Lloyds Pharmacy Clinical Homecare Limited

Lloyds Pharmacy Clinical Homecare

Inspection report

Unit 4, Scimitar Park
Roydon Road
Harlow
CM19 5GU
Tel: 01279456789

Date of inspection visit: 9, 10 November 2021 and 1, 2, 16 December 2021
Date of publication: 25/02/2022

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

Ratings

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

Summary of findings

Overall summary

Lloyds Pharmacy Clinical Homecare provided care to more than 100,000 patients, throughout the United Kingdom, in their own homes, places of work or in the community. Approximately 5,000 patients received nursing care from the service.

The Care Quality Commission completed an inspection of the services provided by Lloyds Pharmacy Clinical Homecare as part of our inspection methodology. For this inspection we looked at the registered location in Harlow, Essex, which covers the South East of England. The provider has three other registered locations in the West Midlands, South West and the North West of England. This inspection was unannounced, meaning the provider did not have advanced notice of the inspection.

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations. For this inspection, we looked at all domains, and have applied ratings to each domain and an overall rating.

Due to the concerns identified during the inspection, we served the provider with a Warning Notice in respect of regulation Regulation 17, good governance and Regulation 18, staffing. A Warning Notice requires the provider to make immediate improvements to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Chief Inspector of Hospitals is placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration

This was the first time we have rated this service. We rated it as inadequate because:

- The patient services department did not respond to contacts promptly and within the service's policy timeframe.
- Nursing staff were working in excess of their working hours to deliver effective care.
- Managers did not ensure staff completed all mandatory or specialist training relevant to their roles, have regular team meetings or supervision and appraisals. Staff did not always feel respected or valued.
- Although nursing staff were aware of and understood how to protect patients from abuse, managers had not ensured staff were reporting safeguarding concerns in relation to omissions of care and neglect. Patient service staff did not complete safeguarding training.
- Managers did not ensure improvements were made following patient and staff surveys. Action plans from patient and staff surveys were incomplete, out of date and did not demonstrate on going monitoring or how improvements were being made.
- The service did not have robust governance processes and did not monitor or update their performance and risks regularly.
- The service did not complete regular clinical audits to monitor their performance and improvements over time.

Summary of findings

- The service did not ensure their corporate and clinical risk registers included all risks, were being monitored and being managed effectively.
- The service did not ensure there were clear records to demonstrate how decisions to categorise and investigate incidents and complaints were determined.
- The service did not ensure they notified the Care Quality Commission of events that stop, or may stop, the registered person from running the service safely and properly.

However:

- Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from investigations.
- 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.
- Managers worked hard to recover their position following a number of issues that led to a backlog of nurse visits and delays to responding to patients and referrers. The performance on number of calls answered had improved to 75% with an average call wait time of 6 minutes.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for adults	Inadequate 	Please see overall summary section of the report.

Summary of findings

Contents

Summary of this inspection

Background to Lloyds Pharmacy Clinical Homecare

Lloyds Pharmacy Clinical Homecare provided care to more than 100,000 patients, throughout the United Kingdom, in their own homes, places of work and in the community.

The service provided medicines to patients to meet their individual needs based on their prescriptions, delivered medicine for patients to administer at home and provided specialist nursing for people with complex conditions in their homes. The service described the treatment they provided as high, mid and low tech therapies. Patients who received high tech therapies were prioritised for treatment due to the complexity and risk of deterioration if they did not receive their treatments. The frequency of treatment for patients varied and depended on the type of therapy required for the condition. Some therapies were required daily whereas others were required on a weekly or monthly basis. The therapies provided were:

- Cancer Therapies
- Enzyme Replacement Therapy
- Growth Hormone
- Home Parenteral Nutrition
- IV Antibiotics
- IVIG
- Oral Immunosuppressants

The conditions treated were:

- Crohn's Disease
- Cystic Fibrosis
- Dermatological Conditions
- Haemophilia
- Hepatitis
- HIV
- Motor Neurone
- Multiple Sclerosis
- Osteoporosis
- Parkinson's
- Pulmonary Arterial Hypertension
- Renal Anaemia
- Rheumatoid Arthritis
- Thalassemia

Lloyds Pharmacy Clinical Homecare had several departments dealing with different elements of the service. This included patient services who managed inbound and outbound calls from and to patients. The compounding department managed medication which was made for individuals according to their prescription and needs, the pharmacy and prescription processing department where prescriptions were managed, and medicines dispensed and checked. The service had a nurse scheduling team who managed the nurse rotas and schedules and the nursing team who visited patients at home to administer treatment.

Lloyds Pharmacy Clinical Homecare is registered with the Care Quality Commission for the below regulated activities:

Summary of this inspection

- Treatment of disease, disorder or injury

For this inspection we focused on nursing care as this relates to the regulated activity, Treatment of Disease, Disorder or Injury. This is the regulated activity monitored by the Care Quality Commission.

Lloyds Pharmacy Clinical Homecare reported at board level to the parent company, McKesson. They worked with the National Health Service, pharmaceutical companies, private medical insurers and consultants.

The service is also registered with other regulatory bodies for specific functions of their service. For example, The Regulation and Quality Improvement Authority (RQIA) Northern Ireland and the Scottish Care Inspectorate. They are registered with the General Pharmacy Council (GPhC) for pharmacy activity, and licensed by Monitor as a provider of clinical services, and regulated by the Medicines and Healthcare products Regulatory Agency (MHRA).

We published our most recent inspection report in January 2014 using our previous inspection methodology. The service had met all required standards following the inspection.

Lloyds Pharmacy Clinical Homecare has a registered manager and a nominated individual.

Information from patients, stakeholders and the service showed there was a significant decline in performance between May 2021 and October 2021 which impacted the service's responses to contact from patients and referrers. The service advised there were a number of factors responsible for this failure. In July 2021, the provider had suffered significant problems with their information technology system, including their telephone and email system. This had resulted in contact being disrupted to the service for a 48-hour period. An outbreak of COVID-19 had also caused significant difficulties with staffing around the same time frame. The provider's trajectory predicted recovery between November and December 2021. During our second site visit, in December 2021, we observed signs of recovery from these incidents.

