

The Bullen Healthcare Group Limited

Bullen Head Office

Inspection report

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

Ratings

Overall rating for this location		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

Bullen Healthcare specialises in delivering stoma, urology and wound care products to people's homes. If the patient lives in England and their GP surgery offers the NHS Electronic Prescription Service, then the patient can nominate the service as a preferred supplier for stoma and urology prescriptions.

This was the first inspection of this service. We rated it as good because:

- The service provided safe care. This was reflected in the number of positive comments from patients about the service. Most patients were seen in their own home. The service had no plans to see patients at the clinic in the foreseeable future due to covid minimisation approaches. However, patients were seen, if necessary, at relevant GP surgeries and clinics.
- The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. Patients told us of how easy it was to access staff when needed. Staff assessed and managed risk well and followed good practice with respect to safeguarding. This was observed during a home visit. Staff followed clear personal safety protocols, including for lone working.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. The care plans created by staff related to the service provided and were noted to be personal to each patient. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided. These audits were used to improve and formulate a high level of care. Staff responded promptly to any sudden deterioration in a patient's health. All nursing staff carried equipment such as blood pressure monitoring machines in order to assess and monitor the health of a patient during a visit.
- The teams included or had access to the full range of specialists required to meet the needs of the patients. It was reflected by GPs that the staff had more specialised knowledge that could be applied on site. Non-medical prescribers ensured that relevant treatments and appliances were quickly sourced. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation. Stakeholders in the service spoke well of the service and their application of agreed goals.
- Staff understood and discharged their roles and responsibilities under the Mental Capacity Act 2005. We saw lots of evidence of consent being sought from patients and carers, reflected accurately in documentation.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. Patients we spoke to, and a visit to a patient's home, indicated the high level of care and kindness that they received from the service. They actively involved patients and families and carers in care decisions. The products and care provided by the service was led by best practice and supported by different national organisations who assist in the care of stoma, colostomy, urostomy and bladder and bowel problems, all of whom were linked and signposted by the service on their website and in information leaflets.
- The service was easy to access. Staff assessed and treated patients who required urgent care promptly and those who did not require urgent care did not wait too long to start treatment. This was reflected in key performance indicator data. The criteria for referral to the service did not exclude people who would have benefitted from care.
- The service was well-led and the governance processes ensured that procedures relating to the work of the service ran smoothly. All aspects of governance were considered, the service had agreements with clinical commissioning groups that were regularly monitored, with no problems noted during inspection. The culture at the service was clearly open and staff were happy to talk about how much they enjoyed working at the service. Staff we spoke to knew who the most senior managers in the organisation were and stated that, as they were on site, they were a visible presence. Senior management were approachable.

Summary of findings

Our judgements about each of the main services

Service

**Community
health
services for
adults**

Rating

Good



Summary of each main service

This was the first inspection of this service. We rated it as good because:
See the overall summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to Bullen Head Office

Page

5

Information about Bullen Head Office

5

Our findings from this inspection

Overview of ratings

6

Our findings by main service

7

Summary of this inspection

Background to Bullen Head Office

Bullen Healthcare is a 4th generation family-owned business that was established in 1858 and during that time has become a specialised home delivery company of stoma, urology and wound care products. The company is a dispensing appliance contractor; if the patient lives in England and their GP surgery offers the NHS Electronic Prescription Service then the patient can nominate the service as a preferred supplier for stoma and urology prescriptions. The service has some 27,000 patients receiving a level of treatment. Bullen has recently started the Merseyside and Region Stoma Service (MARSS) with the contractual agreement of six clinical commissioning groups. It also runs the Liverpool Urology Appliance Management Service and has a recently renewed contract with an NHS trust to provide urology products to its patients.

The service provides the regulated activity of treatment of disease, disorder or injury. This is the first time the service has been inspected. The service has a registered manager.

How we carried out this inspection

A team consisting of two inspectors and an assistant inspector visited the service. During the inspection, we

- toured the facilities
- accompanied a nurse on a visit to the home of a patient
- contacted six patients of the service
- monitored calls to and from patients by call handlers and other staff
- spoke with staff at the service, including the Chief Executive, the Managing Director, the Director of Finance, the registered manager for the service, the lead pharmacist, and nursing staff
- reviewed six care records
- reviewed pharmacy records and procedures, although the pharmacy is not regulated by the Care Quality Commission
- reviewed governance and policies.

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>.

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

Community health services for adults

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

Are Community health services for adults safe?

Good 

Safe and clean environment

The service had not seen patients at the registered location since the first lockdown of the COVID-19 pandemic. The service maintained two clinic rooms that were clean and serviceable. There was no plan in place to see patients at the clinic in the foreseeable future: patients were seen, if necessary, at relevant GP surgeries and clinics. Most patients were seen at home.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. All clinic rooms had the necessary equipment for patients to have thorough physical examinations. The clinic rooms were fully functional, including a variety of methods of explanation regarding the specialist treatments available. It must be stressed that patients were not being seen at the service at the time of inspection, but the rooms were maintained.

