Healthcare at Home Limited

1-101675619

Healthcare at Home Head Office

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-101675619		Community Health Services	DE14 1SZ

This report describes our judgement of the quality of care provided within this core service by Healthcare at Home. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Healthcare at Home and these are brought together to inform our overall judgement of Healthcare at Home

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

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Summary of findings

Overall summary

Healthcare at Home was operated by Healthcare at Home limited. Healthcare at Home provides a clinical homecare, operating UK wide, and works with the NHS, pharmaceutical companies, private medical insurers, consultants, GPs and charities.

The company was established in 1992 and since then have treated over 180 million patients across 49 therapy areas, 450 different chemotherapy regimens and over 90,000 medication orders delivered every month.

Clinical homecare is a term used to describe integrated care and treatment that takes place in a person's own home to minimise the likelihood of an inpatient stay or outpatient visit for the patient.

Healthcare at Home services centres around a specialist nurse team providing clinical homecare to patients in areas including chronic disease, cancer care, supported early discharge complex care and rheumatoid arthritis.

The services provided by Healthcare at Home, were either NHS funded or privately, and dependent on a referral from a GP, hospital consultant or private health insurers.

In detail the services provide:

• Medication support.

• Medication home treatment including chemotherapy.

• Supported hospital early discharge.

• Hospital admission prevention.

• Cancer services.

• Healthcare at Home pharmacy.

• Healthcare at Home care bureau. (on demand call centre).

Services we rate:

This was the first time this service was rated. We rated it as **Good** overall.

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and stored securely and were easily available to all staff providing care.
- The service-controlled infection risk well. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Heidi Smoult (Deputy Chief Inspector of Hospitals)

Summary of findings

Background to the service

The service is a clinical homecare provider, operating UK wide, and works with the NHS, pharmaceutical companies, private medical insurers, consultants, GPs and charities and registered to provide the following regulated activities:

- Diagnostic and screening procedures.
- Management of supply of blood and blood derived products.
- Nursing care.
- Transport services, triage and medical advice provided remotely.
- Treatment of disease, disorder or injury.

During the inspection, we went out with the field staff providing clinical home care visits including the early support discharge teams, we observed and spoke with members of staff from the healthcare at Home care bureau (on demand call centre) and the scheduling teams.

We spoke with 41 staff including registered nurses, health care assistants, reception staff, operating department staff, senior managers and the executive team members. We spoke with five patients and five relatives. During our inspection, we reviewed 10 sets of electronic patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected once, and the most recent inspection took place in September 2019 and this was the first inspection at this site and the first rating inspection since registering with CQC, we found the service was meeting all standards of quality and safety it was inspected against.

Activity (November 2018 to September 2019)

- In the reporting period 2018 to 2019 the service treated over 180 thousand patients during the year, of which 558 patients were children or young people.

We inspected the Midlands region only during this inspection. The service employed over 400 registered nurses of which 120 were based in the Midlands. Ten care assistants, ten transfer coordinators, six physiotherapist, three occupational therapists, as well as having its own bank staff, pharmaceutical staff, care bureau staff, scheduling staff, non-clinical staff, and coordination delivery staff.

Track record on safety in the reporting period August 2018 to July 2019 National figures:

- Zero never events.
- Clinical incidents nationally: no harm (8,818), low harm (31,737), moderate harm (59), severe harm (zero), death of patients who have died within the service (1,878).
- Four Serious injuries Nationally.
- Zero incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA).
- Zero incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA).
- Zero incidences of hospital acquired Clostridium difficile (c.diff).
- Zero incidences of hospital acquired E-Coli.
- Complaints 1,699 received in August 2018 to August 2019 nationally.

Services provided under service level agreement:

- Clinical and or non-clinical waste removal
- Cytotoxic drugs service
- Interpreting services
- Grounds Maintenance
- Laundry
- Maintenance of medical equipment
- Pathology and histology

Summary of findings

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and two specialist advisors with expertise in community nursing. The inspection team was overseen by Bernadette Hanney, head of hospital inspection.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection from 11th, 12th and 18th September 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Good practice

- We saw some information leaflets around enhancing delivery process for patients. Staff told us that from February 2019, Healthcare at Home made positive changes to their delivery process to enhance levels of confidentiality and patient safety. As an added measure of security, patients were required to enter a six-digit pin code into the drivers handled devices upon delivery of medication.
- We saw the provider had recently won a gold accreditation standard for the aseptic non-touch technique (ANTT) and the first healthcare organisation to receive gold accreditation in the UK.

Healthcare at Home Limited

Healthcare at Home Head Office

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

We rated safe as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and stored securely and were easily available to all staff providing care.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
  The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. When providing care in patients' homes staff took precautions and actions to protect themselves and patients.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Good

Are services safe?

- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and the public.

Mandatory training

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

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

Managers monitored mandatory training and alerted staff when they needed to update their training.

- The service followed the provider's corporate mandatory training policy. Staff were required to undertake a wide range of general and role specific mandatory training modules in line with their policy and training schedule.
- Training and development included 'face to face' and 'e-learning' modules. Staff training was kept up to date and each staff member had their own logging system to manage their own training online. Each registered manager kept their own training records and sent reminders to let staff know when their training was due. Staff told us that they could access mandatory training when they required it.
- Most staff had completed their mandatory training, which exceeded the service's target of 90%. Training modules for clinical staff included, Equality and Diversity (96%), Display Screen Equipment (94%), Cyber Security (95%), Modern Slavery (95%), Competition Law (94%), Anaphylaxis (96%), CPR (95%), Health and Safety (94%), ANTT (93%), Clinical Consent (91%), Anti-Bribery (92%), Fire Safety (86%), Adverse Events (99%), Manual Handling (94%), Lone Working (95%), Information Governance (94%), Patient Handling (96%), Infection Prevention and Control – Clinical (94%), Conflict Resolution (97%).
- Training modules for non-clinical staff included, Equality and Diversity (95%), Display Screen Equipment (94%), Cyber Security (96%), Modern Slavery (94%), Competition Law (95%), Health and Safety (93%), Anti-Bribery (92%), Fire Safety (83%), Adverse Events (96%), Manual Handling (94%), Infection Prevention and Control (95%), Information Governance (95%), Good Distribution Practice (96%).
- Basic life support was covered by two different elements such as e-learning and practical face to face training, the completion rate for the cardiopulmonary resuscitation e-learning course was at 95%. As of the time of inspection practical basic life support compliance was at 53%, by October the provider told us they will be at 82% and will increase further by end of October 2019.
- Paediatric nurses received an annual face to face training in paediatric basic life support (BLS); Managing anaphylaxis in children and using Healthcare at Home paediatric early warning scoring (PEWS) system to recognise and respond to the deterioration of child. An observation structured clinical examination of effective BLS was completed annually using resuscitation dummies. All nurses receive an assessment through e-learning to assess understanding.
- Paediatric nurses attend a paediatric conference, topics include paediatric safeguarding, implementation of PEWS scoring system, clinical holding, consent, the importance of effective transition, understanding the adolescent brain, PREVENT and service specific training from specialists within the NHS.
- We saw the Healthcare at Home chemotherapy compliance training register and 150 nurses nationally were trained in chemotherapy, all nurses were undergraduate degree and/ or master's degree level trained.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Nursing staff received training specific for their role on how to recognise and report abuse.

