Glodwick Health 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

Glodwick Health Centre is operated by Lancaster House Diagnostics and Surgical Services Ltd. Community services in urology and continence and stoma services have been provided since 2013 with gynaecology and cardiology services provided since November 2016.

We carried out an announced inspection of Glodwick Health Centre on 23 February 2017. We carried out the unannounced inspection on 3 March 2017. As part of our inspection we visited Glodwick Health Centre and Oldham Integrated Care Centre which provides Continence & Stoma Care services.

During our inspection we inspected the two core services; community health services for adults and community health services for children and young people.

We did not inspect other services that operate at these locations as these are services provided by another provider.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005. The main service provided was community health for adults. Where our findings on community health for adults for example, management arrangements also apply to community health for children, young people and families, we do not repeat the information.

We regulate independent community adults and children's services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- There were systems in place to keep people safe and learn from incidents.
- There were adequate numbers of suitably qualified, skilled and experienced staff (including doctors, nurses and technicians) to meet patients' need.
- Care was delivered in line with national guidance and the outcomes for patients were good.
- Patients could access care when they needed it.
- Care delivered was caring, compassionate and people were treated with dignity and respect.

However, we also found the following issues that the service provider needs to improve:

- Governance processes including the risk register, audit trail and incident recording were not robust.
- Patient records were inconsistently completed.
- Some provider documentation in relation to care and treatment was inconsistent with no version control, start date or review date.
- Not all substantive staff had access to policies and procedures to perform their job.

Summary of findings

- Not all staff had completed mandatory training.
- Not all patients had access to information leaflets in different languages and for those who are blind or partially sighted leaflets were not available in a suitable form.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and should make other improvements. We also issued the provider with a requirement notice that affected community health services for adults, children, young people and their families. Details are at the end of the report.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for adults		Community health services for adults were the main services provided by the service. Where our findings on community adults also apply to children's services, we do not repeat the information but cross-refer to the community adults section. All aspects of the service including staffing, training and governance were managed jointly with children's services.
Community health services for children, young people and families		Community health services for children, young people and families were a small proportion of the activity provided by the service. The main service was community adults. Where arrangements were the same, we have reported findings in the community adults section.

Summary of findings

Contents

Glodwick Health Centre

Services we looked at
Community health services for adults; Community health services for children, young people and families

Summary of this inspection

Background to Glodwick Health Centre

Lancaster House Consulting Diagnostics and Surgical Limited Consulting & Diagnostic & Surgical Limited registered in 2013 and provided community adult and children services in continence, stoma and urology at three locations: Phoenix Health Centre, Oldham Integrated Care Centre and Glodwick Health Centre. Since November 2016 services at Phoenix Health centre have been transferred to Glodwick Health Centre.

Lancaster House Consulting Diagnostics and Surgical Limited recently expanded in October 2016 to provide outpatient services in gynaecology and cardiology.

The service primarily serves the communities of Oldham, Greater Manchester areas.

The providers registered manager is Neeraj Sharma who has been in post since 2013.

The provider is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Treatment of disease, disorder or injury.

This service has not previously been inspected.

We carried out an announced inspection of Glodwick Health Centre on 23 February 2017. We carried out the unannounced inspection on 3 March 2017. As part of our inspection we visited Glodwick Health Centre and Oldham Integrated Care Centre which provides Continence & Stoma Care services.

Our inspection team

The inspection team was led by a CQC lead inspector and two other CQC inspectors. The inspection team was overseen by an inspection manager.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive inspection programme.

We carried out the announced inspection on 23 February 2017 and an unannounced visit on 3 March 2017.

How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services:

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

We regulate independent community adults and children's services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Before the inspection visit, we reviewed a range of information we held about the services provided and asked other organisations to share what they knew about the service.

We carried out an announced inspection on 23 February 2017 and an unannounced inspection on 3 March 2017.

During the inspection visit, the inspection team:

- Visited cardiology, continence and stoma and urology services, looked at the quality of environment and observed how staff were caring for patients;

Summary of this inspection

- Spoke with six patients and carers who were using the service;
- Spoke with the registered manager and managers of some of the services
- Spoke with 17 other staff members; including consultants, nurses, technicians and reception staff
- Received feedback about the service from 1 commissioner;
- Collected feedback from 25 patients using comment cards;
- Looked at 29 care and treatment records of patients:
- Carried out a specific check of the medication management ; and
- Looked at a range of policies, procedures and other documents relating to the running of the service.

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What people who use the service say

Patients and relatives of the services were positive about the care and treatment they received.

We spoke with six patients and their carers who were using the service.

Patients and carers we spoke to were positive about the care and treatment they received. They stated that staff were supportive and they felt fully informed regarding decisions made and their plan of care.

The 25 comment cards completed by patients were all mostly positive with comments made stating that they were happy with the service and staff were friendly.

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 do not currently have a legal duty to rate independent community adults and children services.

We found the following areas of good practice:

- There were systems for the reporting and investigation of safety incidents that were well understood by staff. Incidents were shared at team meetings and we saw evidence that processes were changed following an incident.
- There was sufficient staff across all services with positions for new services being actively recruited to.
- There was appropriate equipment to provide care and treatment for patients in the departments. The equipment was well maintained and tested to ensure its safety and effectiveness.
- There were appropriate protocols for safeguarding vulnerable adults and children and staff were aware of their roles and responsibilities in regard to safeguarding.
- Emergency equipment was available to staff and staff knew how to respond to deteriorating patients. Training, systems and processes were in place, to ensure risks to these patients were minimised.

However, we also found the following issues that the service provider needs to improve:

- Mandatory training compliance was below the provider target of 80%.
- Records were not always completed consistently.
- Carpeted clinical areas in urology clinics increased the risk of infection.
- Medicines were stored in a locked cupboard however during our unannounced inspection we found the lock to be broken and therefore accessible to members of the public. We raised this and all medication was moved into a secure locked cupboard. All medications we randomly checked were in date apart from two boxes of medication which had expired. These were disposed of immediately when we pointed this out. During our inspection staff told us processes regarding stock control, ordering of medication had recently been put in place and we saw documentation that was to be put in place.

Summary of this inspection

Are services effective?

We do not currently have a legal duty to rate independent community adults and children services.

We found the following areas of good practice:

- Care was delivered in line with best practice and in line with national guidelines from organisations such as National Institute for Health and Clinical Excellence (NICE) and Royal College of Nursing (RCN).
- There was good multidisciplinary working between staff and other services across primary and secondary care.
- Staff development and further education was encouraged within the services. 80% of staff had received appraisals.
- Staff were aware of their responsibilities in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberties Safeguards (DoLS) and 53% had received training in these subjects, which was above the 50% target.
- Staff had access to information prior to patient attendance and had access to referral criteria's to ensure appropriate patients attended.

