Bionical Solutions Limited

The Piazza

Inspection report

The Piazza, Mercia Marina
Findern Lane, Willington
Derby
DE65 6DW
Tel: 01283249053

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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	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

We rated The Piazza as requires improvement because:

- Our concerns were mainly focused on the renal service. The provider's other services generally ran smoothly with high levels of staff and patient satisfaction.
- The provider had experienced staffing difficulties in the renal service over the last six months prior to inspection and had seen significant increases in missed visits and treatments. This had not impacted on patient safety but had caused anxiety and distress for some patients and their families.
- The provider had not provided any sepsis training for staff but had a clear escalation policy for managing the deteriorating patient.
- The provider did not have systems in place for staff to record COVID-19 lateral flow tests with the provider to ensure they were being done regularly and to demonstrate the current COVID-19 status of staff.
- Staff had not completed standalone risk assessments or care plans for patients. The provider had stored risk information about patients on its electronic system.
- The process for staff learning from incidents, service developments and complaints was not robust. Team meeting minutes and supervisions we reviewed did not indicate this was taking place.
- Patients and their carers in the renal service had not always found it easy to contact the provider for advice and information about their treatment. The provider had not completed complaints investigations in a timely manner and had a backlog of complaints that had not been completed within timescales laid down in their policy. The provider had not always fed back the outcome of complaints.
- Managers had not always operated effective governance processes throughout their services and with partner organisations. They had not co-ordinated missed visits in the renal service well to protect the most vulnerable patients and had not always established good communication and information sharing with patients, families and specialist hospital teams.
- The provider had stopped taking new referrals in some areas with no clear indication as to when this would resume.
- Not all staff felt respected, valued and supported to develop their skills.

However:

- Staff cared for patients and kept them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well.
- The service controlled infection risk well. They had put additional protocols in place for during the COVID pandemic and which they regularly reviewed to keep up with changing guidance.
- The service managed safety incidents well. Staff collected safety information and used it to improve the service. Staff updated care records during and after visits which they accessed through a tablet.
- Staff provided good care and treatment within the contractual arrangements with their commissioners. Staff managed treatments and medicines well, where appropriate.
- 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.
- 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 and were focused on the needs of patients receiving care.

Summary of findings

- The service planned care to meet the needs of people, took account of patients' individual needs, and had systems in place for people to give feedback. The service engaged well with patients to plan and manage services and all staff were committed to improving services continually.
- Most renal patients accessed the service when they needed it and had not waited too long for treatment,
- Staff understood the service's vision and values, and how to apply them in their work. Staff were clear about their roles and accountabilities.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for adults	Requires Improvement 	See overall summary for details.

Summary of findings

Contents

Summary of this inspection

Background to The Piazza

The Piazza is the registered location of Bionical Solutions Limited and represents the clinical side of their business. Their vision is to improve health outcomes for patients by tailoring services for individuals, including the use of technology to assist this. The service receives referrals from the providers of medical devices and prescription medicines commissioned through national and local NHS contracts. The service provides the clinical support to patients to use these medical devices and medicines.

Bionical Solutions covers the whole country and staffing consists of nurses and healthcare assistants, such as renal technicians. Patients do not visit the providers premises. Staff treat patients at home sometimes supported by the use of telephone calls and virtual technology. Staff participate in healthcare education with patients and their families around medical devices, their presenting condition and environmental considerations.

The provider's headquarters are situated near Derby and they coordinate the service from there. A call centre operated from the headquarters offers a single point of access for patients to their care team. They offer a variety of different services supporting the use of medical devices and medicines. These include women's health, osteoporosis, oncology, dermatology and rheumatology, cystic fibrosis, Parkinson's disease, leukaemia and haematology and renal dialysis.

The service supports 20,000 patients across the country and employs 700 staff. They make up to 25,000 home visits a month, the majority being in the services commissioned by a national home-IV service to NHS patients. It includes a peritoneal dialysis service, including Continuous Ambulatory Peritoneal Dialysis and registered nurse managers, registered nurse clinical trainers and trained renal technicians to deliver this. They also support families with ordering treatments. Staff are employed by Bionical Solutions; initial and ongoing training is provided by both the renal client and Bionical Solutions. We reviewed the peritoneal dialysis service services, cystic fibrosis, Parkinson's and dermatology and rheumatology services. The highest concentration of visits are made in the dialysis service and this is reflected in the focus of the report.

