# Healthcare at Home Clinical Skills Centre

## Quality Report

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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

## Overall summary

We carried out an announced comprehensive inspection on 28 and 29 November 2016 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

**Our findings were:**

**Are services safe?**

We found that this service was providing safe care in accordance with the relevant regulations

**Are services effective?**

We found that this service was providing effective care in accordance with the relevant regulations

**Are services caring?**

We found that this service was providing caring services in accordance with the relevant regulations

**Are services responsive?**

We found that this service was providing responsive care in accordance with the relevant regulations

**Are services well-led?**

We found that this service was providing well-led care in accordance with the relevant regulations

# Summary of findings

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# Healthcare at Home Ltd

**Services we looked at**
Community health services

# Summary of this inspection

## Background to Healthcare at Home Clinical Skills Centre

**Background**

Healthcare at Home is a clinical homecare provider, operating UK wide, and works with the NHS, pharmaceutical companies, private medical insurers, consultants, GPs and charities. The company was established in 1992 and since then have treated 1.4 million patients across 49 therapy areas. Clinical homecare is a term used to describe integrated care and treatment that takes place in a person's home. This can directly minimise the likelihood of an inpatient stay or outpatient visit for the patient. Normally, the NHS provider retains responsibility for patient care.

Healthcare at Home's services centre around a specialist nurse team providing clinical homecare to patients in areas including chronic disease, end of life, cancer care and supported discharge. Accessing services provided by Healthcare at Home, either NHS funded or privately, is dependent on a referral by a GP or hospital consultant or private health insurers. In detail the services provided are:

- Medication support
- Medication home treatment
- Supported hospital discharge
- Hospital admission prevention
- End of life care
- Cancer services
- Healthcare at Home Pharmacy
- Healthcare at Home Care Bureau (call centre)

This service is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides in England. The provider is registered in England to provide; Blood and Transplant services, Community Healthcare services, Domiciliary Care services and Remote Clinical Advice services.

**Our key findings were:**

- Staff were passionate about the care they provided. Support staff understood how their role enabled clinical staff to provide effective, safe and timely care. Patients told us that the staff were 'brilliant' and 'could not do enough' for them.
- Services were tailored to meet the needs of individual patients. Agreements with acute hospital trusts included clear guidance regarding the acuity and type of patients who could be accepted by the service. We saw how this was effective in identifying patients who needed to remain in hospital or those with needs that could not be met by the service.
- Incidents were recorded, investigated and appropriate actions were taken to enable staff to learn from incidents.
- Nursing staff were skilled, had access to training and received appropriate clinical supervision.
- Patients were protected from abuse. Staff were trained to recognise abuse. Concerns were escalated appropriately.
- Care programmes were based on and followed recognised pathways.
- Patients' health and wellbeing was monitored. Support was available for patients who needed reassurance, advice or additional services.
- Governance systems enabled mangers to monitor performance, there were clear communications routes throughout the organisation, from informal meetings and conference calls which the service call 'drum beat' through formal quality assurance and board meetings.
- There was an open culture within the organisation and whilst there were clear lines of authority, this did not operate in a hierarchical manner. Staff treated each other as equals.
- Complaints were handled effectively. We saw robust systems were in place to recorded, analysed and responded to complaints.
- We found provision for patients with a learning disability and patients living with dementia was limited. Staff were trained to assess mental capacity and only provided care when patients were able to actively consent for it to take place. The service had no clear process to monitor or support patients who had, or might develop, dementia.
- Where the provider had a legal obligation to follow the Duty of Candour regulations; processes and documentation did not ensure that responses were given in the spirit of openness and transparency.

# Summary of this inspection

Notifications were not given in person and letters were defensive; apologies related to patient satisfaction with investigations rather than apologising for the incident itself.

## Our inspection team

The inspection team consisted of a CQC Inspection Manager, two CQC Inspectors and a specialist advisor with nursing and senior management experience.

## Why we carried out this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

## How we carried out this inspection

The inspection was conducted over two days; 28 and 29 November 2016.

We spoke with 15 patients and/or members of their family. We spoke with 28 members of staff including nursing staff, support staff and managers. We completed five home visits in company with nursing staff. The home visits and telephone contacts included patients from different work streams and from a wide area of the country which meant we were able to assess the different areas of the service. We examined ten sets of patient records.

We reviewed information about the service which had been provided prior to, during and following the inspection. We also reviewed information from stakeholders and public information services.

## Information about Healthcare at Home Clinical Skills Centre

Healthcare at Home Clinical Skills Centre is part of Health Care at Home Limited. The provider is regulated by The Medicines and Healthcare products Regulatory Agency (MHRA) and The General Pharmaceutical Council (GPhC) in respect of their manufacturing and dispensing of medications. The provider is regulated with the CQC in relation to their nursing services in England; this includes patients' access to medicines supplied by the provider for self-administration or for their nursing staff to administer.

At the time of our inspection the provider had 167,897 patients across the UK, with 149,769 (89%) of these being in England. During 2016 the provider delivered almost 3 million pharmacy items in 735,058 deliveries (88% of the total deliveries) to patients in England.

The provider employs 1,500 staff which includes over 800 healthcare professionals.

The provider delivers services under a number of work streams each of which has a manager registered with the CQC. A registered manager is a person who is registered with the Care Quality Commission to manage the service.

# Summary of this inspection

Like registered providers, they are 'registered persons'. Registered persons had legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

The main work streams are NHS Projects; which included admission avoidance and early discharge. Core/On Demand services which involved longer term care and support, Paediatrics; which encompassed all services provided to children and young people, and Care Bureau; a telephone/email support system for patients and staff.

During our inspection, we met with four registered managers covering the main work streams and the Care Bureau services.

# Summary of this inspection

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

We found that this service was providing safe care in accordance with the relevant regulations.

