months later, my wife Wendy would be similarly nursed after developing a very aggressive grade 4 brain tumour at the age of just 54, which quickly robbed her of her speech and mobility. Marie Curie Nurses spent each of her last seven nights in our home, allowing me to enjoy some real sleep for the first time in some months, knowing that downstairs Wendy was in caring and professional hands.

Since Wendy's premature death, I have retired from paid employment and now undertake voluntary work for The Brain Tumour Charity and for Marie Curie Cancer Care, as a member of the Expert Voices Group and the Research Panel; PLACE auditor; speaker at public events; treasurer of the local fundraising group; adviser to the Medical Director of the West Midlands Hospice – and daffodil seller!

I want to make two points about the charity's quality report.

My wife Wendy was a healthcare professional for her whole working life. My last paid job was as a director of the UK's largest independent social and health care company, with 550 locations and c.30,000 staff. My responsibilities included clinical governance; dementia care brand; risk management systems; quality systems; health and safety; and human resources. I was involved extensively with many government departments and regulators in all UK countries.

I am therefore in a uniquely privileged position to observe the operations of Marie Curie Cancer Care. I find that there is a welcome uniformity of focus on the key objectives of the charity. All managers, staff and volunteers, who I have met, work for the charity because they want to – and because they believe in what it is trying to achieve. There appears to be openness and honesty about performance, and what is needed when improvements are required.

My second point is about the Expert Voices Group. We are now over 50 members strong and we are supported and involved by the charity to a tremendous extent, in a very wide-ranging list of activities. Only when someone has personally witnessed the harrowing terminal illness of a loved one can an accurate experience be described. Involving those of us who have had this experience, in advising on the operation and development of the charity, ensures that the focus is appropriate and correct – and the charity is to be commended for this.

I am aware that the charity has admirable and ambitious plans for expanding its services. The Expert Voices Group has been heavily involved in commenting on these plans as they have been developed – and will continue to be involved as they are implemented.

Peter Buckle
Member – Expert Voices Group,
Marie Curie Cancer Care, April 2014

Statement of directors' responsibilities

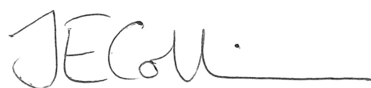
The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Reports) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendments Regulations 2011)).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

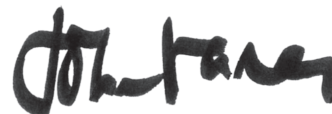
- the Quality Account presents a balanced picture of the charity's performance over the period covered
- the performance information reported in the Quality Account is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board



Jane Collins
Chief Executive
1 June 2014



John Varley
Chairman
1 June 2014

Charity reg no. 207994 (England & Wales), SC038731 (Scotland) T004

Marie Curie Cancer Care gives people with all terminal illnesses the choice to die at home. Our nurses provide them and their families with free hands-on care and emotional support, in their own homes, right until the end.

mariecurie.org.uk