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

- The provider set a target of 90% for completion of safeguarding training. Non-clinical staff had completed safeguarding adult level two (91%) and safeguarding children level two (96%). Clinical staff were trained up to level three for both adult (90%) and children (93%). The service had five senior members that were trained in safeguarding adult and children up to level four and one member was trained up to level five.

Good

Are services safe?

- Paediatric nurses were trained to level three in safeguarding, meeting the requirements of the 'Safeguarding Children and Young People: roles and competencies for healthcare staff fourth edition: January 2019'.
- Staff were aware of their role and responsibilities in making safeguarding referrals. Staff showed us their clear safeguarding guidance and told us this was easy to follow. Staff we spoke with demonstrated good understanding around safeguarding and knew whom to contact within the safeguarding team.
- There were up to date policies in place for the safeguarding and protection of adults at risk and safeguarding children. When we spoke with staff in relation to abuse; they had clear understanding of the types of abuse which constituted a safeguarding concern and they understood how to support patients and how to report a suspected abuse.
- Staff were able to give us examples of incidents which had resulted in safeguarding referrals being made and attended a multi-agency safeguarding meeting. We were shown evidence to support this. We saw the provider carried out a monthly safeguarding and patient welfare report. We reviewed August 2019 report and the overall summary showed 93 incidents were triaged as safeguarding, 84 cases were not safeguarding cases once investigated, and two were high risk relating to poor living conditions and domestic abuse. We saw that a full multidisciplinary meeting was held and in one case the police was contacted. We found this report to be robust and comprehensive.
- Safeguarding concerns were monitored within the services incident and complaints guidance as needed. Significant concerns were monitored directly by the safeguarding lead who gave staff guidance and support as needed. Where there were lessons to be learnt this was cascaded to staff in a variety of means to make sure that staff could readily access the information and guidance.
- The service had systems in place for recording and reporting Female Genital Mutilation (FGM). FGM, also known as female genital cutting and female circumcision, is the ritual of cutting or removal of some or all the external female genitalia. Staff followed guidance for identifying FGM and to safeguard their patients. The guidelines discussed the FGM mandatory reporting and caring for women who had undergone FGM.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment visibly clean.

- We saw all areas at the head office were visibly clean and tidy and staff adhered to regular cleaning schedules. We saw the provider had recently won a gold accreditation standard for the aseptic non-touch technique (ANTT) and was the first healthcare organisation to receive a gold accreditation in the UK.
- Cleanliness, infection control and prevention and hygiene were monitored through a process of internal and external audits. Infection prevention and control measures were in place to ensure patients were protected against healthcare-acquired infections. Staff received infection control training as part of their mandatory training. Between November 2018 and September 2019, 94% of staff had completed their infection prevention and control, and 96.37% (700) of staff were compliant with hand hygiene audit.
- We observed staff using a variety of infection prevention methods during the home visits we attended; including arms bare below the elbows, and the appropriate use and disposal of personal protective equipment (PPE) such as gloves and aprons. Staff adhered to hand washing policy and the safe use of sharps bins. Patients confirmed that staff always washed their hands and used PPE when they visited. Infection prevention and control (IPC) policies and guidance were based on national guidance and best practice.
- We reviewed the annual infection prevention and control report, all incidents were reported at the quarterly infection prevention and control committee meetings; where further information was presented on nursing teams reporting IPC incidents, the themes and therapy area. All incidents were reviewed by the head of patient safety, the head of clinical services or clinical service lead. Since August 2018, when the detailed review of incidents began, there has been six infection risk incidents, and one incident currently being investigated by Healthcare at Home as a potential Healthcare at Home acquired infection, senior staff believe the likelihood was very low.

Environment and equipment

Good

Are services safe?

The design, maintenance and use of facilities and equipment kept people safe. Staff managed clinical waste well. When providing care in patients' homes staff took precautions and actions to protect themselves and patients.

The service had enough suitable equipment to help them to safely care for patients.

- Care was delivered in patient's own home. Risk assessments had been completed prior to patients being accepted for care to ensure that facilities were suitable for the type of service required. We were told that if staff were not happy that care could be provided safely due to the environment they would refer the patient back to their consultant or GP for alternative services.
- All staff we spoke with said that they had access to the equipment they needed, if equipment broke down they would report this to their senior managers who then organised a replacement.
- All staff undertook fire safety training as part of their mandatory training. We saw all fire exits at the head office were clearly marked and fire alarms were regularly checked. We saw evacuation plans on display including evacuation routes, all exit door areas were kept clear.
- Responsibilities for equipment premises safety and maintenance was managed by a third party, all equipment we reviewed were in service date.
- Staff carried personal sharps boxes, but we also saw medical disposal boxes in people's homes. This meant that clinical waste was not mixed with household waste.
- Daily equipment checks were undertaken to ensure equipment was in good working order. Staff we spoke with were aware of the process for escalating faults with equipment, routine servicing and manufactures.
- Anaphylaxis treatment kits were available. The kits were sealed, within their expiry date and stored securely with the nurse. There were kits available for patients with allergies to specific medications.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff knew about and dealt with any specific risk issues.

- During our inspection we saw patients' safety risks were reviewed throughout patients' pathways. At pre-treatment home visits nurses told us they followed guidelines to ensure appropriate information regarding patients' suitability for treatment was collected. This captured patients' health risks prior to any clinical intervention. Any concerns raised were discussed with the patients referring clinician.
- Nurses working for the service had various amounts of experiences, this ensured that staff understood the medical care each patient required and could recognise any deterioration or deviation from expected pathways in patients' health.
- Where appropriate nurses conducted risk assessments with patients, in line the national guidance. These included falls risks, malnutrition universal screening tool (MUST) and vision infusion phlebitis score tool (VIP). Risk assessments were carried out for risks such as home environment, equipment and electrical safety checks. Managers told us that any health and safety risks were reported and highlighted on regular basis. The health and safety processes were reviewed annually to ensure that risks were minimised when caring for patients.
- Staff followed the national early warning score (NEWS) to assess patients' clinical conditions and identify medical deterioration. National early warning system was used for identifying the acutely ill patients.
- Staff provided patients and their carers with information booklets about their condition and treatments. The booklets were produced by the service and contained guidance on what to do if patients felt unwell, including telephone contact to the care bureau, who provided 24 hours a day seven days a week support.
- A combination of healthcare workers and qualified nurses staffed the care bureau department. Calls were screened to ensure clinical advice or guidance was sought. Only appropriately skilled member of staff dealt with the call.
- The provider had a lone working policy and all nursing staff were provided with an electronic panic alarm system which was incorporated into their ID badge and could be used to summon help, in addition to providing location details of the wearer. We observed this being used during our home visits this followed the Healthcare at Home lone working policy.
- Patients were referred to their consultant or GP for any changes in their health, which were not life threatening.