- Incidents were recorded, reviewed and learning was shared.
- Nursing staff all received safeguarding training and understood how to recognise and escalate concerns.
- Computerised allocation systems had been developed and introduced which ensured that only appropriately trained and skilled staff were allocated to patients.
- Medication was stored, dispensed and administered safely.
- Infection prevention and control methods were followed.
- Patient records were electronic and could be viewed and updated on the tablet computers carried by staff. This also meant that notes and records could be viewed remotely by supervisors or care bureau staff if advice or guidance were needed.
- Risk assessments were completed when patients were accepted by the service. These were reviewed following any changes in health and periodically for long term patients.

However

- We found that processes to meet the providers obligations of duty of candour failed to ensure that responses were given in accordance with the act, apologies did not reflect the definition contained in the act and there was no evidence that notifications were given in person.
- Patients who suffered from or were likely to develop memory difficulties were not identified
- We found that staffing of the care bureau had not been reviewed adequately following expansion of services which it supported.
- The provider did not have any means to monitor the number of missed calls which were unable to be answered by care bureau staff.

### Are services effective?

We found that this service was providing effective care in accordance with the relevant regulations.

- Care and treatment followed recognised pathways.
- Patients' health and wellbeing were monitored and fluctuations outside expected levels were appropriately escalated.

# Summary of this inspection

- Care Bureau staff included qualified nurses and were available 24 hours a day, seven days a week for patients who had concerns or required advice or support. The call centre was also available for trained staff to contact if they needed to.
- Contracts with NHS acute hospital trusts included clear guidance on acuity of patients who could be taken on by the service and processes to enable deteriorating patients to be returned to hospital.
- Nursing staff received appropriate clinical supervisions, and training.

However

- Duty of candour notifications were not given in person and letters were defensive; apologies related to patient satisfaction with investigations rather than apologising for the incident itself.

## Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

- Patients were treated with respect.
- Patients' dignity was protected.
- Patients and their carers or family members were fully informed about the treatments and care that were provided.
- Patients described how staff had supported them and their family members by being sensitive to their needs and providing honest and factual information.
- Patients described the level of care they received as 'brilliant' and wonderful'.

## Are services responsive?

We found that this service was providing responsive care in accordance with the relevant regulations.

- Services had been developed covering a wide range of clinical conditions.
- Care packages and treatment plans were tailored to meet the clinical needs of individual patients.
- Patients were able to influence the support they received and could request alterations to visits or deliveries to meet their social needs.
- Provision had been made to accommodate patients with a learning disability.

However

# Summary of this inspection

- The service did not have clear policies to help staff identify and support patients who over time might develop dementia of other memory problems.
- Lack of support for patients who might have difficulty communicating such as hard of hearing or where English was not their first language meant that there was the potential that such patients could be excluding from the service if they didn't have their own support.

## Are services well-led?

We found that this service was providing well-led care in accordance with the relevant regulations.

- The provider had a clear vision which staff understood and felt engaged with. Vision 2020 outlined the aspirations of the company.
- Governance systems were in place which provided clear levels of responsibility. Minutes of meetings showed how issues could be raised and responses cascaded throughout the organisation.
- Managers understood their staff and knew how to support them in their role. Staff in turn felt supported and empowered to do their work.
- Risks were monitored and mitigated. Service provision and risk were assessed using a combination of factors including monitoring and reviewing complaints, incidents, nursing audits, records audits and through external meetings with commissioners.
- We found staff at all levels to be open and honest and whilst lines of authority were clear, there was a non-hierarchical culture.
- Staff engagement included a series of 'away days' where staff attended functions to celebrate the work of the organisation with leaders outlining future plans and aspirations. Every member of staff was required to attend one of the days.

# Location

| | |
|---|---|
| Safe | |
| Effective | |
| Caring | |
| Responsive | |
| Well-led | |

## Is the location safe?

**Reporting, learning and improvement from incidents**

- The provider had an electronic incident reporting system; we saw nursing staff had direct access to the system using their handheld computer tablets. This meant that staff were able to input incidents immediately and did not have to wait until they returned to a base. Staff we spoke with told us this resulted in more accurate and timely information being collected. The system also enabled supervisory oversight. Where appropriate supervisors could view the information and respond to nursing staff whilst they were still on site. There was a positive culture of incident reporting amongst staff. The system was seen as a valuable tool to aid performance.
- The incident reporting system was also aligned to pharmaceutical development. Large external pharmaceutical companies provided medications to the NHS under special contracts which reduced costs in exchange for anonymised clinical outcome information. Where these medications were prescribed to patients under the care of Healthcare at Home, staff were required to complete incidents for any changes in patient health or wellbeing; this was to enable pharmaceutical companies to assess how medications affected different patients in different environments and circumstances. We saw how incident reporting was used to record this detail.
- During the period 1 October 2015 to 30 September 2016 the provider recorded a total of 3,114 low or no harm clinical incidents. This consisted of 294 'no harm' incidents and 2,820 'low harm' incidents. During this period the service had provided 291,793 clinical activities. The reported incidents equated to 1.06% of the total clinical activity for the period.
- During the same period the provider recorded 6,676 operational patient safety incidents as low, no or moderate harm. These were incidents which did not include clinical issues and were predominantly related to deliveries of medication and equipment. During the period a total of 899,711 deliveries were made. The reported incidents equated to 0.7% of the total activity.
- Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff we spoke with understood the need to be open and honest with patients. When things did go wrong there were systems in place to respond to patients and their families. However when we reviewed correspondence between the provider and patients we found that some of the content was not written in the spirit of openness and transparency and did not fully fulfil the providers obligations in respect of their legal Duty of Candour. This was because there was no record that a notification was provided personally by a representative of the provider, and apologies were given regarding satisfaction with investigation outcomes rather than for the incident itself. We fed this back to senior managers and they undertook to review their process and look at examples of best practice following the inspection.
- Between 1 December 2015 and 30 November 2016, four serious incidents were reported. Two incidents

related to unexpected deaths and two were classified as never events. The first unexpected death related to one patient who had deteriorated at home and was re-admitted to hospital where they passed away. The second was a patient who had left hospital and as the Healthcare at Home nurse arrived at the patients home for the first visit, they found that ambulance services were in attendance and the patient had passed away prior to receiving treatment from the service. Investigations were completed by Healthcare at Home and the hospitals involved, these involved joint meetings to discuss circumstances and any learning which might have been available. The investigations concluded that both services had acted appropriately and followed agreed processes. The deaths were not attributable to the level of care provided.

- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. We saw that management had fully investigated the never events that occurred at the service. They both related to patients not receiving deliveries of medication. In one case, Healthcare at Home failed to register a patient following referral and in the second case prescriptions were not received from the patient's hospital and Healthcare at Home were unable to contact the patient as they had changed their telephone number. We saw how additional contact and review processes had been introduced as a result of the incidents.
- Learning from incidents was communicated to nursing staff through their computer tablets. We were shown examples of shared information when staff demonstrated the tablet computers to us. Staff also had regular telephone, video call or face to face meetings with their managers. In addition to this team meetings were held during which incidents and options to avoid further incidents were discussed. Meetings took place weekly, minutes were recorded. We were shown copies of the minutes of these meetings.
- The provider used a central information portal called 'The Hub' which staff could access electronically, either whilst working or at home. The hub was the source for a large amount of information; such as policies, contact information and guidance, but also provided updates on incidents and medical alerts.
- Prior to the inspection we had received allegations regarding a senior member of the executive team. We saw documentation and had reassurances from a senior board member regarding steps the organisation had taken in relation to the allegations, demonstrating that systems were in place to monitor and respond to concerns.
- We found that in some instances where services had not met patients' expectations or mistakes had been made the provider had been defensive in their response. Non NHS care providers have been legally bound to comply with Duty of Candour since April 2015. The duty requires providers to be open and honest with patients or their representatives when errors have been made which result in death, serious harm or moderate harm. Duty of Candour (DOC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
  - We found that some correspondence from the provider contained apologies to the fact that patients or their representatives were not happy with the service, or response to their issues, they did not apologise for the error itself. We discussed this with senior staff, they advised that it had not been their intention to be defensive and they undertook to review the process and look at best practice from other organisations.

**Reliable safety systems and processes (including safeguarding)**

- The provider had an infection prevention and control policy. The policy was approved in July 2015 and was due for review in July 2017. Senior staff advised us that at the time of our inspection the policy was already being reviewed by an external provider. The review was due to be completed in February 2017 which meant the revised policy would be in place five months earlier than the due date, this was an example of the providers pro-active approach to their obligations.

# Location

- Infection prevention and control featured in the Nursing Quality audits completed monthly by supervisors. The audits contained 25 criteria, 14 of which related directly to infection prevention and control. We reviewed eight sets of Nursing Quality audits completed between May and November 2016. We saw that seven minor breaches had been identified in the various audits, all of which were seen to have been corrected in later audits. We noted that with one exception all the audits exceeded the providers target of 90% compliance; with four audits achieving 100%. We saw that audits forms included sections for commendations, recommendations and action plans. We saw that any score below 100% resulted in detailed recommendations and action plans being written by the assessor. Scores below 90% triggered further review. Staff confirmed that audit results were discussed with them which enabled them to learn and improve where required.
- We observed staff using a variety of infection prevention methods during the home visits we attended; these included arms bare below the elbows and appropriate use and disposal of personal protective equipment (PPE) such as gloves and aprons. Use of hand gels and hand washing and safe use of sharps bins. Patients confirmed that staff always washed their hands and used PPE when they visited.
- Staff carried personal sharps boxes, but we also saw medical disposal boxes in people's homes. This meant that clinical waste was not mixed with household waste.
- The provider had a safeguarding policy which included advice and guidance for staff in relation to the different types of abuse and how to identify them. The policy included guidance on Female Genital Mutilation (FGM) and identifying and responding to domestic abuse.
- One of the registered managers also had the role of safeguarding lead and was trained to level 4. Staff knew who the safeguarding lead was and how to contact them for advice or guidance.
- All nursing staff had received both adult and children's safeguarding training. We saw records which showed that 100% of qualified nurses had completed level 3 children safeguarding training.
- Patient records were electronic, encrypted and stored centrally. Each manager reviewed five sets of patient records completed by their staff each month to review content and quality.
- When we spoke with staff in relation to abuse; they had a clear understanding of the types of abuse which constituted a safeguarding concern and they understood how to support patients and report suspected abuse.
- Staff were able to give examples of incidents which had resulted in safeguarding referrals being made and attendance at multi-agency safeguarding meetings. We were shown electronic records confirming what we were told.
- The provider had a lone worker policy and all nursing staff were provided with an electronic panic alarm system which was incorporated into their ID badge and could be used to summon help, in addition to providing location details of the wearer.

**Medical emergencies**

- We saw that nurses carried emergency **anaphylaxis** resuscitation packs in line with the Resuscitation Council (UK) guidance. We saw that the packs were intact and within their use-by dates. Nursing staff also received regular resuscitation training as part of their mandatory training.
- Patients were referred back to their consultant or GP for changes in health which were not life threatening. If nurses found patients required more urgent support they would arrange transfer to hospital via the 999 system.
- Care Bureau staff had access to clinical pathways and could advise and provide reassurance to patients if they called in. Where appropriate they could arrange additional visits by nurses. Care Bureau staff could also liaise with or transfer the call to nurses familiar with the patient or their condition. Where staff identified that more immediate assistance was required they used the 999 system to request ambulance attendance.

- Nurses provided patients and their relatives or carers with care booklets about their condition. The booklets contained detailed information about the possible side effects of any drugs or treatments and advice and contact details for use if patients, relatives or carers had concerns or felt their condition was not being controlled in line with expectations.