However, we also found the following issues that the service provider needs to improve:

- There were no dates on the care pathways and referral criteria documents which meant it was not clear when these had been implemented or reviewed. In addition the pathway in place for cardiology did not reflect current practice. It stated that, for those patients requiring urgent commencement of medication that this would be prescribed by the service for a period of 14 days. This was to ensure that a detailed management plan reached the GP within seven days. During our inspection we were told that medication was not prescribed by the cardiology service and we saw no evidence of this in the records we reviewed.

Are services caring?

We do not currently have a legal duty to rate independent community adults and children services.

We found the following areas of good practice:

- Services were delivered by caring, committed and compassionate staff who treated people with dignity and respect.
- Patients were involved in decisions about their care and treatment and told us they were given adequate information before, during and after treatment.

Summary of this inspection

- Staff provided emotional support to patients and recognised the importance of involving families or carers in their care.

Are services responsive?

We do not currently have a legal duty to rate independent community adults and children services.

We found the following areas of good practice:

- Services had been planned to meet the needs of local people with the focus on getting care to people when it was needed. The longest urgent referral patients waited for an appointment was two weeks and for non-urgent referrals within four weeks apart from cardiology which was 64% in December 2016.
- We saw that urology services operated in the evenings and gynaecology services at weekends to give patients flexible access to these services.
- We saw examples of systems to support patients living with dementia and learning difficulties. The environment allowed for patients with physical disabilities to be safely cared for.
- Services had things in place to meet peoples' individual needs, such as leaflets in easy to read format, images and large print.
- Staff had a good knowledge of the complaints process, so could direct patients if they had a complaint about the service. Complaints about the service were investigated and lessons learnt were shared with some staff.

However, we also found the following issues that the service provider needs to improve:

- Only 20 % of staff had received training about dementia awareness.
- The majority of leaflets available to patients and carers were not available in languages other than English or suitable for those who were blind or partially sighted.

Are services well-led?

We do not currently have a legal duty to rate independent community adults and children services.

We found the following issues that the service provider needs to improve:

- Governance and risk management systems or actions were not monitored or documented effectively.
- Policies and procedures were not always reviewed within identified timelines and substantive staff did not have access to all policies. The service told us that substantive staff utilised policies from their previous NHS employer.

Summary of this inspection

However we also found the following areas of good practice:

- Staff were aware of the mission statement for the service.
- Staff morale was good and they were more proud to work in the service. All staff felt supported by the managers and staff knew how to report and were encouraged to speak up about concerns
- Most staff would recommend the service as a place to work and receive treatment.
- There was a great commitment towards continual improvement and innovation.
- The service was very responsive to feedback from patients, staff and external agencies.

Detailed findings from this inspection

Community health services for adults

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are community health services for adults safe?

Incident reporting, learning and improvement

- Incidents were reported utilising a paper based system which was introduced in June 2016, staff told us there was no formal process to capture incidents prior to this. All staff we spoke to knew how to report incidents and they told us that the process was now more structured.
- There were 11 incidents reported from June 2016 to January 2017, none of which were serious. The incident report showed that six incidents related to record keeping and administration processes for appointments. Immediate actions were documented and we saw that incidents were discussed at team meetings as a standard agenda item to help with learning and prevent issues being repeated.
- During the same period there were no "never events" reported. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Duty of Candour

- We observed Duty of Candour in relation to response to incidents. 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 to were not aware of the term "Duty of Candour" however demonstrated an understanding and awareness of what to do when things went wrong and of the process and gave us examples of when this had been used.
- We reviewed the complaints that had been received by the provider and there was evidence of Duty of Candour being observed when responding to complainants. Apologies were offered and there were clear explanations of what had gone wrong.

Safeguarding

- The service had a safeguarding policy in place. Staff were able to explain and demonstrate they understood the policy and how they used this as part of their practice.
- Staff understood and were able to explain the process for reporting safeguarding concerns. Any referrals made were via the Multi-agency Safeguarding Hub (MASH) and staff informed the safeguarding lead of any referrals.
- Staff told us that if they identified a safeguarding issue they would liaise with the referrer and refer onto the appropriate team. Staff gave us an example of where they had identified and escalated concerns and attended a multidisciplinary meeting.
- The nurse lead on the executive management team was the nominated safeguarding lead for the services.
- The safeguarding policy was accessible to staff on the computer system and a hard copy was available. The policy had been recently updated and ratified in conjunction with the safeguarding leads for adults and children for the local Clinical Commissioning Group (CCG).
- The training figures showed that only 7 (47%) of the 15 staff required to complete level one safeguarding adults had done so and only three out of eight staff required to complete level one safeguarding children. We were told

the staff who were non-compliant were administrative staff and they were in the process of working through mandatory training requirements utilising protected time.
- There were eight staff required to complete level 2 adult safeguarding training and data showed that seven (87%) had completed this at the time of inspection. We found that 12 (80%) of the 15 staff required had completed level 2 safeguarding children training and four (57%) of the seven staff required had completed level 3. We were told the outstanding staff had training booked with the expected completion for all staff within two months.
- Staff told us they received good support from the local authority safeguarding team who had also attended team meetings. Staff were confident in contacting the team if they needed an urgent response.
- Staff told us they had completed PREVENT, child sexual exploitation (CSE), domestic abuse and female genital mutilation (FGM) training. They stated they would feel confident in escalating any identified issues.

Medicines

- There was an administration of medication process, stock control sheet and order form for use in urology clinics. During our inspection we did not see evidence of these completed as we were told this was a new system.
- Medication including oral antibiotics was stored in a locked room in a locked cupboard however on our unannounced visit the cupboard was not locked and was also found to be broken. This was raised immediately and we were informed this had been reported a few days earlier but not escalated to the senior staff. Medications were moved to another locked cupboard at the time of inspection.
- A random check of oral medication and continence products during our inspection showed all were within expiry date apart from 2 boxes of oral medication. This was immediately disposed of by the clinical lead.
- Senior staff told us there was a pharmacist based at Glodwick Health Centre who provided advice and stock as required.
- There was a nurse prescriber who prescribed continence products on initial assessment, the prescription was photocopied and put in the patients' records and a copy sent via safe fax to the patients GP.
- There were no specific prescribing updates for the nurse prescriber, however, they told us that they linked in with clinical leads from other trusts and also was supported within the organisation. Prescriptions pads were kept in a locked drawer in a locked room.
- Continence and stoma products were available for patients to trial and once appropriate products were identified, a prescription would be generated from the continence team.
- As part of the contract with the CCG the stoma and continence service are currently devising a product formulary. This will require review by the CCG prior to use.
- No medicines were used or stored at the clinics held at Oldham Integrated Care Centre.