The service is registered with the CQC to provide the regulated activity of treatment of disease, disorder or injury.

We had not previously inspected or rated this service.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information.

Summary of this inspection

During the inspection visit, the inspection team:

- visited the office location near Willington, Derby on 9 and 10 November 2021 and spoke with the joint chief executive officer and nominated individual, the registered manager, quality assurance director, head of clinical quality, account directors and clinical operations managers for four of the services;
- spoke with seven staff members at a staff focus group;
- spoke with 22 other staff members including clinical leads, nurses and renal technicians;
- looked at nine care and treatment records of patients;
- spoke with 21 patients and six family carers of patients who used the service;
- observed eight episodes of care in different services and different parts of the country;
- had contact with 10 service commissioners of renal services;
- looked at a range of policies, procedures and other documents relating to the running of the service.

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 is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure there is adequate training for staff in relation awareness of sepsis in line with published national guidance. (Regulation 12(2)).
- The service must ensure and demonstrate all staff learn from incidents and complaints in team meetings and supervisions. (Regulation 17(2)).
- The service must ensure complaints are investigated in a timely manner as laid down in their policy and provide feedback of the outcome to the complainant. (Regulation 16(1)(2)).
- The service must ensure there are robust systems in place to measure the performance of their services, identify areas of poor performance and take action where needed. (Regulation 17(2)).

Action the service SHOULD take to improve:

- The service should ensure they complete standalone risk assessments and care plans for patients. (Regulation 12(2)).
- The service should ensure and demonstrate all staff receive regular supervision and appraisal to reflect on practice and their professional development. (Regulation 18(a)).
- The service should ensure the plan to address the need for additional staffing in the renal service is carefully monitored and provides clarity to renal units as to if and when they can accept new referrals in areas where these have been suspended. (Regulation 17(2)).
- The service should ensure the plan to reduce missed visits in the renal service is well co-ordinated and protects and mitigates the risk for the most vulnerable patients. (Regulation 17(2)).
- The service should ensure there is good communication and information sharing with staff, patients, families and specialist hospital teams. (Regulation 18(2)).

Summary of this inspection

- The service should consider developing a system to evidence staff are testing for COVID-19 in line with their policy so they can demonstrate the COVID-19 status of staff.

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Community health services for adults

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

Are Community health services for adults safe?

Requires Improvement

Mandatory training

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

Staff completed a mandatory training programme for the service they worked in. The training programme covered all the training staff required for the type of service they delivered. Staff completed basic life support including cardiopulmonary resuscitation (CPR), infection prevention and control and service specific training such as dialysis and the use and administration of specific drug therapies. Training was delivered in both practical sessions in the classroom and via e learning. However, the service had not provided any specific sepsis training to staff and staff we spoke with told us they did not feel confident to identify and escalate patients who may have developed sepsis.

All staff were compliant with mandatory training. Most staff said mandatory training was effective and enabled them to carry out their role safely. Managers ensured staff were up to date with relevant mandatory training. They held a training matrix of all staff that alerted them when mandatory training was due to expire. Managers discussed progress against mandatory training with staff in one to one meetings, appraisals and professional development reviews.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

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

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. All staff received training to a minimum of level two in adult and children's safeguarding.

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

Requires Improvement

Community health services for adults

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. They kept equipment and the premises visibly clean.

Staff used control measures to prevent the spread of infection. There was an infection, prevention and control policy that was in date and referenced relevant best practice guidelines. Staff knew how to access the policy and their roles and responsibilities to help prevent the spread of infection.

Staff followed infection control principles including the use of personal protective equipment (PPE). All staff we spoke with said PPE had been available throughout the COVID-19 pandemic and was easy to order.

Staff washed their hands before and after providing care to patients at home. Staff wore aprons and surgical masks and had access to the more secure FFP3 masks where appropriate.

All nurses and support workers we spoke with said they completed regular lateral flow tests (LFT) to monitor COVID-19 infection risk. They had not routinely completed a polymerase chain reaction test (PCR), unless they had a positive LFT in line with government guidance. The company did not have a regular PCR testing programme and had not consistently recorded the COVID-19 status of staff, although some area managers had kept a spreadsheet containing this information.

