Pharmaxo Pharmacy Services Limited

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Inspection report

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Date of inspection visit: 19 October 2021
Date of publication: 15/12/2021

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

Summary of findings

Overall summary

Pharmaxo Pharmacy Services Limited is a provider of clinical homecare services, specifically the delivery of medicines to patients in their own home. The service also provide nursing support to train and/or administer the medicines where required.

We rated this service as good because:

- The service ensured it had enough staff to care for patients and keep them safe. The number of nurse-led services (medicines administration that required the attendance of a nurse) had significantly increased over the last 12 months and there was an action plan in place to increase recruitment. The service did not set up new nurse-led services with NHS trusts if there was not enough staff to care for patients and keep them safe.
- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risks well. Staff assessed risks to patients, acted on them and kept good care records. Staff completed competency assessments for the administration of medicines prescribed and managed medicines safely. The service managed incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- The service completed clinical pathway meetings with referring services, which detailed the service specific requirements. The referring clinical teams were responsible for monitoring the effectiveness of treatment and patient outcomes and the service worked effectively with these external teams to provide good care and benefit patients.
- The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care. Staff supported patients to make informed decisions about their care and treatment. The service made sure staff were competent for their roles.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and helped them to understand their conditions. They provided emotional support to patients. The patients we spoke with were happy with their care and described the service as 'amazing' and 'efficient'.
- The service planned and provided care in a way that met the needs of the communities it served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- People could access the service when they needed it and received the right care in a timely way.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learnt with all staff. The service included patients in the investigation of their complaint.
- Managers were approachable, supportive, and had the skills and knowledge to ensure patients received a quality service. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

However:

- Not all staff received regular clinical supervision from their managers. Although managers completed field visits to observe staff competence and provide support, the regularity of these were inconsistent and some staff told us that they did not receive clinical supervision. However, the service had developed a clinical supervision policy the day before the inspection and were due to implement this for registered nurses.
- Although managers were proactively trying to recruit more nurses, demand for the service had grown significantly in recent months. Nursing staff told us they worked long hours and some overtime and would benefit from more staff.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for adults	Good	

Summary of findings

Contents

Summary of this inspection

Background to Pharmaxo Pharmacy Services Limited

Pharmaxo Pharmacy Services Limited is a provider of clinical homecare services, specifically the delivery of medicines to patients in their own home. The service also provide nursing support to train and/or administer the medicines where required, and the provision of information to patients to support self-administration of medicines at home.

Clinical homecare is a term used to describe care and treatment that takes place in a person's own home, including nurses administering essential medicines. The aim of clinical homecare is to minimise the need for patients to attend an acute hospital setting for their treatment.

The service provides clinical homecare nationally and has regional nursing teams across England.

The service registered with the Care Quality Commission in 2017. The service is registered to provide the following regulated activity

- Treatment of disease, disorder, or injury.

The regulated activities were relevant to the nurse-led services in people's homes (or suitable community locations) that involved support with self-administration or nurse-led administration of the medication.

The service also dispensed, delivered and provided training in the administration of medications and these services were regulated by the General Pharmaceutical Council (GPhC). The pharmacy aseptic services (sterile, controlled environments in which highly trained and qualified staff prepare injectable medicines for IV administration such as antibiotics, chemotherapy and monoclonal antibodies, as well as nutrition, and also medicines for cell therapy and clinical trials) were regulated by the medicines and healthcare products regulatory agency (MHRA).

At the time of this inspection the service had a registered manager.

We had not inspected this service before.

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?

Summary of this inspection

Before the inspection visit, we reviewed information that we held about the service. This comprehensive inspection was announced 24 hours prior to the inspection visit. Due to the service providing services throughout England, we announced the inspection to enable the service to arrange interviews and identify potential nursing visits that the inspection team could accompany staff on.