All areas were clean, well maintained, well-furnished and fit for purpose. The environment, generally, was meticulously maintained due to the nature of the service. We saw that the call-handling aspect of the service was clean, with relevant cleaning materials to ensure desktops and equipment were maintained. The warehouse section of the service was very clean, the recycling equipment was fully functional and constantly ensuring removal of waste packaging. The pharmaceutical area of the service was sectioned off with very limited staff access, and this was also in good order. We went on a home visit with a nursing staff member, and it was noted that high levels of infection prevention and control were followed.

Staff followed always infection control guidelines, including handwashing. Throughout the service, infection prevention and control guidance was followed. The inspection team had their temperature checked on arrival, as well as showing proof of recent COVID-19 testing. Face masks were worn when moving around the service by all staff, with appropriate cleaning stations throughout the service. Staff followed infection prevention guidelines during home visits and GP clinic visits. During an observed home visit, staff were observed following strict guidelines.

Staff made sure equipment was well maintained, clean and in working order. We saw evidence of cleaning of computer keyboards, desktops, and other areas of the service. Equipment that required regular testing had labels affixed with relevant dates of inspection appended.

Community health services for adults

Safe staffing

The service had enough staff, who knew the patients and received basic training to keep them safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.

Nursing staff

The service had enough nursing and support staff to keep patients safe. There were 147 staff in total working for Bullen, including all contact centre staff, nurses and non-clinical staff. There were 8.1 whole time equivalent nursing staff employed by the service. All nurses managed up to 980 patients per caseload, as not every patient required nursing input on a regular basis. Nursing staff did between five and six visits a day, or seven clinic visits, or ten virtual visits, and each day had six full time nurses on duty. Caseloads were monitored by the service clinical lead/head of nursing. The service did not employ doctors, instead working with GPs and relevant clinical practitioners depending upon each individual case.

The service had low and / or reducing vacancy rates. There were no nursing vacancies, the service would recruit specialist nurses as and when needed. There was a total of six vacancies in administrative posts.

The service did not use bank or agency nursing staff.

Managers made arrangements to cover staff sickness and absence. There was a strategy in place for sickness and absence. Due to the nature of the service, staff were able to work from home during lockdowns, and as such there was no real impact on business continuity. The service had a business continuity plan, and this was also recognised on the corporate risk register. The service had a 12-month absence figure of 2.4%, 1.8% non-covid related, 0.6% covid related.

The service had low and / or reducing turnover rates. There was very little turnover in the service. In the 12-months prior to inspection, the turnover rates stood at 0.2%.

Managers supported staff who needed time off for ill health. We interviewed staff who told us that the service was very supportive of staff needs. The staff survey results from 2019 and 2020 were positive about the service, showing a marked increase in all categories including morale, work environment and culture.

Managers used a recognised tool to calculate safe staffing levels. The staffing levels were agreed with clinical commissioning groups during the tender process for contracts.

The number and grade of staff matched the provider's staffing plan. The service was able to recruit new specialist staff as and when needed, depending on the requirement for safe staffing against patient numbers.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Mandatory training figures across the service stood at 100% completed for all staff. There were three new starters at the service, they were scheduled to finish their induction on 19 November 2021, and this included mandatory training.

The mandatory training programme was comprehensive and met the needs of patients and staff. The subjects in mandatory training were relevant to the service. The training was divided into competency packs for service-related training, such as bladder catheterisation and catheter care. There was a competency framework for all stoma nursing staff, this included choice, consent, privacy, dignity, confidentiality, safeguarding, data protection and information

Community health services for adults

governance. In addition, mandatory training also included subjects such as fire safety awareness, data security awareness, infection prevention and control, manual handling, conflict resolution, equality and diversity and human rights, safeguarding adults' level 1, and safeguarding children levels one to three, with level four safeguarding children for the safeguarding lead.

Managers monitored mandatory training and alerted staff when they needed to update their training. There was a comprehensive monitoring process in place. Staff were encouraged to ensure compliance, and time was given if required to complete the training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.

Assessment of patient risk

Staff completed risk assessments for each patient following referral to the service to ensure it could provide the service required, using a recognised tool, and reviewed this regularly, including after any incident. The clinical commissioning groups and GPs referred patients to the service, ensuring that the most vulnerable patients were prioritised by the service, with all relevant pertinent information regarding risk. All visits were planned, and risk assessments completed by the nurse on their initial visit to the home of the patient.

Staff used a risk assessment tool. The risk assessment tool used by the service was an in-house model. At the time of the inspection, we reviewed six patient care records on the electronic record system. This showed that all six records had a full risk assessment completed, and that the records had been recently updated. There was a risk management plan in place for one patient we reviewed, who was deemed of higher risk.