We observed eight home visits and saw staff were compliant with infection, prevention and control policies, procedures, and national guidance. Staff cleaned equipment after patient contact and disposed of personal protective equipment after use. Different services had different practices. In the You First service, staff disposed of PPE, except for masks, in the patient's bin; in the renal service, staff took away and disposed of their PPE.

Environment and equipment

The operational policies around home visits and use of equipment kept people safe. Staff were trained to use them.

Staff used PPE appropriately and disposed of it after visiting each patient. Staff carried with them enough personal protective equipment such as gloves, disposable aprons and gowns, alcohol gel, eye protection and surgical face masks. Individual nurses and support workers managed their own stock of personal protective equipment.

Staff disposed of clinical waste safely within the patient's home but did not remove it when they left. Patients or their carers arranged for disposal of clinical waste. Staff used patients' equipment when needed but had not carried any equipment with them, such as a thermometer, blood pressure monitor or oximeter for infection control reasons. Nurses in the IV service carried adrenaline and the means to administer it when needed.

Medical devices in use were maintained by the manufacturer.

Assessing and responding to patient risk

Staff had access to information about patient risk and removed or minimised risks. However, staff had not received any training in how to recognise sepsis. The service did not have robust audit processes in place

Requires Improvement

Community health services for adults

The service received information from referrers about patient risk in their assessment document. Staff completed risk assessments in the IV service but had not routinely completed standalone risk assessments for patients in other services. Staff interventions were informed by risk assessments and care plans from their referrers. Staff completed environmental risk assessments of patients' homes when needed. Staff updated risk information on their electronic system after visits.

We were not assured staff were equipped to respond appropriately when a patients' health was deteriorating. Services were very task based with staff contributing to a broader care plan led by other health professionals. This meant that their work included no regular assessment of patients' physical health status as the provider told us this was outside their remit and was carried out by other services.

Staff did not carry equipment such as thermometers or oximeters to take physical observations and were not trained to identify some specific risk issues such as sepsis. Staff responded to medical emergencies by phoning the referring services, such as the renal units or the emergency services direct. Staff had access to support from senior staff for advice about patients' health. However, eight staff we spoke with felt that senior managers had not supported them well when they needed advice and that they had not always understood the nature of the work they were doing.

Staff had not received any training in awareness around recognising sepsis. The current National Institute for Care and Health Excellence (2019) guideline NG51 on sepsis recommends that providers 'ensure all healthcare staff and students involved in assessing people's clinical condition are given regular, appropriate training in identifying people who might have sepsis. This includes primary, community care and hospital staff including those working in care homes (1.12.1)'. This guidance has also been referred to as an expectation of providers in the CQC's published inspection framework for Community health services for adults. This omission puts patients at potential risk of harm.

Staff shared key information to keep patients safe when handing over their care to others. However, four commissioners we spoke with told us that communication with the provider was inconsistent and sometimes problematic; information about missed visits was frequently not reported to specialist units and one reported that important information about a patient who came into the emergency services was not passed on.

Staff had completed some audits, for example of incidents and complaints. However, there was not a robust system of regular audits to identify shortfalls and rectify them at an early stage.

Staffing

The service had experienced recent difficulties in providing enough staff to fulfil all its contractual obligations in the renal service and were actively recruiting to address this. This had not impacted on patient safety but had affected the quality of life of some patients and their families. Staff had 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 all staff a full induction.

Bionical Solutions did not always have enough staff in its renal service to ensure patients never missed visits. This was due to staffing structures and to staff isolating after contracting COVID-19. Staffing numbers for this service were taken over from the previous provider. In their renal service, the provider had introduced permanent contracts for staff, reduced the number of staff on zero hours contracts and introduced a new allocation system. A number of renal technicians were in dispute about the new arrangements and felt they had been disadvantaged by them.

Requires Improvement

Community health services for adults

Data from the provider stated that between 1 August and 31 October there were 588 missed visits. Patients, family members, staff and renal units confirmed that missed visits remained a problem in some areas of the country and was worse at the weekends. This caused anxiety and distress to some families and on one occasion a family member took their relative to hospital because of their concerns.

The provider attempted to meet patient preferences where possible when arranging and rearranging visits. However, two patients told us that while regular staff offered a good service, when they could not attend, the provider could not always find replacement staff and when they did, they had not always met their preferences.