During the inspection visit, the inspection team:

- spoke with the registered manager
- spoke with three patients
- spoke with 15 staff members, including registered nurses and pharmacists
- looked at five patient care records
- observed one nurse visit in a patient's home
- reviewed incident reports and the lessons learnt from these
- looked at a range of policies, procedures and other documents related 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 SHOULD take to improve:

- The service should ensure that nurses receive consistent clinical supervision in line with the new service policy.
- The service should ensure that a comprehensive and complete record is documented following clinical pathway meetings.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Community health services for adults

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

Are Community health services for adults safe?

Good

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Staff received face to face and online training, and completed competency assessments. Managers had access to a training matrix and could monitor compliance and identify when training was due. The service used an online system to assign policies, guidelines and standard operating procedures to be read by staff. Managers monitored completion of this, and received an update if staff were overdue.

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. All staff completed safeguarding training level 1 and 2, and managers completed level 3.

There were no safeguarding concerns reported to CQC in the twelve months before inspection.

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.

Prior to visiting patients in their home, staff completed a checklist over the telephone to confirm patients were well. Staff followed infection prevention and control guidance on good hand hygiene, use of personal protective clothing and aseptic techniques (using practices and procedures and applying strict rules to minimise the risk of infection).

Environment and equipment

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

Good

Community health services for adults

We visited the main offices and dispensary unit for the service, which were fit for purpose and well maintained. The care regulated by CQC was delivered in the patient's own home. Risk assessments had been completed prior to the patients being visited to ensure that facilities were suitable for the type of service required.

All staff had access to the equipment they needed and were aware of the process for escalating faults with equipment, and routine servicing.

Assessing and responding to patient risk

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

The referring clinical teams and NHS trust homecare teams completed risk assessments and assessed suitability for clinical homecare prior to referrals. Staff completed an initial risk assessment during a fitness to proceed phone call prior to their first visit. During the first visit to a patient's home staff completed a risk assessment, which considered the home environment, lone working, and needs of the patient.

Staff ensured that they had confirmation of patient allergies and carried adrenaline medicines with them during visits, for use in the event of adverse reactions to medicines (anaphylaxis).

Staff completed physical observations of patients prior to treatment, as necessary. Staff reported any concerns or risks to the referring clinical team through a patient visit record. Staff documented and reported any adverse drug reactions, or events, in line with national guidance.

The service did not accept patients who were assessed as being a risk to others, as they would not be considered suitable for clinical homecare. Staff entering patients' homes carried lone worker devices and could contact the service or emergency help, if necessary.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm.

In response to a rise in demand for the service, the provider was in the process of recruiting more nurses. Nursing staff told us that the current staffing ratio was manageable but that they were working long hours and often worked overtime to ensure patients received their treatment at the right time.

Managers told us that services would not be agreed with NHS trusts and other referring organisations if there was not enough staff to provide safe care.

Managers completed a weekly planner to ensure staffing capacity and schedule patient appointments.

Staffing risks were discussed during quality review and managers meetings. Managers had updated the service risk register and recruited a recruitment lead to help manage this risk.

Records

Good

Community health services for adults

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care. The service had developed a bespoke electronic record keeping system and all staff had access to this. Staff carried personal password protected laptops with them and could access relevant documents from a patient's home. Staff completed feedback on patient visit forms following every home visit and these were sent to the patients' referring clinical team.

The service did not have access to patients' full medical records with the exception of, individual patient details (name, address, contact details, medication prescribed), this was treated as personal and/or sensitive data.

Records we reviewed were clear, up to date and easily available to authorised staff. Staff recorded information in a clear and accurate way which included patient consent to treatment.

Records were securely stored.

Medicines

Staff followed systems and processes when safely prescribing, administering, and recording medicines. Staff followed national practice to check patients had the correct medicines.

The service did not accept referrals and prescriptions without verification that a clinical pharmacist from the referring team had checked the patient's medical history and any necessary blood tests and clinical checks. Staff also ensured that they received the patient's diagnosis and a list of any allergies or known sensitivities to medicines at the point of referral.