Environment and equipment

- Emergency defibrillators were located throughout Glodwick Health Centre and were also available at the Oldham Integrated Care Centre.
- There was emergency resuscitation equipment including medication which was located within the exercise tolerance test clinic room. The trolley was unlocked prior to commencing exercising and locked at the end of clinic. The key was stored in the main office and was accessible to all staff. We saw that daily checks of the top of the trolley and defibrillator were completed and weekly checks of the full trolley were completed by staff for February 2017. Random checks of three drugs found medication to be within date. A stock of spare emergency drugs was stored within a locked cupboard within a fob access store room.
- Treatment beds within treatment rooms were in good condition and were height adjustable.
- Equipment within locations was safety tested by the building provided. Most equipment for cardiology services was new and had not yet had any servicing/ safety testing as per building policy because it was still in date of the guarantee. The provider told us that there was maintenance and servicing contract for all equipment.
- There was a documented list of bladder scanning equipment which included all serial numbers, servicing, calibration and next service date. All other equipment had been calibrated and serviced within the last 12 months.

- Issues pertaining to lack of phone and fax access at clinic buildings had been escalated to the Clinical Commissioning Group, however, this was now resolved and both were available at the time of inspection.
- Waiting areas were spacious and had sufficient seating.
- Staff reported no issues with identifying equipment needs and obtaining same.
- Floor space was clutter free and there were domestic waste bins available.

Quality of records

- Clinical records were in paper form and were stored securely in locked cupboards.
- We reviewed five cardiology clinical records and found that they were inconsistently completed, allergies were not always documented despite allergies being documented on the patients GP referral, some parts of the records were not legible and doctors names were not always clear or printed. We raised this during our inspection.
- We reviewed three gynaecology clinic records and they were clear, legible and fully completed apart from one record which didn't have allergies documented and two dates were illegible.
- We reviewed 13 urology patient records. The care records consisted of a set of letters that had been sent to the patient's GP and there were no consultation records or care plans on file as such. However, the letters clearly showed what had been discussed in consultation with the patient; any change in treatment recommended and why, any advice given to the patient and when the Specialist Urology Nurse or Consultant would like to see the patient again.
- The letters detailed any medication that the GP was requested to prescribe for the patient and any medication that the patient had stopped taking, for example, due to side effects or no improvement in condition.
- There was no written patient consent on the files and the letters were not attached together so there was a risk of the paperwork getting out of date order.
- We also viewed three urology records completed for patients who were having a flexible cystoscopy. We observed these were not fully completed and consent or medication was not always recorded. Following our inspection the provider shared with us a revised procedure form which included consent, allergies and medication.
- We reviewed five sets of patient notes for continence and stoma care patients. We saw that there was a full holistic assessment of patient needs on the records. Care plans were clearly written, detailed and up to date. They included goals and objectives for patients and these were regularly reviewed and monitored and there was evidence that the goals and objectives were being met.
- Nutrition and hydration needs were included in the assessments, as were pain assessments. Patient allergies were recorded and one record showed a patient allergy to penicillin clearly marked on the front of the file.
- One record was for a patient who now only required an annual check-up. The record showed that there was no delay in the follow-up appointment.
- We spoke to two patients at The Oldham Integrated care Centre who reported that their notes had always been in the clinic for their appointment.
- In September 2016 the service participated in a confidentiality audit of records and focussed on information, physical and electronic environment. The audit reported that high levels of confidentiality were observed with no serious remedial actions required. To provide normal briefing on security was the only action point, however, there was no further information to indicate who the responsible person was or if this had been completed. A re-audit was planned for 6 months later.

Cleanliness, infection control and hygiene

- The Infection Prevention and Control policy was accessible to staff via the computer system.
- We viewed monthly hand hygiene audits completed across services from December 2016 to February 2017 which demonstrated compliance. The Service did not measure compliance in percentage terms but marked staff on whether they were compliant or non-compliant.
- Daily cleaning rotas were completed in the clinics we visited. Rooms we inspected were visibly clean and tidy.
- Treatment areas on the ground floor at Glodwick Health Centre were carpeted, including a room utilised for measuring urinary diagnostics. Staff told us that they would utilise plastic sheeting and pads to prevent spillage onto the carpet. Following our inspection, the provider completed a risk assessment for this matter with a review date of 31 March 2017.

- The service provider was still awaiting confirmation of being able to move the gynaecology and urology services to the first floor of Glodwick Health Centre and this remained on the risk register. Floors in rooms on the first floor were covered in a wipe able material and were not carpeted.
- Staff cleaned treatment beds and equipment in clinic after use as part of their cleaning regime to prevent cross contamination. However, one of the treatment beds at Glodwick Health Centre had a rip in the material which could have presented an infection risk. This issue had been raised with the building manager and a response was awaited. Following our inspection, the provider moved the clinic into a different treatment room.
- Handwashing facilities were available in clinic rooms and we observed staff washing their hands before and after patient contact in line with best practice standards.
- Hand hygiene compliance training rates were 97% and Infection control annual training rates were at 70%, below the 80% target.
- Personal protective equipment including aprons, gloves and hand gel was available in clinics. We observed staff utilising these appropriately.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps.
- Sharps bins were all signed, dated, temporarily closed if not in use and stored securely in line with best practice guidance.
- There were foot operated waste bins in clinic rooms which were in good working order.
- Clinical waste bins were available in clinic rooms and disposal was provided by the building provider.
- Floors in the Oldham Integrated Care Centre were covered in a wipe able material.
- Curtains in clinic rooms were disposable and seen to be clean. The date they were changed was clearly shown. The date of next change was not yet due.
- Single use disposable sheaths were used for each patient during a flexible cystoscopy.
- Patients and their carers all reported that they found the clinic areas clean and that they observed staff washing their hands.

Mandatory training

- The provider had a mandatory training completion target of 80%. Evidence was provided which showed that there were 8 modules currently highlighted as below the 80% target. The provider told us that staff were being given at least half a day a week protected time to complete mandatory training and this was being monitored by the clinical lead.
- Mandatory training was delivered both as face to face sessions and via e-learning. Topics included safeguarding, fire safety, infection control, hand hygiene and health and safety.
- Mandatory training is categorised as core training or essential job related training.
- Seven nurses had completed their mandatory training by attending an “All In One Day” mandatory training course that covered health and safety; information governance; equality and diversity; infection control; food hygiene; basic life support; moving and handling; safeguarding children (levels 1 & 2); protection of vulnerable adults; complaints handling and conflict management and lone working. We saw completion certificates for the staff. We discussed mandatory training with staff and they had a good working knowledge of the subjects.
- Staff that had substantive posts elsewhere were required to provide copies of all training completed.