Good

Are services safe?

If nurses found patients that required more urgent support the nurses would arrange transfer to hospital through the 999 system. This followed the Healthcare at Home deteriorating patient and escalation policy.

Nursing and Medical staffing

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

- The service assessed the clinical needs of patients based on recognised regime of treatment. This included the required amount of time, travel between patients and the frequency of treatments and visits required, this enabled an accurate assessment of staff required to deliver the service agreed.
- We saw that systems were in place which ensured that only nursing staff with the appropriate qualifications to meet the needs of each individual patient would be allocated to visit those patients. The service had a specific schedule team that allocated each patient to the qualified nurse. The scheduling team used a computerised algorithm to identify the most appropriate staff to allocate to each patient in the most appropriate order in which to visit, based on clinical need and location. Once allocated this information was shared with each member of staff through email.
- Since the last inspection the service has employed eight clinical nurse specialists (CNS) as a national post, and over 150 chemotherapy nurses which are masters or degree level trained in chemotherapy.
- Healthcare at Home employed 35 paediatric nurses across the United Kingdom, providing services to children and their families within their home. They held the required registered nurse, children's Level one or children's nurse level 1, sub part 1 qualification.
- Most of the treatments required one nurse to each patient, however more than one nurse could be allocated due to treatment regime or complexity and agreed prior to any visits. Staff we spoke to through each division felt they had enough staff and felt supported by senior members.
- Staff we spoke with told us they could access a 24 hours operational manager for support. This was also supported by regional management and central support functions from Healthcare at Home to ensure the service was appropriately staffed and ran smoothly.
- Senior staff told us they did not use an acuity tool for scheduling and roistering of staff, due to the nature of the service. However, staff rotas were available months in advance. During annual leave or unforeseen shortages, the senior managers told us they would re-assess staff rotas and the scheduling, and if needed scheduling team would contact bank staff in line with the service business continuity plan, there were no shifts unfilled.
- Nursing teams operated on a regional basis, supported by clinical mentor teams (CMT), clinical supervisors and clinical nurse specialist (CNS), who reported to regional clinical operations manager (RCOM).
- Planned and unplanned absences were covered from within the service. Agency staff were not used to cover nursing vacancies. Within the midland region Healthcare at Home had 18 bank staff that they used on regular basis.
- The providers sickness absence levels from September 2018 to July 2019 were a little higher than their target. The provider set a target of 7%, healthcare at Home was at 7.2%.
- Healthcare at Home had a medical advisory committee (MAC) whose role included ensuring that any new consultant was only granted practicing privileges if they were deemed competent and safe to do so. The MAC met four times a year. We reviewed three meeting minutes, and we found them to be robust. The agenda covered the service regulatory compliance, clinical reviews, practicing privileges, quality assurance, clinical services and Healthcare at Home business reviews.
- The role of the MAC also included periodically reviewing existing practicing privileges and advising the service on their continuation. They gave examples where practicing privileges had been suspended or withdrawn because of concerns raised. This demonstrated that the MAC was an effective body for monitoring the competence of the consultants. The provider currently has 262 consultants with practising privileges. One consultant has not been awarded practising privileges following an investigation in 2017 and the General Medical Council (GMC) conditions placed on that consultant has been extended until 2020.

Good

Are services safe?

Records

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

- Staff used the electronic device to record patients' clinical interactions and treatment. Electronic patient records contained patient demographic details, patient observations, assessment findings, treatment details and outcomes. Staff told us the electronic device was easy to use.
- Healthcare at Home were working on a large IT system project to support more efficient working for all staff. The new IT system would be used to collect live data, share information and manage clinical audits, this was due to be completed by 2020. Paper documentation was also available if the electronic system failed.
- We reviewed 10 electronic patient records. Some staff we spoke with told us that IT system was not always easy to use, and at times difficult to review information on one page. When we spoke with staff and senior teams they informed us that they were working on improving IT documentation to be more centralised.
- Healthcare at Home had a compliance target of 90% for all patients' records to be documented correctly, according to Healthcare at Home latest figures from September 2018 to July 2019 they had achieved 96.43%. In the month of August 2019, 100% of staff were compliant with their documentation.
- Staff undertook patient safety checks prior, during and after each clinical treatment. All checks included patient's wellbeing pre, during and post treatment and were clearly documented in patient records. We observed nurses completing these checks during home visits.
- Patient records were viewed remotely by senior management teams and care bureau staff if advice or further guidance were needed. The electronic device had various applications that supported clinical community staff such as clinical pathways, medicines and adverse reactions, safeguarding and incident reporting. The electronic device allowed staff to review patient's health against expected outcomes.

Medicines

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

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

- Healthcare at Home had several policies in relation to the manufacture, storage, dispensing, delivery and administration of medicines. Staff demonstrated good understanding of the policies and knew how to access information when required.
- The pharmacist provided specialist advice to ensure the safe and secure management of medicines and to ensure all were in line with the standard operating procedures and policies. We saw the provider used an adapted NHS risk matrix algorithm for the management of medication errors. This algorithm was used to assess the severity of a medication error or a near miss using the risk matrix.
- Patients we spoke with confirmed that nurses had fully informed them about their medication and offered advice regarding safe use and storage in the home. We observed staff as they administered patients' medications, including intravenous procedures, all staff were compliant with aseptic techniques. We observed during the home visits, nurses confirming the identity of the patient against their chemotherapy prescription details and against the actual medicine packaging. Nurses also checked the expiry dates, dose levels and frequencies prior to starting the procedure. All batch numbers were documented on the prescription chart.
- Healthcare at Home had one large medicine distribution warehouse, where medications were stored and distributed. Facilities were regularly inspected by the general pharmaceutical council (GPhC) and medicines and healthcare products regulatory agency (MRHA). Last inspection took place in July 2018. We reviewed the report and saw how the provider responded to any issues highlighted to ensure medicines were stored and distributed safely.
- Since the last CQC inspection in 2017, Healthcare at Home have replaced their external logistic delivery service. All drivers were Healthcare at Home employees. The provider was also working towards a logistic delivery project called 'igloo' to improve their delivery and distribution services due to number of incidents relating to late or missed delivery. Further innovative improvements were being implemented to track

medicines using an electronic tracking device on delivery vehicles and a six-digit barcode for patients to use to accept delivery. This was to ensure patients confidentiality and security when receiving prescriptions.

- Learning from reported medicine incidents was undertaken by the medicine management team and action was taken to prevent the incident happening again. The medicines management team met monthly to discuss all reported medicine incidents for the month and to identify any trends or themes to learn from errors and to make improvements. Reports from these monthly meetings were presented to the Healthcare at Home clinical governance meetings to ensure identified training was reviewed with appropriate actions taken. There had been three serious incidents reported relating to medicine administration errors.
- We reviewed July 2019 and August 2019 meeting minutes from the drug safety committee, that discussed latest treatments, staff training for new medicines and treatment, risk assessments around certain medications and any updates on medicine errors or delays. We also saw a discussion was held around missed doses due to patients not being available to receive their delivery. This highlighted the need to address actions for these patients, and one action was to improve the text ahead service to ensure patients were aware of the deliveries.