In some areas, renal units had seen big increases in the number of patients suitable for assisted home treatment. The provider was not able to meet this demand and expand the service in those areas due to the lack of additional staff, meaning new patients in those units could not be offered a home assisted peritoneal dialysis service. The provider had paused new referrals in some areas until they had deployed additional staff. They had also developed a more robust tool to plan to assess the impact of travel time, annual leave and sickness in order to better organise staff availability.

Data from the provider showed that in August 2021, missed visits constituted 2% of visits made in the renal service and for September and October 2021, this had reduced to 1%. The provider stated they had started to recruit an additional 46 staff to increase staffing levels. We saw evidence of new staff starting and receiving an induction.

Quality of Records

Staff kept detailed records of patients' care and treatment. Most records were clear, up to-date, stored securely and easily available to all staff providing care. However, the provider did not have a regular audit process for patient notes.

Staff could access patient notes easily. They contained information about risk on the assessment form from the referring service. Staff updated and managed patients' individual care records on a tablet device which allowed them to access patient care records when delivering care in patients' homes. However, staff had not routinely completed standalone risk assessments for patients.

Most patient notes we looked at were comprehensive. However, one patient's notes contained mistakes in the transcription of medicines, contained no record of consent, contained incomplete forms and stated that staff had not given a support pack to the patient. Some staff told us that assessment documents sometimes contained little information about the patient and that they had not always felt prepared when visiting a patient for the first time.

Staff stored records securely. Staff shared confidential patient information through a secure electronic communication tool.

Medical Devices

The service used systems and processes to safely administer and record the medical devices in use.

The provider had not prescribed medication but followed treatment plans prescribed by hospital consultants. They were not responsible for administering medicines except in very limited circumstances and all medication and medical devices used for patients was stored in patients' houses. Staff cleaned equipment before and after use as part of the treatment plans for patients.

Staff provided specific advice to patients and carers about their medicines where appropriate.

Requires Improvement

Community health services for adults

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

The service had systems to ensure staff knew about medical devices safety alerts and incidents.

Safety performance, incident reporting, learning and improvement

The service had systems in place to manage patient safety incidents. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Staff apologised when things went wrong.

All staff knew what incidents to report and how to report them. Between 1 May and 31 October 2021, the provider recorded 1914 incidents. These included 315 incidents relating to patients' use of their equipment, 316 incidents of errors by staff and 764 missed visits.

Staff raised concerns and reported incidents and near misses in line with provider policy. However, we spoke with two staff who said they had stopped reporting some issues because the company never responded to them. It was not clear whether this had an impact on patient safety.

Staff reported serious incidents clearly and in line with provider's policy.

Staff understood the duty of candour. There was evidence they had been open and transparent, and given patients and families a full explanation if and when things went wrong. However, staff, patients and renal units said it could be difficult to raise issues about patient care and when making a complaint they had not always received feedback.

There was evidence that staff had made changes as a result of feedback. For example, staff had made efforts to respond to patients' requests in relation to visit times and ringing them to let them know what they would arrive.

Managers investigated incidents thoroughly and made recommendations to improve patient care.

Managers debriefed and supported staff after any serious incident.

Are Community health services for adults effective?

Good

Evidence-based care and treatment

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

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

The service worked to agreed contracts from referring teams and units. They had not made clinical decisions about patient's care and treatment but carried out treatment plans devised and reviewed by professionals in hospital and other specialist teams including renal units. They were contracted and funded by renal care companies and were not funded directly by the National Health Service.

Requires Improvement

Community health services for adults

The provider supported patients by giving them information to promote quality of life and teaching them to maintain their medical devices appropriately and maximise the benefits of their prescribed medicines. They assessed patients' needs to assess the effectiveness of these interventions.

Staff told patients when they needed to seek further help and advised them on what to do if their condition deteriorated.

Handover meetings, supervisions and team meetings were task focused and had not routinely recorded the psychological and emotional needs of patients, their relatives and carers.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Outcomes for many patients were positive, consistent and met expectations, such as contractual standards. The registered manager and staff used the results to improve patients' outcomes. However, although the provider had taken some action in this area, we were concerned at the high number of missed visits in the renal service, which was also a concern for referring teams.

The provider considered trends and themes relating to service delivery and patient outcomes and looked for ways to improve the service. They audited patient outcomes through quarterly monitoring reports.

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.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. Managers assessed staff for competency in a number of tasks and signed them off when they completed this successfully.