**Staffing**

- Nursing services operated between 8am and 8pm Monday to Friday and 8am to 4pm at weekends. Care Bureau operated twenty-four hours a day, 365 days per year. This meant that if patients or carers had concerns they were able to speak with trained staff who had access to their records, history and clinical guidance at any time of the day or night.
- Nursing teams operated on a regional basis, supported by clinical supervisors who in turn reported to regional clinical operations managers (RCOM).
- We saw that systems were in place which ensured that only nursing staff with the appropriate qualifications to meet the needs of each individual patient would be allocated to visit them. Following a trial period in the south of England the provider had rolled out a new computerised allocation system. The system used complex algorithms to identify the most appropriate staff to allocate to each patient, the most appropriate order in which to visit based on clinical need and location, and the most appropriate route to take between locations. The information was then available to each member of the nursing team as they came on duty.
- Most procedures required the attendance of one qualified nurse. Where patients had complex needs or other issues existed which may have impacted on the safety of the patient or staff, two nurses would be allocated to attend.
- Staffing levels for the service were based on contractual capacity, for example an NHS project may require that a certain number of patients with certain conditions in a particular area be nursed at home by the service, thereby freeing up NHS acute hospital beds. Healthcare at Home would assess the clinical need of the patients based on recognised procedures which required a set amount of time to deliver. By also factoring in the travelling time between patients and the frequency of treatments required, this enabled an accurate assessment of the staff required to deliver the service. In November 2016 the service had 1,421 employees and 110 bank staff.
- Planned and unplanned absences were covered from within the service. Agency staff were not used to cover nursing vacancies although agency staff were used in administrative roles in various parts of the organisation.
- We found that staffing levels within the Care Bureau had not increased in line with the demands on the service since it opened in 2014. Daytime staffing consisted of two qualified nurses and two call advisors who were trained to the same clinical knowledge level as healthcare assistants. On nights, staffing was one qualified nurse.
- When originally set up the Care Bureau supported the core service and one NHS project. At the time of our inspection the provider had 17 NHS projects ongoing. Staff in the department told us that at busy times it could be difficult to cope with the volume of calls. They said that on occasions calls went unanswered. The provider did not have any means to monitor the number of missed calls.

**Monitoring health & safety and responding to risks**

- Nurses working for the service either had a background in, or had received in house training in, various nursing specialities. This ensured that staff understood the medical care each patient required and could recognise any deterioration or deviation from expected pathways in a patient's health.
- Where appropriate nurses conducted risk assessments with patients in line with national guidance. These included falls risk assessments, early warning scores and malnutrition universal screening tool (MUST).
- Patient records were electronic and could be viewed and updated on the tablet computers carried by staff. This also meant that notes and records could be viewed remotely by supervisors or care bureau staff if advice or guidance were needed. The tablets also had clinical pathways and contraindications which meant staff could review the patients' health against

expected outcomes. Care Bureau staff could review patient's records and see up to date nursing information, risk assessments and monitoring tools, if contacted by staff or patients.

- Risk assessments were completed when patients were accepted by the service. These were reviewed following any changes in health and periodically for long term patients. We saw examples of the risk assessments and reviews in the electronic patient records.
- Staff provided patients and their carers with information booklets relative to their condition and the treatment they were receiving. The booklets; which were produced by the provider, contained guidance on what to do if they felt unwell including contact numbers for the provider's Care Bureau.
- Care Bureau was staffed by a combination of healthcare workers and qualified nurses. Calls were screened to ensure that where clinical advice or guidance was sought, an appropriately skilled member of staff dealt with the call. We observed Care Bureau staff receiving calls and providing appropriate support and guidance.

**Premises and equipment**

- Care was delivered in the patient's own home. Risk assessments had been completed prior to patients being accepted for care to ensure that facilities were suitable for the type of service required. We were told that if staff were not happy that care could be provided safely due to the environment they would refer the patient back to their consultant or GP for alternative services.
- We reviewed information relating to reasons why patients were not accepted by the service when referred by the NHS providers. We saw that reasons included concerns over the ability to provide the services safely in the patient's home which confirmed what staff had described.
- The provider had a number of storage locations where staff could access or request equipment from. Staff we spoke with told us they had never experienced difficulty obtaining equipment or arranging service or replacements.
- We saw staff checking and cleaning equipment such as syringe pumps and lines; prior to and following use in patients' homes.
- Computer tablets carried by all nursing and health care staff were password protected to prevent unauthorised access to personal and medical information. Senior staff explained how the tablets do not store information but act as a monitor and link to the services main computer system. This meant that if a tablet were mislaid or stolen confidential information was still protected.

**Safe and effective use of medicines**

- The provider had a number of policies in relation to the manufacture, storage, dispensing, delivery and administration of medicines. Staff understood how to access the policies if they required information or guidance.
- Patients confirmed that nursing staff had fully informed them about their medications and had advised them regarding safe use and storage in the home. We observed staff as they administered patients' medication, including intravenous procedures and compliance with aseptic technique. We saw how nurses confirmed the identity of the patient against the prescription details on the drugs packaging. Checked expiry dates, dose levels and frequencies with the patient prior to given the current dose.
- The provider had 15 locations where medications were stored and distributed. These facilities were inspected by the General Pharmaceutical Council (GPhC) and Medicines and Healthcare Products Regulatory Agency (MRHA). Inspections took place on a monthly basis and rotated round the different locations. We saw records of these inspections and saw how the provider responded to any issues highlighted in order to ensure medicines were stored and distributed safely.
- Medicines deliveries had caused issues for the provider. In 2013, the provider outsourced the warehousing and delivery of medicines to an external provider. Following the outsourcing, the number of incomplete, late or failed deliveries increased which had an adverse effect on patient care.

# Location

- Following an inspection by the General Pharmaceutical Council (GPhC) and involving the Medicines and Healthcare Products Regulatory Agency (MHRA), NHS England and the CQC pharmacists, an action plan was put in place and the problems were resolved and the delivery service was brought back 'in house'.