Incident reporting, learning and improvement

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

Staff knew what incidents to report and how to report them. Patients and their families were involved in these investigations. Staff met to discuss the feedback and look at improvements to patient care.

- Never events are a serious patient safety incident that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. Healthcare at Home reported zero never events in the reporting period November 2018 to September 2019.
- Healthcare at Home used an electronic incident reporting system. We saw that nurses had direct access to the system using their electronic device. This meant staff were able to input incidents immediately. We saw two examples during our home visits of nursing staff reporting an incident, one related to a missed delivery of medicines and another related to a failed delivery of a patient starter pack information. Staff we spoke with told us having direct access to incident reporting resulted in more accurate and timely information being collected. Senior management team also had a full oversight. We observed a positive culture of incident reporting among staff throughout the inspection.
- Staff understood their responsibilities to raise concerns, reports incidents and near misses. Staff gave examples of when something went wrong, investigations were conducted, and lessons were learnt.
- Managers investigated incidents and shared lessons learned with the local team, the wider national teams and their contractual NHS partnerships. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. Duty of candour (DoC) is a regulatory duty that relates to 'openness', 'honesty' and 'transparency' and requires providers of health and social care services to notify patients or other relevant person(s) of certain notifiable safety incidents and provide reasonable support to that person. Since the last inspection of 2017, the provider had updated their DoC of candour policy, updated their DoC training and staff including senior teams were able to demonstrate the importance of being 'open', 'honest' and 'transparent' to ensure the service fulfils their obligations in respect of their legal duty of candour.
- Staff told us that they were encouraged to report incidents. Learning from incidents was shared via email, briefing newsletter and Healthcare at Home internet hub that was used as a central information portal, and staff could access electronically. Staff members told us that "incidents are always a topic for discussions". Staff

Good

Are services safe?

went on to tell us any incidents that have trends and themes may result in some additional training to support staff and any immediate concerns would be escalated. Incidents were divided into clinical and non-clinical incidents and included actions taken to make improvements.

Safety performance

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and the public.

The service continually monitored safety performance.

- The safety performances data such as chemotherapy related side effects and central line care was used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline was intended to focus attention on patient harms and their elimination.

Good

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as **Good** because:

- The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.
- Staff regularly checked if patients were eating and drinking enough to stay healthy and help with their recovery. They worked with other agencies to support patients who could not cook or feed themselves.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

- The provider monitored all relevant National Institute for Health Care Excellence (NICE) guidelines to ensure staff were always kept up to up to date in practice. Staff were able to show us how they accessed clinical guidelines and local policies on their hub intranet page.
- Policies we looked at were accessible, current and referenced good practice guidelines and where relevant, referred to professional body guidance and published research papers. Staff used the national oncology pathways grading system for the triage of patient symptoms and side effects.
- Care bureau staff were fully trained and competent to use the recognised tools when taking calls from patients, this included the United Kingdom Oncology Nursing Society (UKONS) triage assessment tool. The UKONS 24-hour triage tool was a widely utilised recognised tool that was used to perform risk assessment for patients who have received systemic anti-cancer therapy including chemotherapy in the previous six to eight weeks, radiotherapy, or disease related immunosuppression.
- Care bureau staff also used the 'odyssey' triage system, a clinical decision support system in providing advice to numerous ranges of care pathways. This was to support and deliver the best possible clinical advice to patients.
- Local key performance indicator (KPI's) data was gathered locally and nationally across the services. There were KPI's for a range of clinical treatments provided such as cancer treatment or biologics. This information related to whether national guidance and evidence-based care was followed effectively.

Nutrition and hydration

Good

Are services effective?

Staff regularly checked if patients were eating and drinking enough to stay healthy and help with their recovery. They worked with other agencies to support patients who could not cook or feed themselves.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

- Staff provided advice on nutrition whilst on chemotherapy treatment and advice for those patients receiving a total parenteral nutrition (TPN). TPN is a method of feeding that bypasses the gastrointestinal tract. Fluids are given into a vein to provide most of the nutrients the body needs. The method is used when a person cannot or should not receive feedings or fluids by mouth.
- Senior staff told us for patients who were diabetic, their treatment time was coordinated to maintain a normal blood glucose level. Staff offered drinks to patients on a regular basis throughout their visit if suitable or would ask patient when they last ate or drank. Patients we spoke with said staff were very attentive during their home visit.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

- Staff were trained to assess patient's experience of pain, A systematic process of pain
- assessment, measurement and re-assessment, enhanced the health care teams' ability to reduce pain and achieve comfort. Any concerns Healthcare at Home would advise patient to contact their GP or their consultant.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. Outcomes for patients were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve patients' outcomes.

- Healthcare at Home provided systematic anti-cancer therapy (SACT). All organisations providing a cancer chemotherapy services are required to provide statistical information. The provider did not supply any data directly to SACT but the information was collected through the NHS trusts where the patient had originally been seen and referred.
- Clinical service managers told us they met with NHS managers often, to discuss all aspects of patient care and anticipated outcomes were regularly discussed. The service leaders reviewed the effectiveness of care and treatment that staff provided through local audits along with benchmarking against other similar services.
- Senior managers we spoke with told us that Healthcare at Home provided statistical information to pharmaceutical companies regarding the use and effects of drug therapies. The provider used their own incident reporting system and triage calls to record the data. Staff told us any minor changes to patient's health or wellbeing were recorded, and this information was used by the pharmaceutical companies to develop new treatment or improve their treatments.
- Healthcare at Home can provide over 1,800 different treatments across 49 medical therapies. All patients who were referred to the service received an initial assessment to ensure each individual patient could be safely supported in the community. Patients' health and wellbeing were monitored and fluctuations outside the expected levels were escalated appropriately to referring consultant would be contacted.

Competent staff

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

Good

Are services effective?