Staff told us they received yearly, constructive "field" appraisals of their work, which gave an overview of their competencies.

Managers supported staff to develop through clinical supervision of their work. However, five staff we spoke with said they received little or no supervision as support staff. One staff member said they had informal support, but this was not written down. Written supervision documents we reviewed lacked detail and it was not clear how frequently this occurred.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

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

Staff had the opportunity to discuss training needs with their line manager who supported them to develop their skills and knowledge. Managers gave staff objectives through appraisals and supervision and encouraged them to contribute to this process. Managers made sure staff received any specialist training for their role.

Requires Improvement

Community health services for adults

The registered manager reviewed staff performance and working with the company's human resources team would support staff to improve if required.

Multidisciplinary working

Nurses and technicians worked together as a team to benefit patients. They supported each other to provide good care.

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

Staff worked with other agencies when required to care for patients, including hospital departments and renal units. Staff liaised with hospital teams leading on the care pathways for their patients. Patients had their care pathway reviewed by relevant consultants in hospital teams. The provider did not make clinical decisions for patients or review their care and treatment.

The provider stated that they reviewed all renal incidents on a weekly basis in an incident review meeting between Bionical and the commissioning company to ensure that all actions taken and planned were appropriate to the incident. Staff escalated clinical incidents to patients' healthcare professionals and updated patient records so healthcare professionals were aware in case of the need to change therapy or pathways. However, specialist renal teams told us that the provider had not always communicated with them effectively. This included information about missed visits, physical health issues and feedback about patient treatment. One specialist told us this included issue relating to technicians not connecting the dialysis machine to the internet. This meant hospital staff had not always had enough information about how the patient was responding to treatment.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and positive choices about health.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available.

The provider had not made formal mental capacity assessments for patients but followed the prescription laid down by the specialist hospital team responsible for their care.

Staff clearly recorded consent in the patients' records.

Requires Improvement

Community health services for adults

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

Are Community health services for adults caring?

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.

Patients said staff treated them well and with kindness. We observed staff interacting with patients in their own homes in a caring and considerate way.

Staff followed the providers policy to keep patient care and treatment confidential.

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 to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it in relation to their condition. Staff gave patients time to talk and ask questions when needed.

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. They engaged patients and family members positively and provided emotional support when required.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. They provided health education about medications and treatment pathways and offered advice and support for patients when needed.

Staff talked with patients, families and carers in a way they could understand.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make informed decisions about their care.

Requires Improvement

Community health services for adults

We spoke or had contact with 21 patients. 20 were broadly positive about the service and about the staff who visited them; many said the service had had a positive effect on their lives. They told us staff were kind and competent and came at convenient times. Staff always wore personal protective equipment and were mindful of infection control. They offered emotional support as well as the medical intervention, did not rush patients and gave them time to ask questions. However, some patients commented negatively about the number of missed visits and the quality of communication by the company; patients said this could be late or non-existent and non-clinical staff had not always understod the treatment programmes patients were on, even after this had been explained to them. Two patients told us that while regular staff offered a good service, when they could not attend, the provider could not always find replacement staff and when they did, they had not always met their preferences.

We spoke or had contact with six carers. Carers generally spoke positively about the service and the staff who came to visit. They described them as friendly, supportive and competent. However, two carers said it could be difficult to get consistent workers to visit in line with the patient's cultural or mental health needs. On occasions, patients were not visited and given little or no notice or explanation of this. This caused anxiety and distress to the patient and to the carer. They told us the provider had not always answered phone calls and when they had staff were not always helpful. This was supported by evidence from staff and specialist hospital teams.

The provider conducted regular patient surveys which indicated high levels of patient satisfaction. The latest survey, across all services in March 2021, indicated that 92% of patients would speak highly of the service they had received. Comments about the service were very positive. Staff were caring and kind, listened to patients and carried out their tasks competently. Patients said they were overwhelmed by the enormous difference the service had made to their lives and spoke very positively about individual members of the team. However, a number of renal patients and their families felt the provider was inconsistent and unreliable and had caused additional anxiety and distress due to the number of missed visits or the lack of availability of female workers needed for personal and cultural issues.

Are Community health services for adults responsive?

Requires Improvement

Planning and delivering services which meet people's needs

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

Managers planned and organised services, so they met the changing needs and distribution of the patient groups. The company provided a national service, patients were widespread, and visits needed to be carefully co-ordinated to ensure staff could meet patients' needs.