Pharmacists checked the medicine strength, dose and route was appropriate for the patients and communicated any concerns back to the responsible clinical team. Staff gave a recent example of raising a concern to the clinical team.

Medicines stored on the pharmacy premises were stored in line with national guidance and processes were in place to ensure medicines were stored at the correct temperature and expiry dates checked routinely.

Incidents

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

The service had a quality team who triaged all incident forms submitted by staff and ensured any immediate actions had been taken before allocating staff to investigate. The service had processes in place to ensure incidents were investigated and contributory or root causes identified. The outcome of investigations included lessons learned. Managers attended a weekly meeting to discuss the necessary corrective and preventative actions following investigation of incidents. These actions were discussed and progress towards them monitored through the weekly meeting.

Staff received feedback from incident investigations through a quality risk dashboard and weekly team meetings.

Good

Community health services for adults

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 were aware of this duty and the need to be open and honest with patients where incidents occurred.

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. Staff protected the rights of patients in their care.

The service was part of the National Clinical Homecare Association (NCHA). The NCHA represents and promotes organisations whose primary activity is to provide medical supplies, support and clinical services to patients in the community.

Clinical screening including physical health assessment and suitability for clinical homecare. These were completed by the referring clinical team prior to referral to the service. Staff did not receive information on the patients' medical history other than their allergies and diagnosis. The referring service were responsible for ensuring they followed the Royal Pharmaceutical Society's standards for homecare services. The service reported that some NHS trusts did not always follow these guidelines and therefore staff would escalate this and ensure that the correct clinical screening and verifications took place.

Staff followed administration guidelines for medicines set out by the manufacturers of the medicines. Staff also kept up to date with and followed relevant National Institute for Health and Care Excellence (NICE) guidelines. Staff had access to a standard operating procedure for each treatment offered. Managers assigned new standard operating procedures or medicine guidelines for reading to staff through an online system.

The registered pharmacy complied with guidelines from the General Pharmaceutical Council and Medicines and Healthcare Products Regulatory Agency.

Patient outcomes

Patient outcomes were captured and reported within annual key performance indicator reports provided to the National Homecare Medicines Committee (NHMC). This included data on safeguarding, adverse medicine reactions, duty of candour, and patient safety incidents. Further key performance indicators were captured around prescribing, caseload and financial returns.

The patient's clinical team from the referring organisation was responsible for monitoring treatment outcomes. Staff completed patient visit forms after every visit and sent these to the responsible team. Staff monitored for any adverse medicines events or reactions and reported and escalated these appropriately.

Managers provided examples of staff supporting patients to become more independent with administration of their medicines. Staff assessed the suitability of clinical homecare and took action to resolve any issues, such as difficulties with use of cannulas.

The service had previously completed annual National Homecare Medicines Committee approved patient satisfaction surveys and received positive feedback. However, these were suspended during the coronavirus pandemic due to only being available as paper copies and had not been restarted at the time of inspection. An updated version of the survey had been developed and the service were awaiting availability of this in the Welsh language, so that it could be sent to all patients under the service at the same time. The service used a 'net promotor' score to monitor patient satisfaction. Staff requested patients to rate the service from 0-10 following each visit. This process did not include a free text field for patients to provide further feedback or an explanation for their score.

Managers had also sent and evaluated patient satisfaction surveys to provide feedback to specific NHS trusts on the experience of referred patients.

The service was one of four providers to provide clinical homecare for rare diseases (lysosomal storage disorder) under an NHS England contract. The lead nurse for rare diseases attended regular service reviews with referring trusts, and an annual rare diseases meeting with NHS England that all specialised treatment centres attended and provided feedback to.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and provided support and development opportunities. However, the service did not have a clinical supervision policy in use at the time of our visit, and staff told us that they did not receive supervision consistently. The service did not keep a record of clinical supervision compliance but did record the number of patient visits that were observed by nurse managers (field visits). All staff had been observed in practice and discussed this review on at least one occasion in the last 12 months. Staff attended weekly team meetings and felt able to raise concerns with their managers.