Assessing and responding to patient risk

- We reviewed completed patient stoma and continence nursing assessments and documentation. Risks were assessed on initial visit and required actions identified. Assessment including nutrition and hydration, mobility, pain, infection risk and emotional needs.
- Clinicians in the continence and stoma service used an assessment document when assessing patient needs and planning care.
- We saw that, before a patient came to clinic for a stoma care assessment the healthcare professional was fully familiar with the patient’s health condition and any ongoing treatment being received elsewhere (such as chemotherapy) and was able to respond appropriately to any change in risk to the patient or deterioration to their health.
- Risks were reviewed when required and when patient’s circumstances changed in anyway.
- We observed that staff had access to emergency buzzers in each of the clinical areas which could be used to seek assistance if a patient deteriorated. All staff we spoke to were aware of the buzzer. In an emergency staff stated they would ring for an ambulance.

Community health services for adults

- Data provided showed that 67% of staff required had completed basic life support training and 75% of required staff had completed intermediate life support training.
- Meeting minutes from the stoma and continence service evidenced discussions around incidents and also utilised situation simulation of how to respond to certain incidents.

Staffing levels and caseload

- The services had 12 substantive staff in post including nurses, healthcare assistants, technicians and a clinical lead in addition to 15 staff on zero contract hours. Five consultants and two specialist nurses were sessional consultants.
- The Continence and Stoma care service was run by a Band 7 Nurse Lead, supported by three Band 6 part-time Nurses; one part-time Band 5 Nurse, a full-time Band 4 and Band 3 Healthcare Assistant, one part time band 3 prescribing co-ordinator, one part-time administrative staff and two part time assistants.
- The Urology service was run by two Consultants; 3 Associate Specialists and one Specialist Nurse who worked in the NHS as substantive trust employees. They were supported by three Healthcare Assistants who were employees of Lancaster House Consulting Diagnostics and Surgical Limited.
- The Cardiology Service was run by three Consultants who were sessional and had substantive posts in NHS trusts. They were supported by three Technicians. There was an agreement in place with an NHS trust to provide cardiac rehabilitation to patients. The Clinical Commissioning Group had been made aware of the arrangement.
- The Gynaecology service was provided by two Consultants; one staff grade Associate Specialist and one Specialist Nurse. They were supported by the same three Healthcare Assistants who supported the Urology service.
- The Ultrasound service was run by two Consultant Radiologists who were sessional. They were supported by the administrative team.
- Consultants provided their availability on a monthly basis and clinics were then booked as appropriate. The clinics were amended accordingly if demand increased or decreased.
- Two further non-clinical staff had been recruited to the administrative team and were due to start work in March 2017.
- Data provided by the provider showed there were no current staffing vacancies and no recorded sickness at the time of our inspection. The overall staff sickness rate had been relatively low in the twelve months prior to December 2016 and was 2.92 %

Managing anticipated risks

- A lone working policy was in place and staff told us about it.
- Staff visiting patients at home told us they had a buddy system for lone visits and would leave their diaries open on the office desk so others could see their planned visits. We observed this during our inspection.
- Staff stated that any risks highlighted during visits were cascaded verbally and documented on the front of patients' records to ensure staff safety.
- Exercising stress tests were only completed whilst a cardiologist was on site however there is no formal pathway in place.

Major incident awareness and training

- There was an emergency planning and business continuity policy dated September 2016 which included provision of services in exceptional circumstances such as where there was loss of power and poor weather conditions. Staff we spoke to were aware of the business continuity plan.
- The Business Continuity Action Plan included risk likelihood and impact scores.

Are community health services for adults effective?

(for example, treatment is effective)

Evidence based care and treatment

- The service used National Institute of Health and Care Excellence (NICE) and Royal College of Nursing (RCN) policies and best practice guidelines to support the care and treatment provided for patients. Coordinated care pathways for each service made reference to treatments and onward referrals being made in line with the latest NICE guidelines.

Community health services for adults

- We saw that documents referred to compliance with the Medicines Act and the policies of the Greater Manchester Medicines Management Group in instances where medication was prescribed.
- We saw evidence of references to and use of national guidelines including association of stoma care nurses (ASCN) guidelines, excellence in continence care guidelines, RCN catheter care guidance.
- The continence and stoma service performed an audit of ten patient records in August 2016 and September 2016 with the focus on staff documentation for example NHS number, dates, times, signatures and contemporaneous records. The record keeping monitoring form submitted by the provider showed that in 18 out of 20 records entries were legible and signed in full, 17 were dated for each entry and 15 records were contemporaneous.
- We did not see any evaluation of the results, action taken, recommendations or if the audits would be performed again. We requested any further information from the provider however this had not been received at the time of writing the report.

Nutrition and hydration

- Data provided showed that 100% of patients who were seen by the stoma and continence service from April 2016 to October 2016 had received nutritional screening. We saw evidence of this in patient records.
- Stoma and continence service assessments included a section on nutrition and hydration.
- Continence and stoma patients requiring a dietetic assessment were referred utilising a specific referral form.

Technology and telemedicine

- Staff from the continence and stoma service completed telephone follow ups to monitor progress, offer support and discuss any issues. We observed this during our inspection and saw this recorded within the patient records.
- Staff told us that patients could contact them within working hours to discuss any concerns and they would provide support.

Patient outcomes

- Each service had key performance indicators (KPI) and targets which were agreed and monitored with local clinical commissioning groups. These measured service delivery and patient outcomes on a monthly basis.
- Cardiology was a new service and started operating in November 2016 therefore there was little current audit data for review. Similarly, gynaecology services were also new and had no audit data as yet.
- The executive team told us that the services do not currently participate in national audits.
- Urology services were benchmarked nationally in regards to value for money. We saw evidence of this via the National Programme Budget Database 2010-2015.
- Stoma and continence team meeting minutes included discussions about completed audits and outcomes were shared.
- Data provided by the stoma and continence service showed that from April 2016 to October 2016 100% of patients referred with a long term condition had an individualised care plan in place.
- Twenty patients had returned a questionnaire in a stoma patient audit survey. The survey showed that 16 of the patients had received elective surgery and 62% of these (10 patients) had seen a stoma nurse at home before their operation. Seven of the patients (44%) felt they had benefitted from this and 88% (14 patients) felt they had good information, both verbal and written, before surgery, which led to better understanding and better ability to make informed decisions.
- All twenty stoma patients were seen at home post-operatively by the stoma nurse and all felt that they were given adequate time to speak about their emotional and psychological concerns and that any changes in products were communicated properly to the prescribing service. However, five patients (25%) said that they had received no information on patient support groups and only two of the elective patients were offered the opportunity to meet an existing stoma patient.
- The service had addressed the audit results by setting performance standards for service improvement. These included seeing 100% of elective patients at home prior to their operation; giving verbal and written information to all patients; offering all patients the opportunity to meet an existing stoma patient and providing all patients with information on local and national support groups.