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

- Chemotherapy training was available to nurses. Healthcare at Home had a contractual plan with the local university for nurses to complete either a degree or masters in chemotherapy. As of September 2019, Healthcare at Home had 150 nurses that are competent in chemotherapy. The provider also had a clinical lead available for additional support. We saw an example of a chemotherapy workbook to ensure that all chemotherapy staff were competent. On an annual basis practice development nurses carried out a competency update work with each chemotherapy nurses to ensure they were up to date on practice.
- Clinical staff were registered with the appropriate body. Nurses are required to register with the nurse and midwifery council (NMC) and are required to re-register annually. They are required to undertake continuous professional development (CPD) and receive clinical supervision as part of their registration and revalidation. Clinical supervision of nursing staff took place monthly, we saw evidence to support this and we were assured staff received appropriate support and guidance if they failed to meet any of the standards.
- Staff were required to have a minimum requirement of skills and competency. This was achieved through statutory and mandatory training as well as additional training specific for staff working for Healthcare at Home. Staff had the appropriate qualifications, skills and experience to do their job. Staff we spoke with were knowledgeable about their role.
- Clinical staff were supported by a comprehensive competency assessment toolkit, which covered key areas such as use of equipment and any applicable assessment across all roles. Staff were also expected to pass a probation period depending on the skills of the staff. The recruitment process ensured that staff had the right qualifications, skills, knowledge and experience to do their job when staff start their role.
- Care bureau staff included qualified registered nurses and were available 24 hours a day seven days a week for patients who had concerns, required advice and support. The care bureau also provided support for field staff out in the community if needed.
- Scheduling team provided patients with the right skilled staff member. All clinical staff were supported to complete relevant additional training to improve their knowledge and skills. The scheduling team demonstrated how they used their allocation system to allocate the right skilled clinical staff to fulfil the requirement of patients' individual needs. The allocation system was able to identify where the geographical skills gaps were, such as the area where patient required certain treatments and where the right skilled staff members were. This enabled the provider to recruit in a specific location or to provide additional training for those staff in that area. This ensured all patients were cared for by the right skilled staff.
- All staff we spoke with reported they had received a yearly appraisal. This was beneficial as it aided in the identification of further development that each staff member required. The provider recorded appraisal compliance using a combination of mid-year and full year appraisal meetings, along with set of objectives that require an annual completion. Information provided by Healthcare at Home showed that as of November 2018 to September 2019 98% in the Midlands region had completed their appraisals.

Multidisciplinary working and coordinated care pathways

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies. Patients had their care pathways reviewed by the relevant consultants.

- Staff worked effectively as a multidisciplinary team (MDT). All health care professionals work as one team to ensure patients' needs were met. Healthcare at Home nurses would refer to other specialist services when required such as social services, psychological support and learning disability teams to promote an integrated approach to any health condition management. All communication was shared with patient consultant and GP.
- Staff also had access to additional support from pharmacy, physiotherapists, and other specialist services. Other services provided support on an on-call basis.

Good

Are services effective?

- Contracts with NHS trusts included clear guidance on the acuity of patients who were suitable to be treated by Healthcare at Home and processes to enable deteriorating patients to be returned to the hospital if needed. Healthcare at Home worked with over 250 NHS hospitals to support and manage patients that were suitable and well enough to be discharged home but still required a short period of additional support. Patients that were cared for in this way, remained under the care and supervision of their hospital consultant but received their nursing care at home. Healthcare at Home had their own specific team for this role called the early support discharge team, one senior staff member from the early support discharge team was based at the hospitals to provide additional support for the hospital discharge team to increase bed capacity at the hospital.
- Nursing staff also worked alongside other health providers such as district nursing teams, GP's and private health insurers to provide a range of services from complex nursing support through training patient or their carers in administering of medications such as injections.
- We saw good examples of team work during home visits. One patient requiring their first cycle of chemotherapy, Healthcare at Home chemotherapy nurse had been to see this patient 72 hours prior to treatment to take blood samples and during the visit the nurse had identified the patient was difficult to take blood sample, this was raised with their consultant and an alternative intravenous access discussion had been made with an agreement and consent from the patient. We saw this was documented in-patient record. During our chemotherapy day visit the nurse was unable to access a vein, the nurse escalated this with a senior team member, within one hour another chemotherapy nurse attended the visit and managed an intravenous access, this did not delay patient treatment.
- We saw an example of Healthcare at Home nurse calling a GP as they were concerned about their patient's well-being around nutrition and weight loss. The nurse gained patient consent and arranged an appointment with GP.

Health promotion

Staff gave patients practical support and advice to lead healthier lives. The service had relevant information promoting healthy lifestyles and support.

- Staff were able to access an online service specifically for patients, providing them with different tools for self-care and how to recognise allergic reactions to medication or chemotherapy related effects such as neutropenia sepsis.
- All patients receiving chemotherapy or biologics treatment were provided with a hotline or an alert card to keep with them in case they were ever in an emergency and needed to alert any healthcare profession of the treatment they were receiving.
- We saw staff promoting health and wellbeing verbally during interactions, including advice on alcohol intake, smoking and healthy eating. Staff were able to access information and provide patients with relevant information and advice.
- We saw some information leaflets around enhancing delivery process for patients. Staff told us that from February 2019, Healthcare at Home made positive changes to their delivery process to enhance levels of confidentiality and patient safety. As an added measure of security, patient was required to enter a six-digit pin code into the drivers handled devices upon delivery of medication.
- The provider provided an occupational health services for all staff. This covered sickness absence, assessments and reviews, new starter medicals, needle stick management and any vaccination programmes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records.

- Staff demonstrated good understanding around the principles and values that underpinned the legal requirements in the mental capacity act 2005 and deprivation of liberty safeguards. For example, that a person must be assumed to have capacity unless it was established that they lack capacity.
- Parental consent was sought for treatments for children. Staff were aware of, understood and implement the principles of Gillick competence where appropriate.

Good

Are services effective?

Gillick competence is a term used in medical law to decide whether a child under the age of 16 years of age can consent, object to their own medical treatment, without the need for parental permission or knowledge. We did not observe any home visits with children receiving treatment during our inspection.

- Staff were able to demonstrate good understanding of the need to gain full consent prior to any treatment and clinical interventions. Staff we spoke with had a good knowledge of assessing capacity. They were aware of what to do if a patient lacked capacity to consent to treatment.
- Consent forms were signed by the patient at the start of any treatments. We saw that consent forms were completed in patient records. During our inspection when we attended home visits we saw nursing staff requesting patients to sign if they were happy to proceed with the treatment. Patients were able to sign their signature on the electronic device which was then imported into their own patient record.
- During our home visits we observed staff explaining to patients what they were intending to do during the visit and gave the patient opportunity to ask questions and the nurses continually asked the patients permission to continue with their task. Staff told us if they felt patient behaviour was different and they were not happy to continue with treatment they would document this within patient records and would seek senior advice, contact either the GP or their referring clinician.
- Patients we spoke with told us they were fully informed about their treatment, procedure and plans and felt empowered by their nurse to make their own decisions.
- Part of the standard assessments for patient record included a psychiatric assessment section. It included prompts and information on different sections of the Mental Health Act and directed staff to the appropriate mental health guidelines when required. Body map was part of a standard assessment, which also included a mental health related risk.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

We rated caring as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

- Staff were respectful when addressing patients. All staff spoke with patients respectfully and used preferred choice of name. Staff introduced themselves before any interactions with their patients and their loved ones. Staff were always respectful, polite and friendly.
- Feedback from all patients we spoke with was consistently positive about the way staff treated them. One patient said "communication is absolutely brilliant, great, always there and keeps in touch prior to any appointment especially if staff are running late" another patient told us "very professional and friendly, I feel at ease and confident in the staff ability".
- Staff took the necessary time to engage with patients. Engagement with patients was caring and staff were always calm despite being very busy. Staff did not allow work pressures to impact upon patient care.
- Communication between the nursing staff, patients and the family were consistent, clear and effective. Staff also used appropriate humour to help with patient engagement.
- Staff demonstrated a courteous and compassionate manner towards all patients and their families, we saw this reflected in the feedback from Friends and Family questionnaire, 98% of patients were satisfied with the service over 30,000 patients had taken part in the survey, 65 reviews and 50 were rated with five stars.
- Staff who undertook the pre-treatment home visit or telephone call were the same staff who cared for those patients during their first day of treatment. Staff were passionate about this process as they could offer continuity and support for their patients. This offered some reassurance for their patients. Senior staff told us they aim to have around three nursing staff for each patient during their treatment journey.
- We spoke with patients and their relatives who provided positive comments regarding the care given by all levels of staff from clinicians to delivery person. Patients told us that staff spoke kindly and respectfully towards them; and took time with care and treatment.