The Care Quality Commission completed an all staff survey in October 2021 and received 62 staff responses (representing a response rate of 9%). The subject areas included leadership and organisational culture, serious incidents and safeguarding reporting, raising concerns and speaking up and the health and safety of staff.

How we carried out this inspection

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

Areas for improvement

Action the service MUST take to improve:

- The service must ensure staff working in the patient services department answer calls promptly and within the service's policy timeframes. Regulation 9 (1) (b).
- The service must ensure staff recognise and report any safeguarding concerns in relation to their regulated activity. Regulation 13 (1) (2).
- The service must ensure it notifies the Care Quality Commission of events that stop, or may stop, the registered person from running the service safely and properly. Regulations 18 (1) (2) (g) of the Care Quality Commission (Registration) Regulations 2009.

Summary of this inspection

- The service must ensure they complete regular clinical audits to monitor their performance and improvements over time. Regulation 17 (1) (2) (a).
- The service must ensure their corporate and clinical risk registers include all risks and are monitored and managed effectively. Regulation 17 (1) (2) (a).
- The service must improve their patient and staff survey action plans to demonstrate on-going monitoring and plans for improvements. Regulation 17 (1) (2) (a).
- The service must ensure their business continuity plans are updated. Regulation 17 (1) (2) (a).
- The service must ensure they have clear records to demonstrate how decisions to categorise and investigate incidents and complaints are determined. Regulation 17 (1) (2) (c).
- The service must ensure staff complete mandatory training. Regulation 18 (1) (2) (a).
- The service must ensure staff receive specialist training relevant to their roles. Regulation 18 (1) (2) (a).
- The service must ensure staff in patient services department receive safeguarding training. Regulation 18 (1) (2) (a).
- The service must ensure sufficient staff are deployed within the nursing department to ensure staff are not working in excess of their working hours to deliver effective care. Regulation 18 (1).
- The service must ensure staff receive regular clinical supervision and appraisal in accordance with policy. Regulation 18 (1) (2) (a).
- The service must ensure staff have access to regular team meetings. Regulation 18 (1) (2) (a).

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate

Inadequate

Community health services for adults

Safe	Inadequate
Effective	Requires Improvement
Caring	Good
Responsive	Requires Improvement
Well-led	Inadequate

Are Community health services for adults safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

We could not rate the service higher than inadequate because we have issued a warning notice relating to Regulation 18(2), Staffing, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Mandatory Training

The service did not provide mandatory training in key skills to all staff or make sure everyone completed these.

Nursing staff were not in receipt of all mandatory training. Whilst overall compliance with annual mandatory training was 83%, complaints, incident management and reporting training was only 53% and equality and diversity training was low at 32%.

Clinical staff completed training on recognising and responding to patients with autism and dementia. Staff could complete mental health first aid responsible person training which was available to them. The service had a policy to guide staff in 'Supporting Patients with a Learning Disability' available which was updated in 2019. The service sent regular emails to staff providing information on and updating them on mental health. For example, a recent email invited staff to participate in a discussion on mental health stigma and to join a sponsored challenge to raise money for the Alzheimer's society.

Safeguarding

Most Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Clinical Staff had training on how to recognise and report abuse, but they did not always apply it. Staff working in the patient services department (call centre) did not receive safeguarding training.

Staff raised safeguarding concerns when they related to concerns observed in patients' homes. However, the service did not include adequate guidance to staff to ensure they met legal responsibilities to inform statutory bodies of safeguarding concerns, for acts of neglect or omission.

Inadequate

Community health services for adults

The service had policies and procedures to instruct staff on the escalation of serious incidents for investigation, for example, the policy advised staff that if a patient had not taken, or a nurse had not administered a medication according to the frequency on the label or prescription then escalation was required. Equally, if the patient had to seek medical attention or was transferred to a clinical setting or any medicine incident had resulted in patient harm or hospitalisation, this too should be escalated. However, these policies did not provide implicit instruction for staff to consider whether a safeguarding should be raised with the local authority or a statutory notification submitted to the Care Quality Commission. The Care Act 2014 states specific adult safeguarding duties apply to any adult who has care and support needs, including a person with a long-term health condition. The service acknowledged, and evidence showed, that staff routinely reported safeguarding concerns related to concerns identified whilst in patients' homes, but that failures in service delivery did not receive the same attention. The service acknowledged these concerns and took immediate action to rectify these issues.

Compliance with safeguarding training for adults and children was 93% for nursing staff in October 2021. However, staff in the patient services department did not receive safeguarding training. We were concerned these staff were not sufficiently equipped to identify or manage concerns raised related to safeguarding adults or children.

Between May and October 2021, 66 safeguarding concerns were raised by staff groups including Patient Services, Transport and Nursing.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Overall, staff knew how to identify adults and children at risk of, or suffering, significant harm and liaised with referring teams and external agencies to protect them.

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.

The service had policies and clinical guidance in place for staff on hand hygiene, safe use and disposal of sharps, management of sharps, waste disposal, clinical waste and protective personal equipment. However, the service had not completed their hand washing audits since October 2021 due to the pandemic. Nursing managers were unable to regularly meet face to face with nursing staff and were working clinically to ensure care was delivered to patients. Managers were planning to recommence this in January 2022.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after patient contact.

The service had an outbreak of COVID-19 in July 2021 at their patient services department in their head office location. As a result, Public Health England conducted an audit and set recommendations which the service followed and made improvements to the infection prevention control management of the site as a result.

Environment and equipment

Inadequate

Community health services for adults

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

Equipment was provided and staff were trained on how to use them in people's homes.

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

Staff disposed of clinical waste safely.

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 for patients at risk of deterioration.

Nursing staff completed a risk and needs assessment that included patient information, the referrer, previous medical history, patient treatment plan, home circumstances and level of support a patient required to receive their specific therapy.

The service used recognised protocols and guidelines such as agreed by the referring hospital.

Staff used a variety of assessment tools when caring for patients, including assessing patient and carer competency to administer medicines, pre-assessment tools, national early warning scores and sepsis screening tools.