The service had systems to help care for patients in need of additional support or specialist intervention. Nurses and support workers escalated concerns to the referring hospitals and units, to GPs or to the emergency services where appropriate.

Managers monitored and took action to minimise missed appointments. However, missed visits in the renal service had increased during the last 12 months. Staff, patients, carers and some commissioners confirmed that this was a significant issue at the moment and had caused a lot of anxiety, distress and anger. Some specialist units said that staff

often cancelled visits late in the day and had not always informed them, leaving patients to ring them the following day. Professionals were also concerned that the provider had not managed missed visits well and had not prioritised the most vulnerable and anxious patients as they had requested. The provider had a recovery plan in place to address missed visits in the renal service and provided regular updates to the client company for this service.

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.

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 patients and local communities. Staff worked with specialist hospital teams to ensure they could communicate effectively with patients.

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

Access to the right care at the right time

People could not always access the service when they needed it and receive the right care in a timely way.

Managers monitored waiting times and the workload of the teams to maximise the number of patients who could access services when needed and receive treatment within agreed timeframes and contractual targets. However, in the renal service, specialist hospital teams had significantly increased the numbers of patients they referred to the provider over the previous six months. Due to this, the COVID-19 pandemic and difficulties in recruiting and retaining staff, the provider had struggled to expand the service. In some areas of London, the provider had stopped accepting new referrals to their renal service.

Managers worked to keep the number of cancelled appointments and treatments to a minimum. However, in the renal service, the number of missed treatments had increased for existing patients in the service, leading to additional anxiety for some patients and their families. The provider was trying to recruit additional staff to address these issues, but it was not clear when new patients would be able to access the assisted dialysis service in these areas. Staff could not always rearrange cancelled appointments due to the nature of the treatment. However, these appointments were about 1% of the provider's total visits for this service.

Learning from complaints and concerns

It was not always easy for people to give feedback and raise concerns about care received. The service investigated concerns and complaints but not responsively in a timely manner and had not routinely shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns. However, staff and patients said it was difficult to contact managers to raise a concern and they had not always received a response.

Staff knew how to acknowledge complaints, but patients and professionals had not always received feedback from managers after the investigation into their complaint. Feedback from specialist units was that the provider had not always provided feedback to complaints and one person commented that they had never done so.

Requires Improvement

Community health services for adults

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. However, staff had not always completed these in a timely manner. Between 1 January 2021 and 6 December 2021, the provider received 220 complaints, of which 165 were from the renal service. We reviewed six complaints which demonstrated staff had responded to them in line with the provider's policy. However, of the 65 complaints open to this service on 19 October 2021, staff had not investigated 54 complaints within the agreed timescales of the provider's policy.

Managers had not routinely shared feedback from complaints with staff and we could not see managers facilitated staff learning consistently to improve the service. However, staff could give examples of how they used patient feedback to improve daily practice.

Are Community health services for adults well-led?

Requires Improvement

Leadership

The service was managed and led by a team which included clinical staff. They understood and managed the priorities and issues the service faced. Regional lead nurses observed and gave direct feedback to staff performance.

As the service was a national one, leaders were not always visible to staff. Most staff said they could contact leaders for advice and support, but four staff said they were hard to contact and had not always returned calls and that patients were not given contact numbers of local managers to contact them when things went wrong.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

The provider's stated aim was to ensure the service to each patient was tailored to their specific needs wherever possible.

Staff had not always had confidence that senior managers were able to deliver this effectively and did not always have a clear understanding of the work staff were doing.

Culture

Most staff felt respected, supported and valued. Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.

Most staff felt respected and valued. During a recent staff survey, the majority of staff who responded reported that they had regular access to their manager and that their manager was approachable. However, eight out of 22 staff we spoke with felt the provider had not supported them well when they needed advice and that managers had not always understood the nature of the work they were doing. Five staff said they received little or no supervision as support staff. One staff member said they had informal support, but this was not written down.

Staff also told us that when they raised issues to managers, they would not always be addressed.

The provider supported lone working through a mobile phone app which monitored and alerted them to update their status and safety.

Staff we contacted and spoke with were focused on providing a high-quality service and meeting the needs of the people they saw.

Specialist hospital teams worked well with local teams and with individual workers but said that communication with senior managers was inconsistent and patchy.