## Is the location effective?
(for example, treatment is effective)

**Assessment and treatment**

- All patients who were referred to the service received an initial assessment which ensures that the patient could be safely supported. This included their medical history, general health, mental capacity and treatment based issues. Patients' health and wellbeing were monitored and fluctuations outside expected levels were appropriately escalated.
- The service is able to provide 1,700 different treatments across 49 medical therapies.
- The service provided Systemic Anti-Cancer Therapy (SACT). All organisations providing cancer chemotherapy services in, or funded by NHS England are required to provide statistical information. Healthcare at Home did not supply data directly to SACT but the information was collected for this data set through the NHS trusts where the patient had originally been seen.
- The service leads met with NHS managers during which all aspects of patient care and anticipated outcomes were discussed.
- Chemotherapy training was available to nurses and the provider had a lead clinical facilitator who was available for advice or support.
- Staff used the national oncology pathway grading system for the triage of patient symptoms and side effects.
- Healthcare at Home provided statistical information to pharmaceutical companies regarding the use and effects of drug therapies. The company used their incident reporting system to record this data. We saw from the records how even minor changes to a patient's health or wellbeing were recorded, staff told this information was used by the pharmaceutical companies to develop new treatments or improve current treatments.
- In 2016, the provider completed a comprehensive review of the treatments and services offered. This was in preparation for the introduction of the computerised allocation system. All 1,700 treatments were reviewed by clinical staff against national best practice. Three workshops were held involving 18 senior clinicians including nurses, clinical managers, heads of therapies and regional clinical operations managers. The review provided insight into compliance with best practice and recognised pathways of care, the skills and qualifications required by staff in order to deliver each treatment and the time required to safely deliver each treatment.
- The system was trialled in another of the provider's registered locations, Bristol. Of the 1,700 treatment pathways, only three were found to require amendment. An example of an amendment involved an intravenous procedure to which a patient had an adverse reaction. After further review and consultation with the patient's consultant, the procedure was extended from three-hours to five-hours to enable the patients system to cope with the toxicity of the drugs.
- Nursing staff had easy access to information including medical alerts, care pathways, advances in treatment plans through their hand held computer tablets.
- Care Bureau staff used recognised tools when taking calls from patients; this included the United Kingdom Oncology Nursing Society (UKONS) on**TriageTool.**
- Between 1 January and 28 November 2016 the Care Bureau had taken a total of 70,845 calls.

**Staff training and experience**

- All qualified nurses and healthcare workers (100%) had completed their mandatory training.
- The provider recorded appraisal compliance using a combination of mid-year and full year appraisal meetings and completion of objectives. Appraisals were spread throughout the year and usually occurred on the six month and 12 month anniversary of employment. This meant appraisal rates increased. Information from the provider showed that in

November 2016 complete appraisals 63% of staff in the East Midlands area had completed appraisals and 61% in the West Midlands. Completion of end of year objectives by all staff was 88%.

- Clinical supervision of nursing staff took place monthly. We reviewed five sets of nursing quality audits, completed during the clinical supervision. The audits identified 25 areas which staff were required to comply with. We saw that staff received appropriate support and guidance if they failed to meet any of the standards. Supervisor's notes included commendations, recommendations, which clearly outlined why an area had not been met and action plans which informed the member of staff what they needed to do to comply.
- Qualified staff were supported to re-validate with their professional body. At the time of our inspection, a nationally recognised body accredited 100% of qualified nursing staff and therapy staff.
- Staff were supported to complete relevant additional training to improve their knowledge and skills. We saw how the new allocations system had identified geographical skills gaps; areas where patients required certain treatments but staff local to the area were not able to provide. This meant staff from other areas had to travel long distances to meet clients' needs. As a result, local staff were identified and provided with additional training.
- Care Bureau staff included qualified nurses and were available 24 hours a day, seven days a week for patients who had concerns or required advice or support. The bureau was also available for trained staff to contact if they needed to.

**Working with other services**

- Contracts with NHS acute hospital trusts included clear guidance on acuity of patients who could be taken on by the service and processes to enable deteriorating patients to be returned to hospital. Healthcare at Home worked closely with a number of NHS acute hospitals to provide a managed discharge for patients who were well enough to be discharged from an acute environment but required a short period of additional support to enable them to manage outside the hospital. Patients cared for in this way, remained under the care and supervision of their hospital consultant but received their nursing care at home. We saw documentation which showed how senior staff from Healthcare at Home and the respective hospitals met regularly and reviewed the service provided.
- Nursing staff also worked alongside other health providers such as district nursing teams, G.P.'s and private health insurers to provide a range of services from complex nursing support through training patients or their carers in the administration of medication to delivery of medication. We saw how standard operating procedures were developed for each type of service which included liaison with other providers where appropriate. Patients were given care booklets which contained information about the services they were receiving and nursing notes which might be useful to other services.

**Consent to care and treatment**

- Consent forms were signed by patients at the start of any course of treatment. We saw that consent forms had been completed in patient records when we visited their homes. When nursing staff attended a patient in their home, they had to update their electronic records which included a reference to consent.
- Parental consent was sought for treatments for children. Staff were aware of, understood and implement the principles of Gillick competence where appropriate. Gillick competence is a term used in medical law to decide whether a child (under 16 years of age) is able to consent or object to his or her own medical treatment, without the need for parental permission or knowledge. We were told that children of all ages who were able to understand had their treatment explained to them and asked to consent in the same way that adults were, we observed this in practice during one of the home visits with staff.
- We observed staff explaining to patients what they were intending to do and asking patients' permission to continue. In most cases treatments were repetitive and staff could explain that the treatment was 'the same as last time', which patients understood and nodded or expressed their consent.