The service had an 'Emergency Care Policy' based on the recommendations for clinical practice and training in cardiopulmonary resuscitation and management of anaphylaxis published by the Resuscitation Council UK (2021). The policy described the process for managing and mitigating risks associated with resuscitation and care of the deteriorating patient. The policy included guidelines for managing medicine related reactions, hypersensitivity and a flow chart to inform staff on the escalation process.

Staff informed referring hospitals of patients thought to be at risk of self-harm or suicide.

Staff shared necessary key information with referring hospitals and consultants during a weekly meeting. All relevant information was shared with referrers to keep patients safe.

Staffing

Patient services (call centre staff)

The service did not deploy sufficient staff within the patient service call centre with the sufficient skills, training and experience to deliver an effective service. Managers regularly reviewed staffing levels and an ongoing recruitment campaign was in place.

The service employed 125 staff to support the patient services function and had 15 vacancies in the following roles:

five call centre advisors, five patient services co-ordinators, one call centre shift leader, one patient services subject matter expert, three patient services operatives.

The service did not employ sufficient staff within the call centre to ensure calls from patients and referrers could be answered with the service's targets. Between May 2021 and October 2021 an average of 49% of calls were answered (against a target of 80%). The lowest month was July 2021 at 30%. Between May 2021 and October 2021, the provider handled an average of 3,216 calls per month and the average call wait time was 22 minutes (against a target of 5 minutes). The worst month was July at 48 minutes. However, during our second site visit in December 2021, the service showed signs of recovery. The performance on number of calls answered had improved to 75% with an average call wait time of 6 minutes. Managers reported high turnover of staff within this department and we were concerned the assessed staffing establishment was insufficient to meet the current demands on the service.

Nurse staffing

The service did not have sufficient nursing staff with the right qualifications, skills, training and experience to deliver an effective service. Staff were working in excess of their contracted hours to deliver effective care to patients. Managers regularly adjusted and regularly reviewed staffing levels and an on-going recruitment campaign was in place.

The service had vacancies for homecare nurses. The establishment was recorded as 49 in total with 28 in post. However, a further 12 homecare nurses had been recruited, with starting dates between December 2021 and February 2022. Healthcare nurses to fill the remaining nine (18%) vacancies were actively being sought as part of the ongoing recruitment campaign.

We were not assured the service accurately calculated how many nursing staff were required to deliver the service. The service used a system to calculate staffing needs and skill mix, which included regional planning of allocation and nursing resource. The regional operations manager and resource planner for the region held fortnightly meetings to review assessment of capacity and skills required to perform tasks during this meeting. Additionally, ongoing review of capacity, therapy allocation and skill mix were assessed three times each week during nursing region scheduling operational meetings. However, clinical staff were working in excess of their contracted hours.

The service advised they used a tool to calculate the number of visits and distance of travel for nursing staff, and that staffing levels were calculated using data from clinical hours (patient visit duration) and average travel per visit. The service used scheduling software which included a skills matrix. This ensured that only a nurse with the required skill and availability within their shift were assigned to undertake the visit. Nurses' shifts were planned and uploaded by the scheduling team to align to staff contractual hours, this included estimated travel calculated using a web-based map. The service advised their system prevented the nurse from tasks being allocated outside of their working hours. However, the results of our staff survey indicated that 9% of clinical staff and 36% managerial clinical staff reported working 11 or more unpaid hours above their contracted hours per week. Nurses' completed timesheets on a daily and weekly basis which were reviewed weekly by nursing managers to monitor nurses' weekly hours to give time back or investigate underutilisation. The service had recorded nurses working too many hours on call and without a break due to driving on their risk register since 2015, identifying that working time directives were not being met. We were concerned that actions taken to mitigate this risk were not fully effective.

The service ensured bank and agency staff were effectively and safely utilised. The service employed bank and agency nurses on zero-hour contracts. Nurses provided their availability on a monthly basis as to the dates and shifts that they

could cover and depending upon the skills and competencies of the nurse would depend on the types of patient visits and treatment they could support. Each nurse completed a three day induction, spent one day with the local manager and completed patient visits accompanied by a senior nurse to assess their level of competence and approve them to deliver patient visits independently.

Medical staffing

The service did not directly employ medical staff. The service relied on doctors from the referring NHS organisation to prescribe medication and to send prescriptions to them for patients.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and stored securely. However, not all staff had easy access to relevant information to inform decision making and deliver care to patients.

The service operated a number of different electronic record systems. Dependent upon their job role, access was granted to specific systems for review and input of information. Staff told us this was often problematic. For example, homecare nurses could not view contents of conversations with the patient services team in relation to previous concerns, delivery of medicines and equipment and scheduled or completed nurse visits. However, the service was aware of these difficulties and we were told, and evidence showed, there were plans to review staff access to key information. Managers had been in contact with organisations to support these changes to implement improvements.

Homecare nurses had access to laptops to review and update patient information. Paper records were also available in patients' homes.

The service was aware of and had plans in place to use a new system that enabled all departments to access and share patient information.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, the pharmacy activity is regulated by the General Pharmacy Council (GPhC).

Pharmacy staff received prescriptions from referring hospitals or private consultants. Staff within the prescription holding team processed prescriptions which were screened and sent to dispensary to be dispensed. The prescription management team screened prescriptions to ensure the medicine was correct and patient services staff arranged deliveries of medicines with patients.

Due to the information technology outage in the summer of 2021, there were some key challenges around staffing in the dispensary. This was a result of multiple members of staff leaving the organisation simultaneously. This had an impact on the ability of the organisation to process prescriptions and therefore deliver medicines to patients. However, according to the latest data made available to us, the current backlog of prescriptions waiting to be managed in November 2021, were 67, compared to a previous backlog of 415. The current backlog of emails waiting to be answered in November 2021, were 667 compared to a previous backlog of 824. Managers expected the backlog to be resolved by December 2021.