Emotional support

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

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

- We saw staff provide high levels of emotional support to relatives of patients. Specifically demonstrating a kind and empathic response and listening to concerns.
- Staff introduced themselves to the patient and explained why they were there and what they were going to do. Staff kept asking patients if they understood and gave clear explanations of care and treatment.
- Patients told us they were kept up to date if the nurses were running behind, some patients we spoke with had used this service before and said they wouldn't go anywhere else.
- Healthcare at Home had eight clinical nurse specialists (CNS) who worked across UK, we saw one example where a CNS visited a patient having their first chemotherapy treatment who attended the visit for additional support this was because the patient had

Good

Are services caring?

expressed to the CNS on a telephone call prior to treatment how nervous and anxious they were to start treatment. The CNS had ensured they were available that day for that patient to offer support.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

- Patients we spoke with told us they had been fully involved in the decisions about their care. Patients told us about how they were referred to Healthcare at Home, and that their consultant spoke highly of the service that Healthcare at Home provided. Patients felt empowered as they were able to manage own delivery time for medicines and equipment, they were able to arrange a suitable time with the nurses and felt they were in control of their well-being.
- Relatives told us they were kept informed of any plans and treatment and told us staff were helpful and approachable.
- Patients and relatives, we spoke with said they felt involved in their care. They said they were given opportunities to speak with their own consultant looking after them and to ask Healthcare at Home staff any questions in relation to treatment, care and medicine deliveries.
- Patients confirmed, and we saw during our visits that Healthcare at Home staff had provided detailed information about their condition and the effects of any treatment or medications. Patients understood how to identify if they suffered effects outside the expected treatment regime, and whom to contact if they needed further assistance.

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

We rated responsive as **Good** because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care in a timely way.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Planning and delivering services which meet people's needs

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

The service had systems to help care for patients in need of additional support or specialist intervention.

- The service had a large variety of patient information leaflets in several different formats, and different languages were available on request. The providers' website provided useful information to patients and their relatives.
- The provider did not provide emergency care and all treatments and appointments were planned and arranged in advance**.** Patients were seen on a planned basis this included private patients and NHS patients.
- The service provided a wide range of different treatments, this meant that services could be provided to a broad spectrum in the community, including those with multiple or complex needs.
- Transition services between paediatric and adult services were planned in advanced, patients being transferred from the paediatric team member to an adult team member were organised between the two teams, joints visits were undertaken to introduce the new team. Most procedures were a continuation of what the individual patient had been used to. We saw evidence of one transition from paediatric to adult services action plan and found the documentation to be robust.
- Patients receiving medication deliveries were able to arrange delivery to their home, place of work, school, prison or to a named representative. Patients were contacted when deliveries were due, and times were scheduled to suit the individual patient. Patients were given alternative options if they required.
- The provider operated on three main services, the early supporting discharge team project working closely with NHS hospitals, home care bureau call centre and the paediatric services.
- The allocation scheduling system included the ability to set specific time for visits where patients were required repeat medications within a specific time limit. The scheduling functionality enabled patients to request visit times in line with their personal, work, school or social patterns.

Meeting the needs of people in vulnerable circumstances

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

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

- The provider was in the process of developing a mobile phone app, where patients were able to track their own medicine deliveries, able to see delays and tracking of their own treatment regime. We asked staff about patients who may not be comfortable or able to use mobile apps, staff told us they will continue to have the care bureau staff providing 24 hours a day service to support all patients. We also spoke with senior staff about patients living with dementia or those who may

Good

Are services responsive to people's needs?

have learning disabilities or those patients who require long term service who may become confused later in life. Staff informed us that during each visit they assess their patients, we saw evidence of staff recording assessments in their electronic device, any concerns raised was shared with the patient GP and the referring clinician.

- We saw improvements had been made since the last inspection around dementia care. We reviewed the provider service operating procedure (SOP) for signposting patients living with dementia or suspected dementia, this was implemented on the 4th of September 2019. The purpose of this SOP was to provide guidance for Healthcare at Home clinical staff on the actions required if a patient had already been diagnosed with dementia and to recognise deterioration in their condition or a patient who may be exhibiting signs of dementia.
- Services were readily available to people from all areas of the community, patients were able to make personal preferences about their care, this included taking account of religious and cultural beliefs and practices.
- The provider was in the early stages of working on improving the services for those patients who were partially sighted, deaf or those with complex learning disabilities. The provider was planning to have patients input to ensure they were able to provide holistic, patient centred care service.
- The provider was able provide a face-to-face interpreter for patients if they did not speak English as their first language. We saw the provider also had access to a translation line; staff we spoke with knew how to access this and said they had used this translation line. Within Burton site, there were over 30 different languages spoken by their own staff, this provided additional support for patients.
- Staff could access appropriate equipment such as intravenous therapy pump devices, cold cap machines, medicine fridge. Equipment were requested if needed prior to treatment. Any additional equipment deliveries were arranged between the patient and Healthcare at Home.

Access to the right care at the right time

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access their services and received treatment within agreed timeframes and national targets.

- People could access the service when they needed it and received the right care in a timely way.
- During our inspection, we did not highlight any concerns relating to the admission, transfer or discharge of patients within healthcare at Home. Patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- Healthcare at Home referrals were received from several sources. Many patients required only the delivery of prescribed medications, which they were able to self-administer, other patients required support such as instructions and competence checks to enable patients to go on to self- administer pathway and other patients were dependent on nurses to administer their medications such as chemotherapy.
- Patients were referred by their GP, hospital consultant or private health insurance. In addition, some NHS hospitals had Healthcare at Home nurses working at the trust to enable them to assess patients and offer them the home service as an alternative to hospital admission or support patients with early discharge.
- Senior staff told us they did not have a waiting list for patients requiring treatment. Any new patients were allocated by the scheduling team to the most suitable staff members. The provider increased their staffing levels to the demand of the service.
- Scheduling staff told us that all referrals were reviewed by the clinical needs of the patients and the support required, each case were prioritised accordingly. Scheduling team were able to re-allocate patients to other members of the nursing team when required. If specific treatments were required that were outside the skill base of the staff available, those patients were passed to the neighbouring teams. All patients involved including those of other staff whose visit may be delayed were contacted by telephone to advise them of

the delay. This occasionally resulted in less critical appointments being cancelled and completed the next day. All visits were recorded in real time when staff attended patients' homes and updated on their devices.