# Location

- Patients confirmed that they were fully informed about treatment plans and procedures and staff always confirmed at each visit that it was in order for them to proceed.
- Nursing staff had received awareness training in the Mental Capacity Act and they told us that they understood how to recognise if a patient lacked capacity. The nursing documentation included a section for staff to complete regarding the patients capacity to make decisions about their health care. However, we were not confident that staff fully engaged with the process, as there was no prompt to identify changes in mental capacity over time.
- Patients who received medication deliveries and some who received nursing care had done so for a considerable number of years. The provider did not have a comprehensive system to monitor deterioration of patients' capacity over time to ensure that patients who might develop dementia or other memory loss issues received appropriate ongoing care. We raised this with senior staff and they undertook to review the processes and look at how they could recognise and support such patients in the future.
- Patients who had returned home from hospital under the care of their consultant tended to be those who had reasonably good physical and mental health other than the condition which they had been hospitalised for. Such patients were only cared for over short periods of time before being discharged. The selection process for these patients would in most instances prevent patients who lacked capacity from being selected.

## Is the location caring?

**Respect, dignity, compassion & empathy**

- We saw outstanding levels of care provided by nursing staff to patients in their homes. Staff were respectful, polite and considerate. Care was personalised with staff displaying empathy and compassion towards patients and their loved ones.
- During our observations we heard how staff empathised with patients who were concerned about their long term health. We heard staff and patients exchanging light hearted conversation and chatting about families and holidays.
- We saw how staff remained professional and caring whilst being approachable and friendly.
- Patients who had left hospital early to be cared for at home told us they could not describe the difference in care and attention they received. They described how the Healthcare at Home nurses had time with them, explained things and were supportive.
- As patients were in their own homes, issues around privacy and dignity were easier to control. However we saw and heard how nursing staff ensured that patients were comfortable to receive treatments with other family members present, or they provided treatments away from the rest of the household.
- NHS Friends and Family test audit results in respect of the providers NHS Projects patients indicated that overall satisfaction with their experience of the service was 100% Excellent.
- Satisfaction with the quality of nursing care responses showed that 14.3% were satisfied and 85.7% were very satisfied.
- Likelihood that patients would recommend the service to family and friends if they required a similar care or treatment was 20% likely and 80% very likely.

**Involvement in decisions about care and treatment**

- Patients and their carers told us how they had been fully involved in decisions about their care. They described how they had initially come to be clients of Healthcare at Home, how they could influence their care through consultation with their consultant or GP and how they could change or rearrange home visits to suit personal commitments.
- Patients confirmed that they had been provided with detailed information about their condition and the effects of any treatment or medications. They understood how to identify if they suffered effects outside the expected treatment regime and who to contact if they needed advice or assistance.

# Location

- Patients were always asked about their health since they had last been visited and concerns or queries were answered openly by staff.

## Is the location responsive to people's needs?
(for example, to feedback?)

### Responding to and meeting patients' needs

- The service operated three main services; "NHS Projects", "On Demand" and Paediatric services. NHS Projects were contracts with NHS acute hospitals enabling patients who had required acute services but were well enough to be cared for at home, to leave hospital. This benefited patients as they were able to return home earlier and receive safe and appropriate care whilst remaining under the clinical oversight of their consultant. On Demand services provided on-going support or long term support for patients referred by their GP or private health insurer. Both services provided treatments and services to meet the needs of individual patients. Paediatric services were centred on children from birth to 18years who had long term conditions.
- The service provided a wide range of care and treatments covering 1,700 treatments across 49 therapy areas. This meant that services could be provided to a broad spectrum of the community, including those with multiple or complex needs.
- Transition services between paediatric and adult services were relatively seamless, with patients being transferred from the paediatric team member to an adult team member. Joint visits were undertaken to introduce new staff. Most procedures were a continuation of what patients had been used to.
- Patients who received medication deliveries were able to arrange delivery to their home, place of work or to a named representative. Patients were contacted when deliveries were due to be made and given a time window which the delivery was expected to be made within. Patients could request alternatives if they wished to.
- The allocation system included the ability to set time sensitive visits where patients required repeat medications within a strict time limit. The same functionality enabled patients to request visit times in line with their personal, work or social patterns.
- Some patients with a learning disability or those with dementia or other memory problems were supported and staff were able to provide examples of such patients. However the selection procedure for patients meant that patients with these conditions were often not referred to Healthcare at Home services. We also had concerns that patients who received support from the service on a long term basis may develop dementia or their condition may deteriorate but the service did not have a process to monitor and respond to any such development. We discussed this with the provider and they undertook to review how they might improve their monitoring systems.

### Tackling inequity and promoting equality

- Services were available to people from all areas of the community, patients were able to make personal preferences about their care, this included taking account of religious and cultural beliefs and practices.
- Comprehensive translation services were not available. Patients who might have difficulty communicating such as those who were hard of hearing or where English was not their first language needed to have their own support in place to ensure that services could be provided safely.
- Senior managers told us the service was looking at ways to support a wider spectrum of disabilities without patients needing to arrange support independent of the service. This included people who were deaf or partially sighted and those with more complex learning disabilities.

### Access to the service

- Referral to the Healthcare at Home services was from a number of sources. A large number of patients required only the delivery of prescribed medication which they were able to self-administer, others required instruction and competence checks to enable them to go on to self-administer and others were dependant on nurses administering medication and providing other nursing services.