Inadequate

Community health services for adults

The service prioritised patients to ensure those that were most vulnerable received their medicines without impacting the safety of patients. These included nursed patients such as those in oncology, home parenteral nutrition, infusions, cystic fibrosis patients and any therapy related areas such as hepatitis and HIV. The next priority included those patients on monthly injections such as for rheumatoid arthritis and dermatology.

Pharmacy staff reviewed patients' medicines regularly and nursing staff provided specific advice to patients and carers about their medicines.

Pharmacy staff stored and managed medicines and prescribing documents in line with the service's policy.

Pharmacy staff followed current national practice to check patients had the correct medicines.

Managers had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Managers ensured staff received information related to medical alerts and recalls. The service's policy clearly defined timeframes for actions and staff responsible to oversee the process.

Incidents

Overall, 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.

All staff knew what incidents to report and how to report them. Staff reported serious incidents clearly and in line with their policy. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

The service had a procedure for the management of complaints and incidents, which detailed how complaints and incidents would be investigated, by whom and within which timeframes. The service treated all complaints as incidents, and reviewed all incidents to determine what level of investigation was required. We reviewed 24 incident reports which demonstrated how decisions were made to resolve complaints and incidents informally and when to escalate to a formal investigation. However, this was not documented. We were therefore, not assured that the process was being appropriately recorded to demonstrate the review of serious incidents and the decisions made to categorise severity accurately.

The service also raised pharmacovigilance events (PV) relating to drug safety and adverse events (AE) or reactions to medicines experienced by a patient following drug administration. Any incident or complaint that resulted in moderate harm triggered a serious incident investigation. The service followed a process where a serious incident cascade meeting would be held for all complaints and incidents resulting in moderate harm. This process guided staff on the actions to take as a result of the incident.

The service reported five serious incidents between May 2021 and November 2021. Two of these involved scheduling errors and communication issues between the nurse scheduling team and the nurses. A further two involved medication errors, which did not result in harm, and the last serious incident related to an error with a delivery where an item went missing. There was evidence of learning from all incidents, which was shared with staff to prevent recurrence of similar incidents in the future.

Inadequate

Community health services for adults

There was evidence that changes had been made as a result of feedback. Learning identified from two recent incidents identified learning and improvements with the prescribing, dispensing processes to ensure errors would not be repeated. The service conducted a robust audit of clinical records to provide assurance of improvements following a serious incident review.

Managers debriefed and supported staff after any serious incident. We saw numerous examples of reflective statements written by staff after an incident which demonstrated de-brief with the staff member and reflection and learning from the incident.

The service had policies for reviewing safety and safeguarding incidents which guided staff on the process required.

The service had no never events.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. We reviewed several examples of letters sent to patients and families who had been given an explanation and apology when things went wrong. Managers maintained a duty of candour register. The service provided information on their website detailing the disruption to their service delivery. The service put information relating to their information technology outage and subsequent delays on their website for patients' information. Detail of the impact of the information technology outage was also included in letters to patients who had complained about disruption in service.

Are Community health services for adults effective?

Requires Improvement

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

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

The service used the National Health Service Framework for Home Parenteral Nutrition to guide them when delivering treatment. They also used the East of England Homecare Service guidance for Immunology and guidance from the NHS Standard Contract for Lysosomal Storage Disorders Service, for adults and children.

The service used protocols such as the St Marks protocol, the Salford protocol, the University College London protocol or their own protocol. The type of protocol used depended on the therapy required and the protocol specified by the referring hospital or consultant.

Staff assessed patients psychological and emotional needs on commencement of treatment and at subsequent visits. Staff feedback to the referrer if there were any concerns or additional needs required with emotional, psychological or social needs.

Inadequate

Community health services for adults

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Nursing staff supported patients with a variety of conditions who required home parenteral nutrition. Home parenteral nutrition is used for people whose digestive systems either cannot absorb or cannot tolerate adequate food eaten by mouth. A specialised form of food is infused through a vein (intravenously; IV) with the goal of treatment to correct or prevent malnutrition. Nursing staff met the specialist nutrition and hydration needs of patients as prescribed by the referring service. Home parenteral nutrition patients had tailor made prescriptions based on their individual nutritional needs. Staff monitored patients for any increase in requests for additional IV fluids, informed the referring hospitals who reviewed the patient and amended the prescription as needed. The referring hospitals would regularly review all of their patients receiving home parenteral nutrition.

The service had an agreement with the referring hospitals to weigh patients receiving specific therapies such as Onpattro (Onpattro is a medicine used to treat nerve damage caused by hereditary transthyretin (hATTR) amyloidosis, a disease in which abnormal proteins called amyloids build up in tissues around the body including around the nerves) and oncology treatments. The frequency would depend on the type of therapy being administered and weights were shared with the referring hospital.

The service would raise with the referring service if specialist support from dieticians or speech and language therapy was identified as a need.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Nursing staff completed pain assessments for oncology patients during their visits on treatment visit forms and pain assessments were completed on commencement of treatment for patients requiring other forms of therapies and as when required. The service liaised with the referring hospital to prescribe pain relief if required.

The service ensured patients receiving home parenteral nutrition were aware of support they could receive from charitable organisations. The service signposted patients to the charity, 'patients on intravenous and naso-gastric nutrition treatment' (PINNT), so that they could seek additional support with adapting to life at home with artificial nutrition.

The service made oncology patients aware of the support they could receive from the charity Macmillan.

Patient outcomes

Staff monitored the effectiveness of care and treatment but did not complete regular clinical audits.

The service's clinical audit summary for 2021 showed audits were not being completed. For October 2021 only three out of nine audits had recorded results. No audits had been recorded for November and December 2021. Audits not completed over this three month period included CPR/Emergency Equipment Audit Tool and Environment and

Equipment Audit Tool. However, minutes of the integrated clinical governance meeting minutes in October 2021 demonstrated managers were aware of the areas where their service required improvements and had plans in place to phase in clinical audits, in a three-prong focus on: infection control, sharps, and documentation to start. No detail was included relating to audits of emergency equipment or environment and equipment within these minutes.

Managers stated they used key performance indicators as a benchmark to identify improvements and monitored these against goals. We saw evidence of key performance indicators being referenced in clinical governance meetings as a monitoring tool for improvement.