- In October 2017 Healthcare at Home introduced a model to identify the closest nurse to the patient's treatment address with the correct competency.Since October 2017 83% of patients now see one of two nurses throughout their treatment regime, prior to this patient's continuity of staff was running at 42%. The staff working at care bureau and schedule team quoted "Our key aim remains getting the right person, with the right skill set, to the right patient, at the right time and to deliver inspirational care".

Learning from complaints and concerns

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

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

- Staff we spoke with told us that any "Thank you" and compliments to individual staff members were shared in their team meetings and an email would be circulated.
- Staff were aware of actions to take if someone wanted to raise a complaint or a concern, and they would seek support from senior staff if they were not able to resolve the complaint. We saw that leaflets with telephone numbers were handed to all patients during their first visit by a Healthcare at Home staff member, patients or relative we spoke with knew how to contact the service if they wished to complain or share their compliment.
- The service had a proactive approach to handling complaints. They addressed concerns at a local level before they became a complaint. Staff told us that this proactive approach helped reduce the number of complaints and gave them opportunities to learn from these complaints.
- We reviewed three complaints investigations from across the organisation. We found investigations into complaints were comprehensive and lessons had been learned and disseminated.
- The complaints procedure set out the three-stage process for the review of complaints, and appropriately referenced the adjudication services: The Independent Healthcare Sector Complaints Adjudication Service and the Parliamentary and Health Service Ombudsman.
- The provider had complaints department with two complaints coordinators and a complaints manager. At time of our inspection complaints were answered within two days of receipt this was better than the NHS guidance which requires responses within three days. Complainants were provided with a named case worker for them to contact if required. The service received an average 1,699 complaints a year, most of the complaints related to issues surrounding the delivery of medications.
- The service excellence team was now in place since May 2019, with two roles, first line triage and pharmaceutical service delivery. Service excellence team provided regular feedback meetings with functions around trending on complaints and supplying valuable data. In August 2018 to August 2019, 250 incidents were raised, following triage 178 were investigated as formal complaints. 182 complaints responses were issued, and four complaints (2%) were sent outside the 20-working day service level. Complaints acknowledged within two working days was at 100% and complaints closed within 20 working days was at 98%.

Good

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well-led as **Good** because:

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

Leadership of services

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

- All managers we spoke with at different levels of the organisation had a clear understanding of their role and understood their accountabilities. Staff told us the provider ran without a hierarchical influence, staff felt respected and supported.
- Staff and managers told us that unprofessional behaviours were challenged and addressed. All staff told us that the provider was a friendly and caring environment and enjoyed working for Healthcare at Home. They told us that they would highly recommend the provider to work for and promote the care and treatment the provider provided.
- Senior nursing staff told us they felt they were being listened to by the management team and there was a real focus on patient safety.
- Staff spoke highly of their immediate line managers and felt well supported by them. Staff told us that both the executive team and head of clinical services were visible and supportive, and they could approach them with any concerns.
- We spoke with senior clinical teams that were able to show us their nurse quality audits, that highlighted areas for improvement but also contained a section where the supervisor could comment on good practice.

Good

Are services well-led?

We saw audit sheets where both good and poor practice had been highlighted. This demonstrated how the provider encouraged a balanced and fair management system.

- There was an experienced senior management team and a supportive medical advisory committee that was well established. Senior managers told us that a member of senior management team attend different team meetings to show support and to answer any questions and provide further information on outstanding actions.
- Healthcare at Home were in the early stages of providing a comprehensive leadership development programme and executives board members were actively encouraging the development of aspirational leaders. This approach placed greater emphasis on a more collaborative and team-focused leadership. Development was targeted to ensure all senior staff were supported in the first instance, though leadership development was available to all eligible staff and formed part of the appraisal process.

Service vision and strategy

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

- Vision and objectives had been cascaded to staff across all areas we inspected, and staff had a good understanding of these.
- Staff we spoke with felt engaged with the providers strategy and understood that there was a clear vision for the service and knew their role in achieving the best outcomes for their patients.
- Healthcare at Home visions were set out the purpose and mission of the organisation moving forward. The service was summarised as," inspirational healthcare in the home for millions of people worldwide". The provider was "aspired to be caring for people in their own home".
- The main elements of the providers visions were to increase the number of people care for in their own homes, embed operational excellence and safety, to be the market leaders in setting improved standards in care and to create a performance culture that engaged all Healthcare at Home staff. In 2017, the service had expanded and were aiming to re-locate into one newly acquired premises and planned to upgrade their scheduling allocation system. During this inspection the provider had re-located to a newly acquired premises and scheduling allocation system had been updated with further IT software updates due for completion end of 2019.
- Managers told us that they discussed the providers values during team meetings, recruitment interviews and staff appraisals. Staff told us as part of their annual appraisals a part of the strategy and visions were measured on their performance against their objectives to demonstrate Healthcare at Home values.
- All healthcare providers are required to meet the fit and proper person requirement in line with Regulation 5 of the health and social care act 2008. This regulation serves to ensure all directors employed by a healthcare provider (both executive and non-executive) are fit to undertake their roles and they are of good character.
- As part of this inspection we undertook checks relating to this regulation to ensure that the healthcare provider was complying with the regulation fully. We reviewed the full employment files of three executive team members. We carried out checks to determine whether appropriate steps had been taken to complete employment checks, in line with the fit and proper person requirements. We found that in all cases all appropriate checks had been undertaken.

Culture within the service

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

- There was a positive culture of staff development and empowerment, which was supported and encouraged by all managers we spoke with. Some staff told us they had developed within their role, to which they are now senior members of the department within Healthcare at Home. Another member of staff told us they were encouraged to complete a nursing degree and Healthcare at Home would support them through this development.

Good

Are services well-led?

- Staff we spoke with said they had worked for Healthcare at Home for considerable number of years and all said it was a good place and a good provider to work for. We found that all staff we spoke with were 'open' and 'honest'. Staff told us that they were able to approach any senior management team members without fear of retribution.
- Staff told us, and we saw there was an 'open' culture that was not about blame. They were encouraged to report incidents, as it was an important learning tool.
- Since the previous inspections the new chief executive had refreshed the skill and capability offered by executive and non-executive board members. We heard and noted some rapid impact of these leadership changes. Most notably in supporting the chief executive to drive an open, honest and professionally challenging culture, and driving a team focused on both quality and finance.
- The executive team was highly visible and approachable. Staff consistently told us that the executive teams were often seen within clinical and non-clinical areas engaging with staff and patients if out with the field nurses. These visits were both formal and informal. Formal visits would take place using an assurance visit framework and informal visits would not be recorded and allowed the executive teams to interact freely with staff.
- All staff told us that they felt the chief executive's style of leadership had made a significant positive impact on the culture within the organisation since been in post. We found there was a good balance of approach and expertise between chief executive and the senior managers.