During induction, staff were supported by their managers through shadowing, observation, three personal development reviews and appraisal. Managers supported and supervised staff following induction, through 1:1 meetings and observing patient visits. Observation of patient visits was outlined as a responsibility in the lead nurse job role specification and provided an opportunity for clinical supervision. However, managers and staff told us that a high caseload had contributed to the regularity of these meetings being inconsistent and not in line with service expectations. However, all staff felt able to seek support and guidance as needed.

Managers completed six monthly appraisals with staff. The service appraisal process included a personal development review, a reflective piece of work completed by the staff member and identification of future development objectives and opportunities.

Staff completed mandatory training and competency assessments and could access bespoke training and development opportunities. Managers and lead nurses assessed staff competencies through observation and reviewing self-certifications. Nurses completed competency documents for each therapy that they were required to administer. These were reviewed annually as a self-certificate and reassessed every two years.

There were systems in place to manage poor performance and managers provided support through performance management processes.

Good

Community health services for adults

Nurses attended an annual study day for learning around rare diseases.

Multidisciplinary working and coordinated pathways

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

The service had access to registered nurses, including specialists, pharmacists and dispensary pharmacists. In addition, there were staff in quality, administration, and patient services roles.

Nurse managers and the pharmacy team worked effectively with referring services and clinical homecare teams within NHS trusts. The service ensured clinical pathway meetings took place, before providing services, to plan homecare services and the documentation of these were signed off by the referring organisation. During clinical pathway meetings the service discussed types of service to be provided, physical health observations that needed completing, leeway for delayed administration of medication, and communication pathways to escalate queries, or escalate concerns about patient's physical health.

The nurse for the rare diseases service attended monthly service reviews and provided feedback on all patients on the caseload.

Health promotion

The service did not take part in formal or specific health promotion activity with patients.

The service worked closely with the patient's responsible clinical team to maximise patients' independence in managing the administration of their own medications.

For patients receiving enzyme replacement therapy from the rare diseases team, staff attended service reviews and discussed patients who were motivated to become more independent with their treatment.

Consent and mental capacity

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing ill health. The service had an up to date policy for consent and capacity guidelines and considerations. Staff ensured consent to clinical homecare and treatment had been gained by the responsible clinical team prior to referral. Staff checked consent again during the pre-visit telephone call and during patient visits. Managers had raised the importance of consent and the associated policy as an agenda during weekly meetings.

Are Community health services for adults caring?

Good

Compassionate care

Good

Community health services for adults

Patients we spoke with told us that staff treated them with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff showed compassion and kindness when discussing patient needs and care with others, and in their documentation of patient visits.

Emotional support

We observed staff being supportive in their interactions with patients during visits and telephone calls.

The lead nurse for rare diseases had completed motivational interview training and used these techniques to support patients towards independence with their administration of medicines.

Staff told us about a case where they had worked with a patient's clinical team to provide support to manage a phobia, that had impacted their treatment, in a way that maximised their independence with treatment and improved their experience of receiving treatment.

The three patients we spoke with told us that the service ensured they had two or three named nurses that provided their treatment. Patients told us this enabled them to develop supportive relationships with those staff and ensured continuity of care.

Understanding and involvement of patients and those close to them

Staff completed a welcome call with all patients prior to visiting them. Nurses contacted patients prior to their visit to confirm a suitable time.

Staff provided patients with a welcome pack with the first delivery of their medications or during the first visit.

The pharmacy team had introduced pharmacy administrator roles to ensure patients could contact the pharmacy team Monday to Friday to discuss any queries or concerns and speak with a pharmacist if appropriate.