Managers told us their goals were to measure outcomes to improve the quality of the care experience, timeliness of care and patient satisfaction by providing a transparent, efficient and accessible environment in line with their strategy.

Managers gave two examples of areas they believed required improvement and where they had two projects in place. The first included the 'utilisation of the nursing workforce project' which was set up to improve the patient experience by increasing patient facing time, increasing the nurses' skills set, having the right people in the right place at the right time and being aligned with their stakeholders. The service also had a project on the 'nurse patient pathway improvement project' which looked at the timeliness of treatment, improving patient experience and the effectiveness of care.

Competent staff

The service did not make sure all staff were fully competent and supported for their roles. Managers did not appraise work performance of all staff or hold regular supervision meetings with them to provide support and development.

Not all nursing staff were in receipt of specialist training for their roles. Adult nurses received training in IV therapies, oncology and rare disorders and children's nurses received training in IV therapies and rare disorders. Data showed a variance in compliance with specialist training across both adult and paediatric nurses. For example, eight adult nurses (100%) had completed oncology training, whilst training compliance for other key skills varied between 3% for a specific rare disorders training and 53% for home parenteral nutrition connection training. Overall compliance across ten specialist training subjects for adult nurses was 37%. For paediatric nurses there were seven specialist subjects, but only five specialisms were required for patients at the time of inspection. The highest compliance was 100% for specific IV training and the lowest was 25% for specialist training in rare disorders. Overall compliance across the five specialist training subjects was 45%. One paediatric nurse had received training in home parenteral nutrition disconnection training to support the adult nurses. The Care Quality Commission staff survey showed 58% of staff agreed or strongly agreed they received appropriate and sufficient training to meet the needs of the people that they care for, while 26% disagreed.

Managers did not ensure all clinical staff received supervision as required by their policy. Field based nursing teams were required to receive supervision every eight weeks. Data provided showed compliance amongst these staff was only 63%. However, we found staff in senior clinical or leadership roles received supervision in accordance with policy.

The service's policy required all staff to receive a mid-year appraisal of their work. Data showed only 68% of staff had received such an appraisal. This was particularly relevant for field-based nursing staff. The service's 2021 staff survey found 72% of nursing staff believed their managers held regular conversations about performance, with 6% disagreeing and 91% of staff felt their managers held them accountable for their performance. The Care Quality Commission staff

survey found 47% of staff agreed or strongly agreed that they received regular supervision sessions in accordance to the organisation's policy, while 29% of staff disagreed. There were also staff in all staff roles who felt they neither did or did not have regular supervision sessions. Seventeen percent of clinical and 18% of managerial (clinical) staff strongly disagreed that they had regular supervision sessions.

The service had a management plan within their policy for 'exceptional circumstances', which stated that some critical functions would be scaled up or down when the service's business continuity plan was activated. This included cancellation of one to one meetings. There was no time limit recorded within the policy during which such meetings resume. Whilst the policy was clear that performance issues would continue to be monitored, it directed staff towards its staff digital resource platform for other areas of support. Staff responses from staff surveys demonstrated that overall staff felt supported in their roles, whilst formal supervision sessions were scaled down. However, we were concerned that formal supervision sessions had not yet resumed, and compliance remained below that expected by the service's policy. Therefore, there was a current risk that staff might not be in receipt of sufficient support and appraisal of their work to allow the service to identify any training needs required, or additional support needed by staff to support them in their roles.

Nursing staff did not attend face to face team meetings due to their lone working, preventative measures due to COVID-19, where face to face meetings had not yet resumed. Managers made a podcast available for staff which covered a variety of topics, including training and development, any new starters, patient updates, regional updates and reminders, any complaints or incidents, important documents to read, and nurse of the month nominations. Staff could download and listen to the podcast.

Overall, managers gave most new staff a full induction tailored to their role before they started work. Compliance for this was 83%.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

The service worked with doctors, nurses and other healthcare professionals from referring hospitals to benefit patients. They supported each other to provide good care.

Staff held regular and effective meetings to discuss patients and improve their care with relevant referring hospitals and consultants.

Patients had their care pathway reviewed by relevant referring hospitals and consultants.

Seven-day services

The service had on call services available for patients to use, if required, 24 hours a day and staff could contact referring hospitals' on call services 24 hours a day, seven days a week if required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Inadequate

Community health services for adults

Staff were able to access support on the application of the Mental Capacity Act via a number of documents, including the safeguarding adults and safeguarding children's policy.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff liaised with referring organisations to assess and determine whether a patient had capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

Are Community health services for adults caring?

Good

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

Compassionate care

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

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.

Due to the vast geographical area covered by this provider, across the South East of England, direct contact with patients' and families to gather feedback was challenging. However, we spoke with 12 adult patients and seven carers of children and young people receiving medicine deliveries and care from nurses in their homes. All patients and carers said they were treated with compassion and kindness.

All patients spoke positively about the nurses providing treatment to them in their homes.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers when they needed it. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Inadequate

Community health services for adults

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.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service. The service conducted an annual patient satisfaction survey. The most recent survey results were provided for 2020 which showed a poor response rate (40,000 surveys and a response rate of 3,647 (9%). Overall satisfaction was recorded at 92% with consistent negative themes from the previous year related to deliveries of medicines and poor communication.

Many patients and carers of young people commented that they were aware of the shortage of registered nursing staff, and the high turnover of staff and how they would prefer to have the same nurse attend each visit.

Staff supported patients to make informed decisions about their care.

Eleven adult patients and seven carers of children and young people told us they would recommend the service to a relative or friend.

Are Community health services for adults responsive?

Requires Improvement

Our rating of responsive went down. We rated it as requires improvement.

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

Managers planned and organised services, so they met the changing needs of the local population.