- A second audit was scheduled to take place in January 2017 to measure improvements; however, this was delayed and the service was awaiting returns from patients who took place in the second audit at the time of our inspection.
- Senior staff told us they working with the CCG and had carried out the survey to identify ways in reducing A and E attendances and how they can be more effective as a service.
- The prescribing service performed a survey in May 2016 on patients who had attended an accident and emergency department to determine if the attendance was in relation to a prescribing issue. 33 out of 86 patients responded with 52% stating they attended due to a continence or stoma issue and all of them attended out of working hours with 63% of those being admitted to hospital. This was agreed with the CCG to try to identify actions to help reduce A&E attendances. There was no evaluation or actions taken provided with the report and therefore we are unsure what if any changes in practice, recommendations or action taken as a result of the survey.
- The Clinical Commissioning Group told us that they had not received any clinical audit outcomes from the provider.

Competent staff

- Data provided showed 80% of substantive staff had received annual appraisal and staff development in the last twelve months. Sessional staff had annual appraisals and training within their substantive posts and provided copies to the governance lead.
- A new induction process had been developed for all new starters to complete. There were two new members of staff who were being supported through the process.
- The lead nurse monitors and supports staff through their professional revalidation process. Three members of staff are due for revalidation in 2017.
- Staff told us they were asked about their training needs and were able to access appropriate training, including conferences. Staff told us that they were supported in attending any training that they regarded would be useful or necessary for them to carry out their role and for self-improvement. For example, a Healthcare Assistant had been supported to attend two master class stoma care training courses for self-improvement and they would usually be attended by staff of a higher grade.
- The service had policies on Management Supervision and Individual Performance and Development Review.
- We saw evidence that staff competencies had been assessed Aseptic Non-touch Techniques and Infection Control. The records showed that nursing and healthcare assistant staff had achieved Level 2 competencies in these areas.
- We saw evidence that nurses and healthcare assistants had undertaken courses in, for example, “ultrasound of the bladder”; “Home instead dementia workshop”; “Managing complex stomas masterclass”; “Managing high output stomas masterclass”; “Management of bowel continence”; “Continence symposium”; “female pelvic floor muscle dysfunction” and “Ostomy care”.
- All clinical staff had undertaken courses in female genital mutilation; PREVENT (regarding extremism and radicalisation).

Multi-disciplinary working and coordinated care pathways

- The provider had coordinated care pathways for urology, gynaecology, continence and stoma and cardiology patients. In addition, there were separate referral criteria for cardiology and gynaecology patients.
- However, there were no version control numbers, date written or review dates on the care pathways or referral criteria documents. In addition, the cardiology pathway did not reflect what we had been told by managers during our inspection. For example the care pathway for this service states that, for those patients requiring medication, urgent commencement will be prescribed by the service for a period of 14 days, ensuring that a detailed management plan reaches the GP within seven days. We were told that medication was not prescribed by the cardiology service.
- Teams worked closely with the local authority and primary and secondary care services in supporting care and treatment for patients in community settings using multidisciplinary teamwork to support the coordination of care pathways.
- GPs were kept fully informed of specialist assessments and following appointments with consultants received a consultation letter which included treatment recommendation and proposed plan of care.
- Stoma and continence service offer support and training for nursing and care homes and were auditing compliance with nursing homes.

Community health services for adults

- Staff told us that learning disability services work in the same offices and they liaise and agree joint appointments where necessary.

Referral, transfer, discharge and transition

- Referrals were received from a variety of services including GP's, secondary care, health visitors, school nurses and self-referral.
- The referral criteria for services determined which patients were suitable to be accepted by Lancaster House Consulting Diagnostics and Surgical Limited and which should be referred to secondary care. These also stated what assessments, treatments and interventions were available.
- All consultant led clinics received referrals and information via the electronic "choose and book" system, with Urology referrals being triaged by Lancaster House Consulting Diagnostics and Surgical Limited. Choose and book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic.
- Appropriate referral information was sought to enable the triage of cases. This included the patient's personal details; registered GP; NHS number; past medical history; drug allergies; current medication; signs and symptoms; family history; clinical history and examination findings and pre-referral diagnostic results such as blood counts, pulse and blood pressure and BMI height and weight.
- Data provided showed that from November 2016 to February 2017, 593 new patients and 68 patients were followed up in cardiology services. In gynaecology 336 new patients and 38 were followed up in clinics from October 2016 to January 2017.
- From June 2016 and January 2017 there were 1359 new and 4047 continence and stoma patients followed up. Urology services saw 1,324 new patients and 1,781 were followed up during April 2016 to January 2017.
- Post-operative stoma patients were seen within 24-48 hours following discharge from hospital for assessment and support.
- Discharge occurs when the clinician reaches a stage where no further action will take place with the patient's referral and the patient is directed back to the referring GP or health care professional. The care pathways for each service determined when discharge of the patient was appropriate. We saw patient records for some continence and stoma patients who had been appropriately discharged and were self-managing their conditions. They were able to re-contact the service for further treatment and advice if their condition worsened.
- Patients assessed as requiring procedures were referred to secondary care for treatment.

Access to information

- Staff told us that they had access to information on the computer and this information was clear and accessible.
- Consultation letters were dictated and typed and staff told us they were scanned onto the computer system so that in the event that clinical records were not available they could have site of previous details.
- Staff received emails and other updates about particular themes on a regular basis.
- In community locations, information displayed in the staff area was up to date and relevant.
- Information technology services and maintenance of information systems was provided by a local NHS Foundation trust, with which they had a service level agreement.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- TheMental Capacity Act(MCA) is in place to protect and empower individuals who may lack themental capacityto make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over. The Deprivation of Liberty Safeguards (DoLS) aim to protect people who lack mental capacity, but who need to be deprived of liberty so they can be given care and treatment in a hospital or care home.
- We observed that Mental Capacity Act (2005) courses attended were included in the member of staff's individual training log. The training compliance was recorded as 53%, against a target of 50%.
- There was a consent policy in place for staff to follow, this had been reviewed and updated in January 2016. Staff we spoke to were knowledgeable and clear regarding their responsibility around consent and we observed staff gaining verbal consent when required.
- There was also a department of health (DH) leaflet available for people with learning disabilities that was easy read (with pictures) and enabled patients with learning disabilities and reduced capacity to understand consent and why it was required.