The service were one of four providers contracted to provide specialist clinical homecare services for patients with lysosomal storage disorder. Staff from the service had voluntarily attended the last two family weekends, held by associated charities, for family members of patients with rare diseases, such as lysosomal storage disorders.

Patients completed a satisfaction rating for the service, following nurse visits. These scores were monitored and discussed during monthly quality review meetings. The most recent results showed that overall, patients were happy with their experience and would recommend the service.

Are Community health services for adults responsive?

Good

Planning and delivering services which meet people's needs

Good

Community health services for adults

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

All new service requests were assessed and discussed by managers during a fortnightly business implementation meeting. Managers discussed complexity and service capacity prior to agreeing implementation of new services.

Following agreement to provide a service, managers met with the referring services clinical homecare and pharmacy team for a clinical pathway meeting where communication pathways and specific requirements of the service were agreed. However, we reviewed two records of clinical pathway meetings and noted that there was limited detail and some fields had not been completed without a rationale for this. Although guidance was available elsewhere on the forms and within standard operating procedures, this meant that it was not always clear for someone who did not attend the meeting to confirm the decisions and discussion that took place in relation to these areas.

The service had effective links with homecare teams within NHS trusts and was able to discuss patient needs before and at the time of referral.

Agreements with the referring hospitals and the patient included arrangements to tailor nurse visits and/or support calls to the needs of the individual and at the time to suit the patient.

Any issues identified by the clinical team during visits or through telephone contact were reported back to the referring hospital team to ensure they were fully aware about an individual's treatment.

The individual nurse recorded and provided feedback to the referring hospital team after every visit or call.

The service was part of the National Clinical Homecare Association and attended fortnightly meetings as part of the association. The service were also one of four clinical services contracted by NHS England to provide enzyme replacement therapy for patients with lysosomal storage disorder. The lead nurse for rare diseases and registered manager attended annual meetings with NHS England and the other commissioned services to provide feedback, plan services and share information.

Managers attended a weekly meeting where any new business was discussed. During this meeting staff considered whether there was enough staff to support the proposed service and whether they had the right skills or level of training. This process ensured that the service did not have a waiting list, as managers only accepted services and patient caseloads that they could provide care to. The service was trying to recruit more nurses to further expand the number of services offered.

Meeting the needs of people in vulnerable circumstances

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

Patients were seen in their own homes and staff were flexible with appointment times to meet patient preferences.

The service had access to a translator service if required.

Staff completed training in equality, diversity and inclusion.

Good

Community health services for adults

Access to the right care at the right time

People could access the service when they needed it and received the right care in a timely way.

The service did not have a waiting list.

If medication deliveries or nurse visits were delayed the service ensured this was communicated to the patient. The service discussed and agreed any leeway for the administration of medicines to ensure patients received medicines on time, without experiencing a deterioration in their physical health. Managers prioritised rescheduled visits and ensured there was a range of delivery companies available to mitigate against the risk of severely delayed medicines impacting on patients' physical health.

Staff communicated with the patient and the patients' clinical teams in a timely manner to ensure relevant blood tests and physical health checks had been completed before the patient visit.

Learning from complaints and concerns

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

Patients told us they knew how to complain or raise any concerns. Nurses asked patients to rate the visit on an application following home visits and monitored the results.

The service had responded to reviews of nurse-led services that had been posted online, to offer further support or investigation.

The quality team reviewed and triaged all complaints and ensured that these were responded to and investigated. All investigations and outcomes included any lessons learned and corrective and preventative actions that were required. These actions were discussed with managers and the nursing team in weekly meetings and through clinical governance meetings.

The service investigated identified trends and themes in relation to concerns and took action to resolve these. We were provided an example of an audit that was completed to consider root causes and trends in relation to late prescriptions received for nurse-led services. This enabled the service to tailor an action plan to target root causes and themes.

Are Community health services for adults well-led?