The service reported a low number of occasions when nurse visits failed to be completed as required. Data provided between November 2020 and October 2021 showed an average of 10,801 visits were scheduled each month. On average, staff failed to provide 32 (0.29%) visits per month. The worst month recorded for failed nurse visits was June 2021, with 9,765 visits recorded and 58 (0.6%) failed. We did not identify any harm to patients when nursing visits were not completed as planned. The backlog of nursing visits had decreased significantly since early October 2021 and had

reached the service's target by mid November 2021. Nursing managers received daily information on delayed or failed nurse visits from the patient services department and contacted patients to rearrange the visits within the three day therapeutic window timeframe. We reviewed 10 complaints relating to failed nurse visits which showed that nurse managers contacted patients with failed nurse visits.

The service recorded monthly when medication deliveries, that did not include nurse administration, had been attempted, achieved and failed. Between November 2020 and October 2021, staff attempted between 6,263 and 7,608 medicine deliveries to adult patients. Failed deliveries varied between 152 (2% of attempted deliveries) in February 2021 to 856 (11%) in June 2021.

For the same reporting period, staff attempted to deliver medicines to children between 583 and 778 occasions. Failed deliveries varied between 103 (13%) in June 2021 and 3% in March 2021. Data did not, however, show whether subsequent attempts to deliver medicines had been successful, why the delivery had been unsuccessful and for how long patients were without medicines.

Equally, the impact of failed deliveries was not always understood. The Care Quality Commission does not regulate medicine deliveries where nursing care was not also required. However, we were concerned the service lacked oversight of the impact on patients' wellbeing when medication was not received in accordance with the due date. The service had developed an action plan to review the management of missed medication doses for patients. This included an action to establish skills and competencies required to perform assessments for patients that had late deliveries or nursing visit and to reinforce use of the service's existing safeguarding email mailbox for all staff to use to alert managers of safeguarding events for neglect or omission. This plan was newly implemented and at the time of the inspection, all actions remained in progress with target dates for completion between the end of November 2021 and January 2022.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

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

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Access and flow

People could access the service when they needed it and received the right care promptly, but the service was not responsive to contact from patients or referrers. Waiting times from referral to treatment were in line with national standards.

The service did not report long waits for treatment. At the time of the inspection there were five adult patients awaiting treatment. No information was provided relating to waiting lists for treatment for children.

Inadequate

Community health services for adults

Information from patients, stakeholders and the service showed the service was not effectively responsive to contact from patients or referrers. The service did not manage the volume of calls to the service effectively. Whilst data prior to April 2021 showed compliance with the service's standards, from May 2021 to October 2021 there was a significant decline in performance. The service advised there were a number of factors responsible for this failure. In July 2021, the service had suffered significant problems with their information technology system, including their telephone and email system. This had resulted in contact being disrupted to the service for a 48-hour period. An outbreak of the COVID-19 virus had also caused significant difficulties with staffing around the same time frame. Between May 2021 and October 2021, the service handled an average of 3,216 telephone calls from its patient services call centre. Of these 1,261 calls were inbound. The service had a target to answer 80% of all calls. During this time frame an average of 49% of calls were successful, meaning 51% of calls to the service went unanswered. The service had a target to answer all calls within five minutes. The average time waiting for a call to be answered during the same period of 22 minutes. We observed long waits for calls to be answered during our inspection. However, the service predicted they would see improvements in performance between November 2021 and December 2021. During our second site visit in December 2021, the service showed signs of recovery. The performance on number of calls answered had improved to 75% with an average call wait time of 6 minutes.

Adult patients raised concerns about the delay in call wait times when they rang the service. We spoke with 12 adult patients and five said they had to wait between 3 minutes and up to 40 minutes for patient services to answer the phone. Carers of children and young people did not raise any concerns about delays in waiting for a call to be answered.

Two patients told us they had delayed medication deliveries on just one occasion and one patient spoke of occasional delays, but they would receive their medicine delivery within the next day or two.

Eight patients told us there had been some occasions when nurses had been late in visiting them and one patient told us a nurse had missed a visit to them which led to them having to receive treatment from their referring hospital. Carers of children and young people did not say they had experienced any missed nurse visits to their relatives.

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.

The service had a policy for the management of complaints and incidents, which was aligned with the Royal Pharmaceutical Society, Handbook for Homecare Services, Appendix 19. Appendix 19 outlines the guidance homecare organisations should follow to appropriately manage complaints and incidents.

Between November 2020 and November 2021, a total of 94 complaints and incidents were received. Of these, 86 were responded to within 30 days, five were over 30 days and three were not yet resolved.

Patients, relatives and carers knew how to complain or raise concerns.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Inadequate

Community health services for adults

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice.

Are Community health services for adults well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate.

We could not rate the service higher than inadequate because we have issued a warning notice relating to Regulation 17 (1)(2), Good Governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

Not all leaders had completed leadership training courses. The service ran leadership courses for managers around a number of subjects, including investigation skills and time management. Data provided showed a total of 40 staff eligible for this training, with a total of 28 having completed all six available courses. The lowest compliance was for disciplinary and grievance training at 46%. The overall average compliance across all training was 81%.

Vision and Strategy

The service had a strategy for 2021 – 2022, entitled FY22. Whilst we were shown examples of improvements the service wished to implement, including improving patient experience, developing their people, embedding a culture of operational excellence and increasing commercial profitability and sustainability, we did not see an identified policy document or clear and updated action plans to demonstrate progress against the strategy, with most actions having no status recorded. Not all staff were aware of the service's vision and values,

The service's values were ICARE which stood for integrity, customer-first, accountability, respect, and excellence, however not all staff were aware of these. The CQC survey showed 62% of staff strongly agreed or agreed that the organisation had clear vision and values that they were familiar with, while 29% said they disagree or strongly disagreed with this. Sixty-eight percent of managerial (non clinical staff) agreed they were familiar with the vision and values, whereas over 20% of clinical, administration and managerial (clinical staff) disagreed.

Culture

Inadequate

Community health services for adults

Not all staff felt respected, supported and valued, but were focused on the needs of patients receiving care. Overall, the service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The Care Quality Commission requested for staff to complete a staff survey devised by the Care Quality Commission to ascertain staff views about working at the service. There were 648 surveys issued, 108 were received, however only 62 were completed in full, response rate of 9%.