Governance, risk management and quality measurement

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet and discuss the performance of the service. Staff could find the data they needed, in easily accessible formats. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required. Leaders did not always operate effective governance processes throughout their services and with partner organisations.

The providers services generally ran smoothly with high levels of staff and patient satisfaction. Managers produced regular reports on performance for the corporate team to review against targets. These included incident data, complaints and missed visits. They reported and monitored these at regular clinical governance meetings with their commissioners and at board meetings.

We were concerned about some aspects of the renal service. Senior managers analysed data for missed treatments in the renal service and implemented an action plan to alleviate this. The provider had recorded this issue on their risk register in August 2021. At the time of the inspection, although this issue had not been resolved, it had been removed from the active risk register, but managers had discussed this at recent board meetings. Some action had been taken in relation to reducing the number of missed visits, including recruiting additional staff. However, renal units, staff, patients and carers told us this the provider had not always followed their protocols in relation to missed visits, and that communication was frequently poor.

Communication with some specialist hospital teams was inconsistent. Several teams noted that communication with senior managers was difficult with telephone messages and emails often going unanswered. However, they said communication with support staff and out-of-hours staff was generally good.

There continued to be high levels of complaints in the renal service. We could find no evidence that managers had taken action to reduce the backlog of uncompleted complaints investigations and the numbers of complaint investigations completed outside the provider's target.

However, the service had experienced difficulties in staffing the renal service due to increased referrals from specialist renal units, difficulties in recruiting and retaining staff, an unresolved dispute with its renal technicians and increased pressure on the service from the COVID-19 pandemic. Missed visits remained a small proportion of overall appointments but had increased significantly over the six months prior to inspection, causing anxiety, inconvenience and distress to some patients and their family and carers. Renal units were concerned managers had not managed staffing proactively or equitably and that the service had deteriorated over the past six months. Some patients had more missed treatments than others, including where units had prioritised some patients as being particularly vulnerable. The provider had taken some action to address this by halting new referrals in some London areas and attempting to recruit additional staff. However, it was not clear how or when managers might resolve staffing concerns and there was no clear audit process in place to support this work.

Staff had the opportunity to attend regular team meetings remotely. However, meetings were clearly focused on service tasks and the format of these meetings had not enabled staff to discuss learning from incidents, issues and complaints in order to make improvements to the service.

The provider produced comprehensive and clear advice for staff in relation to the COVID-19 pandemic. This included guidance in relation to undertaking additional cleaning and hygiene tasks, personal protective equipment, testing and isolation procedures should a member of staff have a positive test result. However, managers did not have oversight of the COVID-19 status of staff haphazard. There was no centralised system to record this. Some managers set up local arrangements but these were not consistently deployed across the organisation.

Information Management

There were robust arrangements in place to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards? We saw evidence of learning and service improvements in relation to data security breaches.

The information systems were integrated and secure. There were effective arrangements in place to ensure staff submitted data or notifications to external bodies as required.

Public engagement

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

Managers gathered patients views and experiences through regular surveys. The most recent one stated an overall satisfaction rating of 94%.

The provider had developed collaborative relationships with external partners. However, communication with specialist renal units was inconsistent and the referring system for some units was through their commissioners rather than directly with the provider. It was not clear that the provider built a shared understanding of the challenges within the system, the needs of the relevant population and a plan to deliver services to meet those needs.

Staff engagement

Managers gathered staff views through regular meetings and more formally in staff surveys. The majority of staff who responded reported that they had regular access to their manager and that their manager was approachable. However, staff expressed concerns about their ability to progress within the organisation.

Innovation, improvement and sustainability

Managers monitored individual staff performance through supervision. Staff were set goals to improve performance where appropriate.

Staff had not routinely discussed incidents and complaints at team meetings. There was no evidence that this took place in team meeting minutes we reviewed.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service had not ensured there was adequate training for staff in relation to the awareness of sepsis in line with published national guidance. (Regulation 12(2)).

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The service had not ensured complaints were investigated in a timely manner as laid down in their policy and provided feedback of the outcome to the complainant. (Regulation 16(1)(2)).

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service had not ensured and demonstrated all staff learned from incidents and complaints in team meetings and supervisions. (Regulation 17(2)). The service had not ensured there were robust systems in place to measure the performance of their services and take action to make improvements where needed. (Regulation 17(2)).