# Location

- Patients were referred by their GP, hospital consultant or private health insurance. In addition some NHS hospitals had Healthcare at Home nurses working in the hospitals to enable them to assess patients and offer them the home service as an alternative to hospital admission or to speed up their return home.
- We were told that there were no waiting lists for patients wanting treatment. New patients were added to area teams and absorbed into the demand. If demand increased sufficiently additional staff would be recruited. Managers explained that they had also had to lay nursing staff off when one NHS project ended and the contract had not been renewed.
- We were told that appointments are sometimes cancelled due to staff sickness, unexpected emergencies with other patients or other problems such as breakdowns or traffic problems. We did not review the number of cancelled appointments; however, we were led through the systems used by managers when unexpected issues arise. The projected caseload for the member of staff concerned is highlighted to their manager. The manager reviews the clinical needs and support required by each patient and prioritises them accordingly. Where possible they re-allocate patients to other members of their team for visits the same day. If specific treatments are required which are outside the skill base of the staff available they are passed to neighbouring teams. All patients involved including those of other staff whose visit may be delayed are contacted by telephone to advise them of the delay. This occasionally resulted in less critical appointments being cancelled and completed the next day. We were assured that virtually all cases were seen on the same day, albeit outside the originally agreed time band. All visits were recorded in real time when staff attended patients homes and updated their tablet computers.

**Concerns & complaints**

- The provider had a complaints department with two complaints coordinators and a complaints manager.
- Complaints systems had changed following a major breakdown in services in 2013. At that time the provider had, at short notice, taken on an additional 10,000 patients following the collapse of a similar provider and was outsourcing the medication warehouse and delivery services. The new warehouse/ delivery service proved less reliable than the original in house service. Deliveries were late, missed, or left in inappropriate locations. The additional customer base also created an increase in concerns and complaints for which the provider was not prepared. There were insufficient telephone lines or call takers to cope with the volume of complaints being made. This meant patients with queries or failed deliveries were unable to contact the provider. At one point during this period, the service had over 6,000 outstanding complaints.
- As a result of increased complaints to regulators the General Pharmaceutical Council (GPhC) led a joint inspection of the service in 2013. The inspection included the GPhC, Medicines and Healthcare products Regulatory Authority (MHRA), NHS England and the CQC pharmacy inspectors. Following the inspection the provider produced an action plan which included the recruitment of additional call centre staff to receive complaint calls.
- The provider also introduced a quality manual for complaints staff to follow. This sets quality issues for each section of the complaints process and enables managers to assess the quality of investigations and responses from each member of staff.
- At time of our inspection complaints were answered within two days of receipt this is better than the NHS guidance which requires responses within three days. Complainants were provided with a named case worker for them to contact if required. The service received an average 130 complaints per month, the majority relating to issues surrounding the delivery of drugs.
- We saw evidence of how the complaints system had been used to improve services. One patient had a number of health issues and saw several different consultants each of which prescribed medication through Healthcare at Home. Prescriptions were received at different intervals from each consultant. This meant the patient was being contacted three times and had to be home to accept deliveries on three separate occasions each period. As a result of the patient complaining to Healthcare at Home, a member of the complaints team made protracted enquiries with the different hospitals and consultants.

After some initial reticence the consultants reviewed the medications and prescription times. This resulted in all the prescriptions being issued at the same time and at the same frequency; reducing deliveries from three to one.

## Is the location well-led?

### Leadership, openness and transparency

- Managers at all levels of the organisation had a clear understanding of their role, they understood the staff they had working for them and knew how to support them. There were clear lines of seniority but the organisation ran without a hierarchical influence. Staff at all levels were treated with respect and reciprocated in kind.
- Schedulers who support staff with the allocations system were aligned regionally which meant they built good working relationships with local managers and understood each other's role and needs. Managers were able to request changes to schedules for individual nurses or to cover unplanned absences.
- We saw how Nurse Quality Audits not only highlighted areas for improvement but also contained a section where the supervisor could comment on good practice. We saw audit sheets where both good and poor practice had been highlighted. This demonstrated how the provider encouraged a balanced and fair management system.
- We found all staff we spoke with to be open and honest. Whilst there were clear lines of authority we found that there was a non-hierarchical culture. Staff told us that they were able to raise concerns if they needed to and could do so without fear of retribution.
- Individual nursing staff understood the need to be open and honest with patients. They told us that they believed they had always done so.Nurses were able to describe incidents where they had apologised to patients, these included when they had arrived late for appointments, or if they had caused discomfort when providing care or treatment.

### Governance arrangements

- Healthcare at Home Limited's Vision 2020 set out the purpose and mission of the organisation moving forward. Summarised as, "inspirational healthcare in the home for millions worldwide". The company aspired to be caring for two million people in homes across the world by 2020.
- The four main elements of Vision 2020 were to increase the number of people cared for, embed operational excellence and safety, to be market leaders in setting improved standards in care and service and to create a performance culture that engaged all Healthcare at Home staff. We saw evidence of the strategy being put into practice; over a number of years the business had outgrown their original accommodation and due to expansion had taken over a number of separate units. The service was due to move most of the business from these units into one newly acquired premises during early 2017. We also saw how the planned upgrade to the allocation system had taken place.
- Governance structures were in place which enabled executive oversight of the systems and processes. Board level service leads oversaw and had responsibility for areas including finance, human resources, legal, information technology, commercial, marketing analytics and innovation and operations.
- Clinical operations were led by the clinical director who was a board member. The clinical director was interviewed as part of the inspection process, and described the governance process and how this was used to promote change and improvement in services. Regional clinical directors reported to the clinical director and in turn were supported by teams of managers and supervisors including the services registered managers. Team meetings were held at each level and issues and information were cascaded between the levels at each consecutive meeting.
- Registered managers understood their role in promoting the vision, values and purpose of the organisation. They told us they felt supported by senior managers and executives and believed that systems were in place to enable staff to deliver the companies goals. Managers understood their staff and provided an environment which enabled them to support their patients
- We saw evidence of an effective governance framework which supported the delivery of the

strategy and good quality care. The provider received referrals from either NHS Trusts or Private Medical Insurance Consultants. As an independent provider, these bodies would be seen as the commissioners of the services provided. They monitored the outcomes of treatments as did the consultants.