The subject areas included were; leadership and organisational culture, serious incidents and safeguarding reporting, raising concerns and speaking up and the health and safety of staff. Staff respondents came from a variety of roles including 37% clinical staff, 18% managerial clinical staff, 19% administration staff and 26% managerial non-clinical staff.

Findings showed that 60% of staff disagreed or strongly disagreed that the organisation valued staff and provided staff with effective support to do their jobs to the best of their ability. Seventy-five per cent of clinical staff did not feel valued. The responses from staff in relation to staffing levels showed that 64% of staff disagreed or strongly disagreed that there were enough staff for them to do their job properly, while 26% agreed or strongly agreed. Staff views on well-being showed that 70% of clinical staff disagreed the most and felt the organisation did not have the welfare of staff in mind and 83% of clinical and 73% of managerial (clinical) staff appeared to have suffered more work related stress in the last 12 months than other roles. Fifty-one percent of staff did not recommend the organisation as a place to work, while 30% would. During the inspection we interviewed five nursing staff, who felt they were being supported by their immediate line managers and they received learning from incidents. Staff said they enjoyed their jobs and the time they had to spend with patients whilst delivering nursing care. Nurses spoke about always striving to deliver excellent care to patients. However, they raised concerns at the number of hours they were working which were in excess of their contracted hours. Although they were paid for the additional hours, staff felt this had an impact on their morale.

The provider ensured survey results were sent out to teams for their review and action. The provider shared their actions and summary plan from the 2021 survey, which was divided into four key themes: engagement, corporate responsibility, rewards and recognition and senior leadership. Whilst the action plan indicated that all actions were completed, it lacked detail and we were unclear how the action plan accurately reflected the results of the survey, or how improvements were being made and monitored.

The service had a whistleblowing policy which identified how staff could raise concerns. However, all contacts were within the parent company and no local champions or contacts within Lloyds Pharmacy Clinical Homecare were identified.

The service had a whistleblowing register, which recorded ten whistleblowing concerns raised since June 2021. We found four were raised anonymously, five were recorded as raised by patients and one was from a named person, three were raised directly to the Care Quality Commission.

Overall, the service managed equal opportunities and diversity well. The service had an equal opportunities and diversity policy and the service's most recent staff survey results indicated that 80% of staff believed people of different backgrounds (sex, age, nationality, culture, etc.) could succeed at all levels of the organisation. The Care Quality Commission staff survey found 58% of staff felt that staff with protected characteristics under the Equality Act were treated equitably in the organisation, while 6% did not.

Inadequate

Community health services for adults

Governance

Leaders did not always operate effective governance processes. Staff at all levels were clear about their roles and accountabilities but did not have regular opportunities to meet, discuss and learn from the performance of the service.

The service's governance reporting fed into the parent company (McKesson) at board level.

The service did not have sufficient systems and processes in place to ensure all safeguarding's for neglect or omission, linked to avoidable harm and delivery of the regulated activity, were raised to either the local authority safeguarding team or to Care Quality Commission via statutory notifications. The duty of candour register did not include a requirement to state whether a safeguarding has or should be raised or whether Care Quality Commission had been notified.

The service did not include adequate guidance to staff to ensure legal responsibilities to inform statutory bodies of safeguarding concerns for acts of neglect or omission. The service had policies and procedures to instruct staff on the escalation of serious incidents for investigation, for example, the policy advised staff that if a patient had not taken, or a nurse had not administered a medicine according to the frequency on the label or prescription then escalation was required. Equally, if the patient had to seek medical attention or was transferred to a clinical setting or any medicine incident had resulted in patient harm or hospitalisation, this too should be escalated. However, these policies did not provide implicit instruction for staff to consider whether a safeguarding should be raised with the local authority or a statutory notification submitted to the Care Quality Commission. The Care Act 2014 states specific adult safeguarding duties apply to any adult who has care and support needs, including a person with a long-term health condition. The service acknowledged, and evidence showed, that staff routinely reported safeguarding concerns related to concerns identified whilst in patients' homes, but that failures in service delivery did not receive the same attention. The service acknowledged these concerns and took immediate action to rectify these issues.

There was no evidence of team meetings taking place at local level - therefore it was not clear how escalation of concerns around practice, capacity or wellbeing of staff were feeding into clinical governance meetings.

The integrated clinical governance meeting minutes did not demonstrate scrutiny or challenge and discussion around key metrics. Findings were not explained and lacked detail. We observed no updates from the nursing clinical governance meeting within the integrated clinical governance meeting minutes for five months since May 2021.

The service had a policy for the management of complaints and incidents, which was aligned with the Royal Pharmaceutical Society, Handbook for Homecare Services, Appendix 19. Appendix 19 outlines the guidance homecare organisations should follow to appropriately manage complaints and incidents. However, we found the policy did not contain key information, for example timeframes for investigation and responding to complaints. We found this policy did not give easily accessible information on the service's processes for management of complaints to staff; without reference to Appendix 19. No links for this document were contained within the policy. Whilst complaints and incidents were discussed informally, there was no record of the discussions and decisions to determine the severity of complaints and incidents and if they were categorised as serious incidents or if they required an investigation.

Managers had not ensured staff received supervision in line with policy.

Management of risk, issues and performance

Inadequate

Community health services for adults

Leaders and teams managed performance effectively, identified and escalated relevant risks and identified actions to reduce their impact, but they did not update these to demonstrate on-going monitoring or improvement.

The service's clinical risk register did not provide assurance that leaders were appropriately managing risks within their service. The clinical risk register identified 15 risks. Overall, these reflected the areas of concerns discussed during our site visit. However, whilst detail of the risk, the impact on the service and current controls were recorded, the service had not ensured the risks were weighted, or updates were included to demonstrate the actions being taken were effective. Therefore, the risk register did not provide assurance the identified risks were appropriately managed or reducing over time.

The corporate risk register did not include one of the service's biggest clinical risks, the extensive length of time patients were waiting for calls to be answered and the high abandonment rates for calls. Whilst there was evidence of plans to make improvements, including updating infrastructure and onboarding of staff, there was no oversight via the corporate risk register to ensure ongoing monitoring and management of this was effective.