Good

Leadership

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

Good

Community health services for adults

Staff told us they could approach senior leaders at any time to raise concerns or receive support. Regional nurse managers were supported and encouraged to enrol on management courses. However, staff told us that they did not currently have the time to engage in these but were expecting to complete the training following the recruitment of additional nurse managers.

Service 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 vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood how to apply them and monitor progress.

Staff understood and worked within the vision and values of the service. The staff survey was aligned with the service values, and these were referred to in job role descriptions and personal development plans.

The service strategy was aligned with the standard operating procedure for risk assessment of new business opportunities.

Culture

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

Staff promoted openness and understood how to apply the duty of candour. Staff were aware of what the term duty of candour meant.

Staff told us they felt 'invested in' and had opportunities for development and progression within the service.

Managers had ensured there were enough staff to respond to patient contact and provide support and guidance or respond to any concerns raised.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

The service systematically improved service quality and safeguarded high standards of care by creating an environment for good clinical care to flourish.

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

The service held a range of weekly and monthly meetings with all staff to support these processes. This included a monthly quality and risk management meeting, managers meeting and regular reviews of key performance indicators, progress with corrective and preventative action plans, and the service risk register.

Good

Community health services for adults

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The service had a risk register that staff could add to. Managers reviewed the risk register monthly and updated progress and associated actions. The risk register included an action plan to increase recruitment and ensure the service continued to have staff employed with the specialist skills to meet the treatments offered.

During the clinical pathway meetings, the service agreed an interval period for regular service review meetings. These meetings enabled a review of performance and feedback from clinical teams and patients.

Any potential risks were taken into account when planning services, such as changes in demand or disruptions to staffing or facilities. The service worked well with NHS England and the National Medicines Homecare Committee to assess potential capacity requirements to be able to respond to increases in patient referrals. The service was also part of the National Clinical Homecare Association business continuity plan that was developed to support all clinical homecare service members.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service reported collected and reported data on key performance indicators, to the National Homecare Medicines Committee and referring centres. Managers discussed key performance indicators during service reviews and NHS engagement meetings and acted on any findings or themes.

Engagement

Leaders and staff actively and openly engaged with patients, staff, and partner organisations to plan and manage services.

The service conducted quarterly staff satisfaction surveys, with questions aligned to the service vision and values. Managers met to discuss the results and took action to respond to any concerns. Overall satisfaction with questions related to the service cause (what they do) and community within the wider team were good. However, there had been a recent reduction in staff satisfaction in areas related to career, this included staff roles and development. This coincided with feedback from staff that there had been an increase in workload and decrease in staffing, and supervision could not take place as regularly as expected. The service was aware of these concerns and had plans in place to increase staffing and further support staff with supervision and development opportunities.

Nurse leads and managers attended regular service reviews with providers and engaged in annual meetings for rare disease diseases with NHS England. At these reviews, the service discussed patient outcomes, and service design and development. The annual rare diseases meetings were also attended by a patient group representative.

Members of the team had voluntarily attended the last two annual family weekends, held by rare diseases charities, for family members of patients receiving treatment for rare diseases.

Good

Community health services for adults

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well and wrong and promoting training.

The service used a 'corrective action and preventative actions' process to identify learning from all incidents and complaints and monitored progress with these effectively.

The service had developed a purpose-built mobile treatment centre, in addition to their homecare service provision. The treatment centre was based in a specially designed vehicle, that included all the usual facilities patients might expect from a visit to hospital including; reclining chairs, access to drinks, wi-fi, and a tablet computer with access to television. The mobile treatment centre allowed patients to access treatment facilities closer to their home. The centre also provided increased choice for patients as they could continue to be seen at home, or travel to the centre. It would also enable one nurse to support two patients at a time, and therefore increase the services capacity. Along with the reduced travel time for nurses, this provided an opportunity for a greater number of patients to transition to out of hospital care where appropriate.