Community health services for adults

- Staff we spoke with demonstrated a clear understanding of the Mental Capacity Act, (2005) of their responsibilities and of Deprivation of Liberty Safeguards (DoLS) procedures. Mental capacity assessments were undertaken if nursing staff had a concern that the patient might not have capacity to consent.

Are community health services for adults caring?

Compassionate care

- We saw 18 Friends and Family Test cards that rated the service received as "Excellent".
- In addition we saw six "Thank you" cards and letters to individual staff about the care that patients had received. One card said "I am delighted at the service I received from the Incontinence Nurse. I was treated with respect, caring and concern. They made me feel that I mattered and she understood how I felt. I now feel more confident when I go out."
- Staff took the time to interact with people in a respectful and considerate manner.
- As part of the inspection process, we left comment card boxes in clinics for patients to give us feedback. We received 25 responses. The majority of comments were positive about the care and support they had received from staff with comments including ''staff were very caring, friendly and professional'', ''I was treated with respect….I now feel more confident when I go out'' and '' everyone explained to me what was going to happen in a way I could understand''.
- All patients, carers and relatives we spoke with were very positive about the care and treatment they received. They reported that staff were helpful and kind and introduced themselves.

Understanding and involvement of patients and those close to them

- We saw e-mails from staff at the local acute hospital trust thanking the Continence and Stoma Care Nurses for seeing patients pre-operatively and for patients being so well-prepared for their surgery and informed of what to expect post-operatively.
- We observed that stoma care staff had a full understanding of the patient's ongoing condition and treatment, even if that treatment was being delivered elsewhere and fully involved patients in their care planning and offered choices.
- We saw that patient's partners or carer's were able to be present during stoma care consultations and involved in learning about care of the stoma.

Emotional support

- Staff were aware of the emotional aspects of caring for patients living with long term conditions and provided specialist support and education for patients where this was needed. Data provided from April 2016 to October 2016 showed that 100% of stoma patient's pre and post operatively were offered counselling, education and support.
- Staff explained patients had access to the service, if required, and were given contact details. Patients and relatives were referred to specialist services to provide support where appropriate.
- All patients and relatives we spoke to reported that they had adequate emotional support and would know who to contact if they were worried about their treatment or condition.
- We observed that nursing staff asked patients how they were feeling emotionally and patients were given as long as they liked to talk about anything that was worrying them.

Are community health services for adults responsive to people's needs?
(for example, to feedback?)

Planning and delivering services which meet people's needs

- The organisation worked closely with Commissioners, local acute hospital trusts, other key providers and the local authority to plan services.
- Complex needs were discussed between services and there was a multidisciplinary approach to care planning and treatment.
- Stakeholders, such as GPs, Care Homes, Social services and Carers were involved in planning and delivering services to meet the patient's needs.

Community health services for adults

- Treatment plans were discussed with patients during visits and clinic appointments including how often they would need to be seen and how long the period of treatment may take.
- Gynaecology patients requiring a hysteroscopy were treated at a local NHS acute trust by Lancaster House Consulting Diagnostics and Surgical Limited Consulting staff. Clinics were held monthly for these patients.
- The premises used at Glodwick Health Care Centre and Oldham Integrated Care Centre were close to a number of nearby GP surgeries who referred patients to the services. We were told that the provider had built a good relationship with local GP services who were referring patients to the provider.

Equality and diversity

- Staff received mandatory equality and diversity training on an annual basis.
- Not all information leaflets were available in different languages.
- Interpreters were used when required and were booked in advance if requirements were known; in addition language line was available for use at short notice. There were Asian language speakers working at the services reception at Glodwick Primary Care Centre and they were used to interpret when required,
- Some of the leaflets that were available for the various services were in an easy read format with images and larger print. However, we did not see the availability of any leaflets in braille for blind or partially sighted patients.
- The service had an equality and diversity action plan, which has identified objectives, actions and completion dates. Each objective had an identified lead person.

Meeting the needs of people in vulnerable circumstances

- Dementia training was available to staff, however, data provided at the time of inspection showed only 20% were compliant against the target of 80%. Staff training was being monitored by the Clinical Lead.
- Patients' needs and wishes were recorded in their notes.
- There was provision of chaperone service policy which staff were aware of. In addition we saw chaperone notices and leaflets available within clinic settings.
- Patients living with dementia or learning difficulties were identified and care provided to meet their needs and liaise with those people who helped to care for them.
- Health centres were accessible to wheelchair users and there were hearing loops available. Lifts were available to clinic rooms on the first floor of Glodwick Health Centre and the clinics in Oldham Integrated Care Centre were held in a ground floor clinic room.
- Easy read (picture) leaflets were available on consent and capacity for those patients with learning disabilities or reduced capacity.
- There was documentation available to staff on "good ways to communicate with people with complex needs" and a "Communication jargon buster".

Access to the right care at the right time

- There was a focus upon getting care to people when it was needed which included access to some clinics at the weekend and during the evening on weekdays.
- The Key Performance Indicator Reports had a target of more than 95% of patients to be seen within four weeks for every service for routine scheduled referrals. All services had met this target to January 2017, with the exception of the cardiology service that had only achieved 64% of patients seen within four weeks in December 2016. However, in January 2017; this increased to 100% again and was maintained by all the other services in all months since the services began.
- Urgent scheduled referrals had a target of two weeks for 95 % of patients to be seen. Data shows that in all services 100% of patients, for all services, were seen within this timescale, up to and including, January 2017.
- All services had a target of 95% for a first appointment within two weeks for urgent referrals and had achieved 100% against this target in every month since the services had been operating.
- Data showed that 0% of appointments were cancelled by the provider and this was consistent since each service began.

Learning from complaints and concerns

- There were 14 complaints from February 2016 to February 2017. None of these were classed as serious incidents.
- Complaints per 1000 appointments was consistently less than 1% per month for each service.

- Complaints were responded to within the required timeframe, 100% of the time for all services.
- The complaints reported were in relation to prescribing of products, waiting time in clinic and appointment times. There were three written complaints and the rest were verbal complaints.
- Complaints were dealt with promptly and staff we spoke to were aware of the process of handling complaints.
- There was evidence of the service responding to complaints and changes to the service where appropriate
- There were complaints cards available on reception and posters displayed in the clinic rooms.
- Meeting minutes reviewed showed that complaints were discussed for example an issue had been identified relating to delivery of products resulting in several complaints. Staff told us they received feedback on complaints received.
- Complaints files were kept securely in a locked cabinet.

Are community health services for adults well-led?

Leadership of this service

- Staff reported there was clear visibility of the executive management team and they were accessible and responsive to staff.
- All staff we spoke to felt that the services were well led and managed in a very supportive and friendly environment.
- There was strong service level local leadership and staff spoke positively about their leaders. Staff told us that they felt supported by their managers and felt able to approach senior staff.