The clinical scorecard had an item recorded as "other". This was largely RAG (red-amber-green) rated red. However, managers were not able to identify to what this referred.

The service had a variety of business continuity plans. However, we found these had not been updated following the IT outage in the summer of 2021, which the service advised, and stakeholders confirmed, had a major impact on their ability to effectively run their service. We also noted that the business continuity plans did not include the legal requirement, under Regulations 18 of the Care Quality Commission (Registration) Regulations 2009, to notify the Care Quality Commission of events that stop, or may stop, the registered person from running the service safely and properly. Managers had failed to comply with this legal requirement and no required notification was received. This was raised with the service during the inspection.

The service shared their review of the current challenges for the service, which included an analysis of staffing requirements and improvements to infrastructure. Additional actions were recorded with specified timeframes for completion. We found the highest vacancies for nurses lay within the south of England, where the service reported 77% capacity in November 2021.

The service's recruitment and retention plans were not detailed. The service did not provide their recruitment and retention strategy when requested following the inspection. They did provide an action plan which showed for recruitment of new staff there were eight completed actions and one action ongoing. Actions to support staff retention showed seven actions, of which four were ongoing, with completion dates for the end of November 2021. Longer term plans for recruitment and retention, including student nurse placements and review of the apprenticeship model had no progress reported. We were concerned that taking into consideration the pressure on staffing within the service, the service did not have a detailed strategy, had not fully included reference to the staff survey results and was not doing all possible to encourage new staff or retain those already employed.

Information Management

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

Inadequate

Community health services for adults

The information governance data we were shown was visual and provided the reader with clear themes and trends for discussion and scrutiny and action.

The service reviewed all reported data breaches. Between October 2020 and November 2021, five breaches were reported. Of these, one was reportable to the Information Commissioner's Office. This incident was investigated and subsequently closed.

Engagement

Leaders and staff engaged with patients and staff, to plan and manage services but did not adequately demonstrate how improvements were being made. They collaborated with partner organisations to help improve services for patients.

The service's parent company completed an annual employee opinion survey for nursing and patient services. The 2021 employee survey for nursing staff achieved a 52% response rate (159 responses out of 304 surveys). Of these responses, 40% were neutral, 34% were favourable and 26% were negative. The results for patient services showed a response rate of 55% (75 responses out of 156 surveys). Of these 29% were neutral, 12% were favourable and 59% were unfavourable.

The service ensured survey results were sent out to teams for their review and action. The service shared their actions and summary plan from the 2021 survey, which was divided into four key themes: engagement, corporate responsibility, rewards and recognition and senior leadership. Whilst the action plan indicated that all actions were completed, it lacked detail and we were unclear how the action plan accurately reflected the results of the survey, or how improvements were being made and monitored.

The service supported the wellbeing of staff via a number of resources, including a monthly information pack which covered a variety of topics and events, alongside a guide for staff on how to support good mental health. However, from the Care Quality Commission staff survey, 58% staff disagreed or strongly disagreed there was a strong emphasis of welfare of staff within this organisation, while 26% agreed there was. Seventy percent of clinical staff disagreed the most and felt the organisation did not have the welfare of staff in mind.

Managers did not ensure action plans from annual patient satisfaction surveys were robust, up to date or completed. The patient services improvement plan included seven actions. All had a target date of March 2021 and all were recorded as overdue. No detail was included relating to current progress or revised completion dates. The patient satisfaction survey departmental action plan 2020 covered five key service departments. This showed 44 actions completed and eight open actions, five relating to nursing, patient services and pharmacy. Action plans lacked detail, and target dates for all open actions were either blank, expired or to be confirmed.

The service regularly liaised with referring hospitals and consultants to review patients lists, referrals and progress of patients.

Learning, continuous improvement and innovation

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 but did not always share this information with staff. Leaders encouraged innovation and participation in research.

Inadequate

Community health services for adults

The service's clinical audit programme was not robust. The service's clinical audit summary for 2021 evidenced audits were not being completed. For October 2021, only three out of nine audits had recorded results. No audits had been recorded for November and December 2021.

The service's process for sharing findings from audits involved discussion with the regional operations manager and presentation to the nursing governance committee on a monthly basis. Findings and agreed actions should then be cascaded down and discussed within regional team meetings. However, during this inspection the service did not evidence team meetings were taking place regularly. We were therefore not assured actions and learning was shared regularly to ensure improvements were made, when required.

The service, in collaboration with Careology, won an award for "most promising pilot" at the Health Tech Awards in October 2021. Lloyds Pharmacy Clinical Homecare (LPCH) and Careology's pilot focused on cancer care delivery. The Careology healthtech platform, which was recommended by Macmillan Cancer Support, helped people living with cancer to feel supported and connected during their treatment. The platform partnered with Lloyds Pharmacy Clinical Homecare to empower patients, who were receiving treatment at home, via a mobile app and remote monitoring dashboard.

The service was accredited to ISO:9001 an international organisation for standardisation for creating a quality management system. The service had consistently attained a level 2 of the NHS Information Governance Toolkit.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The service did not ensure staff recognised and reported any safeguarding concerns in relation to their regulated activity.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The service did not ensure it notified the Care Quality Commission of events that stopped, or may have stopped, the registered person from running the service safely and properly.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The service did not ensure staff working in the patient services department answered calls promptly and within the service's policy timeframes.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not ensure they completed regular clinical audits to monitor their performance and improvements over time. The service did not ensure their corporate and clinical risk registers included all risks and were monitored and managed effectively. The service did not ensure their patient and staff survey action plans demonstrated on-going monitoring and plans for improvements. The service did not ensure their business continuity plans were updated. The service did not ensure they had clear records to demonstrate how decisions to categorise and investigate incidents and complaints were determined.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service did not ensure staff completed mandatory training. The service did not ensure staff received specialist training relevant to their roles. The service did not ensure staff in the patient services department received safeguarding training. The service did not ensure sufficient staff were deployed within the nursing department to ensure staff were not working in excess of their working hours to deliver effective care. The service did not ensure staff received regular clinical supervision and appraisal in accordance with policy. The service did not ensure staff had access to regular team meetings.