- We saw evidence of meetings between senior Healthcare at Home staff and staff from the commissioning organisations. Minutes showed how all aspects of the service were discussed including adherence to contract, compliments and complaints and incidents.
- Staff we spoke with understood their role and how they contributed to the organisations vision.
- Registered managers reported to the director of nursing and to the head of clinical governance who in turn reported to the operational quality meeting. The information from here was relayed to other committees for example the quality committee which in turn reported to the Healthcare at Home board. We saw evidence of issues discussed and recorded at all levels of the organisation which were initiated in nurse team and clinical meetings.
- Systems were in place which enabled senior managers to monitor and assess performance. These included; monitoring adverse incidents, audit of nurse quality indicators, audit of patient records and medicines quality assurance meetings.
- There were arrangements for identifying, recording and managing risks and actions that need to be taken. Risks to services tended to be service wide with exception of the providers Bristol location where additional services were offered which carried local risk. Risks included continuity of services whilst transferring staff equipment and processes to the new site. Introduction of the allocation/scheduling system. We saw how interventions to mitigate risk were included such as fall back procedures to enable allocation staff to use the paper based system in the event of issues with the electronic system. Historic risks had included the outsourcing of medicines delivery.
- Risk registers were maintained locally by managers and had been set up to reflect CQC domains' This meant that when risks were recorded they were assessed as affecting safety, effectiveness, caring, responsiveness or well led aspects of the service. Senior managers described this as enabling staff to focus on the risk affected the service and how it could be mitigated. More serious risks were recorded on the corporate risk register. These included staffing and expansion of the care bureau, and following our inspection inclusion of the Duty of Candour process.
- Risk was overseen by the clinical governance committee which include the head of clinical governance and representation from the board.
- Individual teams met regularly using dial-in or video conferencing.
- The provider used a system of 'Drum Beat' meetings to ensure that all teams within the organisation had relevant up to date information about their area of work and any potential impact from other areas of business. Drum beats took several forms from face to face exchanges where staff were present to telephone or video link exchanges where staff were remote from each other. Weekly drum beats which summarised topics and issues identified were recorded and distributed electronically. Formal governance meetings took place and we reviewed minutes of these meetings.
- There was no system to monitor the number of calls which were missed by Care Bureau staff; therefore there was no analysis available to properly assess staffing levels. Managers in the department told us there was no documented procedure for assessing the workload, and requests for additional staff at busy times had resulted in temporary assistance from other departments by untrained staff which meant they had limited impact. However we were told that a review of the Care Bureau and it strategic future was planned for February 2017 at which time these issues were due to be addressed.
- The Regional Clinical Operations Managers were also registered with the CQC as registered managers. However; rather than each having a location over which they were responsible, they each had a speciality such as paediatrics or number of roles which supported the organisation to operate its own model of care but also complied with the providers legal regulatory requirements.

# Location

**Learning and improvement**

- We saw how changes had been introduced to the management structure, policies and operating procedures following the issues the service had faced in 2013.
- The provider had Investors in People accreditation at bronze level and at the time of our inspection were awaiting the outcome of an application for silver. Investors in People is an independent accreditation service. They describe their standard as "…the standard for people management. Our standard defines what it takes to lead, support and manage people for sustained success".
- Prior to the implementation and roll out of the computerised staff allocations system, senior managers involved in the project attended clinical team manager meetings to inform staff of the changes and how they would impact on practice.
- Clinical Managers were given a target to audit five sets of clinical notes per month. It was noted by one of the managers when auditing the notes that the completion of consent and patient assessment documents were not comprehensive enough. They communicated the shortfall and set out the required standard in e-mails to the team and at team meetings. They also devised a simple audit tool specifically looking at these two areas of the patient record and from that were able to identify individuals who required more training, which was then provided. They shared the findings and demonstrated the audit tool with their peers; as a result the audit tool was taken into use throughout the service.

**Provider seeks and acts on feedback from its patients, the public and staff**

- The provider held annual staff conferences over a number of days. All staff were required to attend one of the dates. These conferences were used to celebrate achievement and to update staff regarding the different areas of the service how they had developed and plans for the future.
- Staff we spoke with told us that Healthcare at Home was the best employer they had ever worked for. The felt supported and engaged.
- Patient feedback was able to be directly input by nursing staff using the computer tablets. Patients or their relatives or carers were also spoken with by the supervisor during clinical supervisions of the nursing staff. This provided assurance to supervisors that the treatment and interactions they observed were consistent throughout all visits by the nursing staff.

# Outstanding practice and areas for improvement

## Outstanding practice

- We saw outstanding levels of care provided by nursing staff to patients in their homes. Staff were respectful, polite and considerate. Care was personalised with staff displaying empathy and compassion towards patients and their loved ones.
- The electronic staff allocation system represented an outstanding programme which ensured that only staff with the appropriate skills and qualifications were allocated to each patient. The system used complex algorithms to identify the most appropriate staff to allocate to each patient, the most appropriate order in which to visit based on clinical need and location, and the most appropriate route to take between locations.

## Areas for improvement

### Action the provider MUST take to improve

The provider must:

- Ensure that they have adequate systems in place to fulfil their obligations of Duty of Candour in accordance with Regulation 20 (1-9) Health and Social Care Act 2008 (Regulated Activities) 2014

### Action the provider SHOULD take to improve

- Review processes to recognise and support patients who have or who go on to develop dementia or other cognitive impairment during the period they receive treatment. This is something which does not breach a regulation but which would improve the service available to such patients.
- Review staffing levels in the Care Bureau to ensure sufficient numbers of suitably skilled and trained staff are available to meet the current and proposed workload.
- When dealing with complaints and Duty of Candour investigations the provider should ensure that responses are given in the spirit of openness and transparency. Notifications should be given 'In Person' by a representative of the provider and apologies should be an expression of sorrow or regret in respect of the incident itself.

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 20 HSCA (RA) Regulations 2014 Duty of candour<br>**How the regulation was not being met:**<br>The provider failed to meet the requirements of:<br>Section 3(a) in that a representative of the company was not providing notification 'In Person' to the relevant person.<br>Section 3(d) The provider did not provide an 'apology' as defined by Section 7. |