Service vision and strategy

- The provider had a mission statement ''to provide cost effective quality community based services for local people by local people''. Staff we spoke to were aware of the vision for the service.
- There was no formal strategy in place however staff were aware of the vision for the expansion of the service.

Governance, risk management and quality measurement

- There was a clear governance structure in place. The governance organisation was divided into areas; clinical governance, safeguarding and regulatory affairs; IT, HR and performance; corporate governance; finance and contract management and business development. Each area had a lead manager apart from the contract management and business development which was led by the executive management team.
- The executive management team consisted of the chief executive, finance manager, operational manager and a governance and safeguarding lead. The executive team's role was to report to the board which included the chief executive, a chair, director of strategy and a non-executive member.
- The chief executive, the lead nurse and the clinical governance lead told us they would to discuss governance issues informally, face to face, via telephone or email on a regular basis. Therefore we are not assured that all matters were addressed and escalated to the board as these were not formal meetings or minuted.
- There was a risk register in place which highlighted risks across the services and contained a description of the risk along with a grade rated from low to high. The register did not include current or additional mitigation action, a named person responsible for dealing with the risk and a date the risk was identified or the review date. We were therefore not assured that actions were being managed within a timely manner.
- The chief executive told us they were responsible for reviewing and managing the risk register with the executive team however we saw no minuted meetings and therefore we were not assured that the executive team had oversight all of the risks.
- Senior staff were aware of the risk register and were able to tell us what the key risks that were related for their area of responsibility.
- Board meetings were held quarterly and attended by the Chair, Chief Executive, director of strategy and the non-executive. We reviewed three sets of minutes from meetings and saw there was no agenda to the meetings with no action log or responsible persons identified for actions to be taken or to mitigate risks.
- Team meetings were held quarterly for urology and continence and stoma services. Cardiology and gynaecology services had had one team meeting since the services began. We saw on the team minutes that

the agendas included incidents, complaints, audits, training and performance apart from gynaecology services which did not make reference to incidents or complaints.

- A number of policies and procedures were in place however not all had been reviewed within the set timelines and which meant we were not assured that evidence based practice was being followed. Most policies had been reviewed and updated within the last six months. We were assured by the governance lead that this was currently being addressed. Minutes of the quarterly meeting and team meetings showed discussion around updated policies.
- However, there were a number of policies and procedures that we would expect to be in place, but were not. These include Sickness absence Policy; Counter Fraud and Corruption Policy, and Expenses Policy. Following our inspection the provider shared a gifts and hospitality policy however this had not been approved, ratified or issued. The provider told us that they planned to formally document the remaining as reduced policies and issue to staff.
- We were shown a number of policies in a file that belonged to a local NHS foundation trust and a primary care trust, which no longer existed and we were told that some staff were still following these policies.
- The Clinical Governance Framework stated that it was undergoing review at the time of inspection. We found that the review date was October 2013. The policy stated that the service provided outpatient and inpatient services. It also stated that the Clinical development Group would develop the profile of clinical guidance to support the delivery of a commissioned service. There were no other references to a clinical development group and this did not appear to exist within the organisation.
- We were told that the Clinical Governance Policy had not been written yet but that the details of the policy had been relayed to the teams verbally. We did not see reference to this in the team meeting minutes we reviewed.
- Staff had personal alarms and accessed lone worker training. Seven (100%) staff had completed this training.
- All Consultants working in the service had their own medical indemnity insurance. Copies of their certificates were kept on their HR file and checked periodically by the Operational Manager and Nurse Lead. A summary was kept on a master database. The provider also had indemnity insurance.

Culture within this service

- Staff said there was a positive, open and honest culture across at the service. Staff understood the need for openness and transparency.
- Staff said they felt supported and able to speak up to their manager if they had concerns. Staff felt very proud of the service they delivered and worked hard as a team and said they felt valued by their peers.

Public engagement

- The service carried out a patient satisfaction survey for the stoma care patients. This involved new patients received from 1 January 2016 to 30 April 2016. Twenty patients (out of forty six contacted) responded to the survey. Five patients (25%) expressed an interest in becoming part of a patient support group. The service was planning to provide patients with a patient volunteer support directory.
- Continence and stoma patients were put in touch with support groups when they wanted this and clinician's patient support attended support groups.

Staff engagement

- The organisation participated in the NHS Friends and Family Test giving staff the opportunity to speak out about their place of work. In January 2017, 77% of staff were extremely likely to recommend the service to friends and family if they needed care and treatment, and 23 % likely. Forty-six percent of staff were likely to recommend the organisation as a place to work, 31% likely, 8% neither and 15% unlikely.

Innovation, improvement and sustainability

- Lancaster House Consulting Diagnostics and Surgical Limited had recently expanded to provide gynaecology and cardiology services and senior staff told us they will be ongoing audit that will be shared with the CCG's.

Community health services for children, young people and families

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are community health services for children, young people and families safe?

Safety performance

- For our main findings please see the Community Health services for adults report.

Incident reporting, learning and improvement

- For our main findings please see the Community Health services for adults report.

Duty of Candour

- For our main findings please see the Community Health services for adults report.

Safeguarding

- For our main findings please see the Community Health services for adults report.
- Staff told us they liaised with other health care professionals including health visitors and school nurses and would carry out joint visits.
- Staff worked collaboratively with the CCG and LA safeguarding leads for support and guidance.
- Staff told us that they accessed the multi-disciplinary safeguarding hub (MASH) for support and referrals.
- Staff would escalate concerns to the local authority if a child was not attending clinic appointments.
- Staff told us the paediatric referral form is currently being reviewed to include a section to document details for children at risk.
- The lead nurse told us that level three training was to be completed by all staff completing home visits and who had direct contact with children.

Medicines

- For our main findings please see the Community Health services for adults report.
- No medicines were provided however, prescriptions were provided by nurse prescribers for enuretic children.

Environment and equipment

- For our main findings please see the Community Health services for adults report.
- There were no play areas, toys or games in waiting areas for children.

Quality of records

- For our main findings please see the Community Health services for adults report.
- We reviewed five sets of children's records for continence and stoma care. We saw that there was a full holistic assessment of patient needs was performed with next of kin this included behaviour, physical and sensory issues. Plan of care was clearly written, detailed and up to date.
- We spoke to the parents of four paediatric patients who reported that the notes had always been in clinic for their appointment.

Cleanliness, infection control and hygiene

- For our main findings please see the Community Health services for adults report.

Mandatory training

- For our main findings please see the Community Health services for adults report.

Assessing and responding to patient risk

- For our main findings please see the Community Health services for adults report.