Governance

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

- We found there was a system of governance meetings which enabled the escalation of information upwards and cascading information from managers to front-line staff.
- Clinical operations were led by the clinical director who was also a board member. The clinical director was interviewed as part of the inspection process and described the governance process and how this was used to promote change and improvement in services. Regional clinical directors reported to the clinical director and in turn were supported by teams of managers and supervisors including the services registered managers. Team meetings were held at each level and issues and information were cascaded between the levels at each consecutive meeting.
- Governance structures were in place which enabled executive oversight of the systems and processes. Board level service leads oversaw and had responsibility for areas including finance, human resources, legal, information technology, commercial, marketing analytics and innovation and operations.
- An electronic tracker was also in place to monitor internal and external alerts to ensure all actions were completed. The electronic reporting system was set up with a central support to include dashboards to monitor any themes or trends of incidents and associated risks.
- Registered managers understood their role in promoting the vision, values and purpose of the organisation. They told us they felt supported by senior managers and executives and believed that systems were in place to enable staff to deliver the companies goals. Managers understood their staff. Registered managers reported to the director of nursing and to the head of clinical governance who in turn reported to the operational quality meeting. The information discussed was then relayed to other committees for example the quality committee which in turn reported to the Healthcare at Home board team members. We saw evidence of issues discussed and recorded at all levels of the organisation which were initiated in nurse team and clinical meetings.
- Healthcare at Home had recently appointed two non-executive directors based on their skills and experience and consideration had been given as to how these would benefit the organisation and complement the skill sets of executive leaders.
- All reports that went to the board meeting and to any subcommittee would receive an assurance rating. This gave an indication on the level of assurance that had been provided around the items.

Management of risk, issues and quality measurement

Leaders and teams used systems to manage performance effectively. They identified and

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escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- We saw evidence of an effective governance framework which supported the delivery of the strategy and good quality care. The provider received referrals from either NHS trusts, private medical insurance, and consultants were known as the commissioners of the services Healthcare at Home provided. They monitored the outcomes of treatments.
- We saw evidence of meetings between senior Healthcare at Home staff and staff from the commissioning organisations, discussions held were around adherence to contract, incidents, compliments, complaints and any open investigations relating to individual organisation.
- Systems were in place which enabled senior managers to monitor and assess performance. These included; monitoring adverse incidents, audit of nurse quality indicators, audit of patient records, deliveries and medicines quality assurance meetings.
- Risk was overseen by the clinical governance committee which include the head of clinical governance and representation from the board. Risks were recorded, assessed as affecting safety, effectiveness, caring, responsiveness or well led aspects of the service. More serious risks were recorded on the corporate risk register. These included effect of Brexit, new technology system, business model and new legislation of increase cost of VAT on certain medications, cyber generated attack and compounding supplier failure.
- The pharmacy risk register was reviewed monthly at the governance meeting. It was also reviewed at the divisional board meeting as a standing agenda item where it could be decided to escalate the risk to the corporate register.
- Care bureau provided the clinical operations out of hours service for all their patients from 5pm to 8am, Monday to Friday, 24 hours a day, seven days a week including weekends and bank holidays. The service operated a bronze, silver and gold escalation process to ensure all routes of escalation were clear and effective, this was reviewed on an ongoing basis to ensure safety of performance for both patients and staff were continuously monitored.

Public and Staff engagement

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

- Staff told us they had regular telephone calls, video call or face to face meetings with their managers. Meetings took place weekly, face to face were monthly, meetings were recorded, and we saw examples of the meeting minutes.
- Staff we spoke with all told us that individual teams based locally and nationally met using dial-in or video call conferencing.
- Healthcare at Home used a communication process system called 'Drum Beat' meetings to ensure that all teams within the organisation had relevant up to date information about their area of work and any potential impact from other areas of business. 'Drum beats' meetings took several forms from face to face exchanges where staff were present, telephone call or a video link exchanges where staff were working remotely from each other. Weekly 'drum beats' meetings which summarised topics and issues identified.
- The provider held annual staff conferences over several days. Attending the conference was mandatory to all staff. Conferences were used to celebrate achievements, update staff regarding any changes and development within Healthcare at Home and their future as a healthcare provider.
- Staff spoke positively about the 'very important person award' which recognised staff and patient compliments. Staff said they felt valued and these awards were given in person by the member of the executive teams.
- Staff we spoke with told us that Healthcare at Home was a good employer. Staff from all areas felt supported, engaged, valued and empowered. We reviewed the staff survey from June 2018, with 86% response rate (1192 online responses), 72% of staff said they were proud to

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work for healthcare at home, 59% of staff said they would recommend Healthcare at Home as a good place to work, 78% of staff felt they want to do the best they can in their work, 64% of staff would like to work for healthcare home in two years' time, and 88% of staff care about the future of Healthcare at Home.

- Healthcare at Home engaged with the public through various mediums such as the internet, social media, charitable events and listening into action events.
- We spoke with staff from all areas who told us they work very closely with local charities. We asked how they decide on the charity to support; all staff voted for their chosen local charity and top three was chosen at random with a final vote.

Innovation, improvement and sustainability

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

There was a strong focus on learning and improvement at all levels of the organisation.

- Healthcare at Home were hoping to start a patient experience group, where patients were invited to tell the management team about their 'Healthcare at Home' experience to support with continuous improvements this was at an early stage. We were given examples of learning from a patient that had difficulty in communication due to hearing loss, staff were working closely with this patient to improve the service for those patients with difficulties in communicating.
- The clinical and quality leads took responsibility for keeping the boards up to date with useful information. This meant that staff could, immediately, be kept up to date. For example, the changes in practice to let staff know what's changed and how it affects them.
- Since the last inspection the service has employed eight clinical nurse specialists as a national post, and over 150 chemotherapy nurses are all masters or degree level trained in chemotherapy.
- Care bureau, the on-demand service, were continuously working to improve their service they provide for both patients and staff. A continuous Improvement programme was in place to ensure the service drives forward. Areas of improvements included: Quality and safety of patients, clear processes for colleagues to follow, identify required resource levels to answer critical calls and provide service excellence, coaching and development plans with documented one to one, roadmap and timescales to ensure the service drive forward and risk register to continually be reviewed on a regular basis.
- The service was working towards an IT system to be able to have direct access to electronic information held by community services, including GPs. This meant that staff could access up-to-date information about patients, for example, details of their current medicine.
- We also saw some information leaflets around enhancing delivery process for patients. Staff told us that from February 2019, Healthcare at Home made positive changes to their delivery process to enhance levels of confidentiality and patient safety. As an added measure of security, each patient was required to enter a six-digit pin code into the drivers handled devices upon delivery of medication.
- We saw the provider had recently won a gold accreditation standard for the aseptic non-touch technique (ANTT) and the first healthcare organisation to receive gold accreditation in the UK.