Community health services for children, young people and families

- Staff would report any safeguarding concerns to the safeguarding lead for the service.
- Staff told us that patients who did not attend first clinic appointments would be sent a letter and a copy would be sent to their GP.

Staffing levels and caseload

- For our main findings please see the Community Health services for adults report.
- There were no paediatric trained nurses within the service.

Managing anticipated risks

- For our main findings please see the Community Health services for adults report.

Major incident awareness and training

- For our main findings please see the Community Health services for adults report.

Are community health services for children, young people and families effective?
(for example, treatment is effective)

Evidence based care and treatment

- For our main findings please see the Community Health services for adults report.
- The Excellence in Continence Care Guidelines utilised, included separate sections for providing a service specific to children and young people.
- Nurses in the paediatric continence service had provided training to local school nurses to assist them to identify potential patients who could benefit from the service in schools.
- Clinicians in the continence service for children assessed the child's needs by completion of a score matrix in consultation with their parents. This directed them to the type and quantity of continence aids that may be required for the child.

Technology and telemedicine

- For our main findings please see the Community Health services for adults report.

Patient outcomes

- For our main findings please see the Community Health services for adults report.

Competent staff

- For our main findings please see the Community Health services for adults report.
- We did not see evidence of any training undertaken by clinicians that related directly to paediatric continence or stoma patients. However staff told us they worked within their competencies.
- The nurse who led the childrens clinics told us she had shadowed a paediatric continence advisor from a local trust and linked up with other clinical leads at other trust for support.

Multi-disciplinary working and coordinated care pathways

- For our main findings please see the Community Health services for adults report.
- Referral criteria for paediatric continence and stoma patients showed that the continence service was available to children aged four years and up and in the stoma services were available from new born babies upwards.
- The stoma and continence pathway states the continence service is available to children (aged 3 upwards) who experience bladder and bowel dysfunction, requiring specialist continence assessment. Patients requiring stoma services including colostomy, urostomy, ileostomy or fistula pouch management was available to patients from birth upwards.
- The continence service staff told us that they worked with school nurses and local schools to ensure that support for children with continence problems was made available.
- We saw evidence in the five records we reviewed that there was contact and ongoing communication with other health care professionals.

.Referral, transfer, discharge and transition

- For our main findings please see the Community Health services for adults report.

Community health services for children, young people and families

- Data provided showed that from July 2016 to March 2017 there was a total of 96 contacts across urology services.
- From August 2014 to March 2017 there were 1187 child contacts in the continence and stoma services. There were 271 new appointments and 916 follow-up appointments during this period.
- We spoke to one parent who had self-referred their child to the continence service and who only found out about the service and that they could get free continence aids for their child from a friend. Similarly, their child attended a school for children with special educational needs and they told us that they too were unaware of the service.

Access to information

- For our main findings please see the Community Health services for adults report.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- For our main findings please see the Community Health services for adults report.
- There was a consent policy in place reviewed and updated in January 2016. which that included links to National guidance. This included consenting for children 16-17 year olds and under 16 years of age. There was a leaflet included for staff, 'Guide to Parental responsibilities for consent'.
- The Consent Policy included a section on treatment of young children. This included what "parental responsibility" is and how to establish whether a child is "Gillick Competent" and therefore able to give consent for their own treatment.

Are community health services for children, young people and families caring?

Compassionate care

- For our main findings please see the Community Health services for adults report.

Understanding and involvement of patients and those close to them

- For our main findings please see the Community Health services for adults report.
- The four parents of paediatric patients we spoke to all said that they felt that staff understood their child's needs as an individual. One parent told us that staff had done some education with their child. All said that they fully understood the plan of care for their child.
- Parents told us that they were very pleased with the plan made for their child and that they were able to participate in the plan of care and felt comfortable discussing any changes that they felt needed to be made.
- It was clear from the records we reviewed that carers were involved in the assessment, planning and delivery of care.

Emotional support

- For our main findings please see the Community Health services for adults report.

Are community health services for children, young people and families responsive to people's needs? (for example, to feedback?)

Planning and delivering services which meet people's needs

- For our main findings please see the Community Health services for adults report.
- The initial clinic appointment is planned for parents to give an overview of the service and identify children's needs, however children can attend also.

Equality and diversity

- For our main findings please see the Community Health services for adults report.
- There were several leaflets available for carers and parents of children who were attending the Paediatric Continence clinics and storybooks and picture leaflets for children to understand bowel management.

Meeting the needs of people in vulnerable circumstances

- For our main findings please see the Community Health services for adults report.

Community health services for children, young people and families

- The children's clinics included sessions for parents to be trained on products that their children will utilise and condition specific information.
- It was evident in the records we reviewed that patient's needs and plan of care were identified and agreed through discussion with the child (where appropriate) and their carer.
- Staff told us that they worked with other healthcare professionals and had arranged joint visits with the learning disability team, school nurses, social workers and health visitors.

Access to the right care at the right time

- For our main findings please see the Community Health services for adults report.

Learning from complaints and concerns

- . For our main findings please see the Community Health services for adults report.

Are community health services for children, young people and families well-led?

Service vision and strategy

- For our main findings please see the Community Health services for adults report

Governance, risk management and quality measurement

- For our main findings please see the Community Health services for adults report.

Leadership of this service

- For our main findings please see the Community Health services for adults report.
- Managers had attended a course on safer recruitment. Safer recruitment training assists employers to safely recruit staff into roles working with children and young people.

Culture within this service

- For our main findings please see the Community Health services for adults report.

Public engagement

- For our main findings please see the Community Health services for adults report.

Staff engagement

- For our main findings please see the Community Health services for adults report.

Innovation, improvement and sustainability

- For our main findings please see the Community Health services for adults report.

Outstanding practice and areas for improvement

Outstanding practice

Stoma and continence staff told us they voluntarily attended the local stoma support group in their own time, out of uniform to build relationships with attendees, offer advice and support.

Areas for improvement

Action the provider MUST take to improve
The Provider must:

- Improve governance systems and processes.

Action the provider SHOULD take to improve
The provider should :

- Improve record keeping standards to ensure consistent documentation and version control.
- Improve patient records to ensure they are consistently completed and audited.
- Ensure all staff have completed mandatory training.
- Ensure all staff have access to all relevant policies and procedures to perform their job.
- Ensure patients have access to information leaflets in different languages and for those who are blind or partially sighted.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA (RA) Regulations 2014 Good governance** **Regulation 17 (1) Systems or processes were not fully established and operated effectively to ensure compliance with the requirements in the Part.** **Regulation 17 (2) (b): Systems and process were not operated effectively to enable the provider to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.** **The provider must ensure they have fully established systems and processes to assess, monitor, mitigate risk and improve the quality and safety of the services provided.**