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health. All nursing staff carried equipment such as blood pressure monitoring machines in order to assess and monitor the health of a patient during a visit. Nurses knew that they had to act appropriately depending on circumstances regarding deterioration of health of a patient, up to and including calling an ambulance for admission to an accident and emergency department.

Staff continually monitored patients on waiting lists for changes in their level of risk and responded when risk increased. Patients who were awaiting treatment were still under the GP or the referring authority, and the service was informed if there was any increase in levels of risk whilst waiting for treatment.

Staff followed clear personal safety protocols, including for lone working. There were lone working protocols in place, each nurse had an emergency contact device in the form of a card that allowed them to alert an alarm receiving centre run by the company that provided the device. This could capture audio from the location and give receiving centre staff vital information including a location via global positioning satellite information.

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.

Community health services for adults

Staff received training on how to recognise and report abuse, appropriate for their role. All staff received safeguarding training. The service had an at-risks adults policy, reviewed in August 2021, that fully outlined recognition of abuse and the actions required to be taken should it be suspected.

Staff kept up to date with their safeguarding training. Training figures showed 100% of staff had completed safeguarding training.

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

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The service had raised three safeguarding alerts with GPs in the year leading up to inspection. Clinical staff had training up to level three safeguarding for children, all other staff had level one safeguarding training. The safeguarding lead had level four safeguarding training for children.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke to were able to state how a safeguarding referral could be made.

Managers could take part in serious case reviews and make changes based on the outcomes. Managers were trained to undertake serious case reviews, but there had been no serious cases requiring such action.

Staff access to essential information

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. We reviewed six sets of care records, as well as pharmacy records and the electronic reporting system. Relevant access to records was strictly adhered to, with some areas that could only be accessed by nursing staff.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff at the service could access GP clinical records on patients, thereby ensuring continuity and accuracy in treatment.

Records were stored securely. The electronic system used at the service was secure. The only paper records were appliance use reviews; these were kept securely for 12 months before being destroyed.

Medication and medical device management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medication and appliances on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. The pharmacy at the service was a working pharmacy, and as such was regulated by another regulator. The service had a head pharmacist. The medication list for the service was mostly for repeat prescribing use. As part of the agreement with clinical commissioning groups, the service allowed for patients to transfer their medication requirements to the service, as well

Community health services for adults

as their appliance needs. The service had repeat prescription and medication review protocols in place. The Merseyside and Region Stoma Service protocols that had been agreed with clinical commissioning groups also had a prescription protocol appended. The protocol included flow charts that clearly explained the processes under which medication was prescribed.

The service had four non-medical prescribing nurses, with a fifth near the end of training: two nurses in the Liverpool urology appliance management service, and two in the Merseyside and region stoma service. Each non-medical prescriber completed a confirmation of competence form which outlined the agreement with the service regarding medical prescribing. The nurses were able to practice, prescribe and make clinical recommendations regarding the gastro-intestinal system, infections, Genito-urinary system, skin, wound management products, continence appliance and accessories, and stoma appliances and accessories.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Review of medication records showed clear review processes that were up to date and held appropriate information. There was a medication review process that allowed a patient to contact a pharmacist at the service or be referred to a pharmacist by nursing staff, should a review of medication be indicated. A monthly audit was carried out by the chief pharmacist ensuring that medication was being prescribed within the boundaries of the protocols agreed. The medication review process adopted 12 months as the standard review interval, with six months for patients over 65 years of age on four or more repeat prescriptions.

Staff completed medicines records accurately and kept them up to date. Monthly and quarterly key performance indicators showed the accurate reporting of medication prescriptions for each clinical commissioning group involved with the service.

Staff stored and managed all medicines and prescribing documents safely. There were protocols in place regarding storage and management of medication at the service. The pharmacy could only be accessed by specific staff, and the use of closed-circuit television cameras over each workstation allowed for close monitoring.

Staff followed national practice to check patients had the correct medicines when they moved between services. The electronic recording and reporting systems allowed access to GP records, ensuring that the most up to date and accurate information was available. National guidance for medication management was followed.

Staff learned from safety alerts and incidents to improve practice. There were lessons learned from the initial introduction of the new Merseyside and Region Stoma Service and Liverpool Urology Appliance Management Service, with initial problems relating to such incidents as non-stoma items not being recognised by the new electronic system. Problems had been dealt with and this was noted from the data for the key performance indicators.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. The medication review protocol ensured that the effectiveness of each item was reviewed, and a decision was made including cessation, cancelling an item or a therapeutic substitution put in place, or drug changed to cost effective alternatives.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. The protocol ensured staff documented any side effects or allergic reactions in records. Other aspects of patient physical health were only dealt with if deemed necessary at the time of a visit or if a call was received that indicated possible health problems, at which point the GP or emergency services were called.

Community health services for adults

Track record on safety

The service had a good track record on safety. There had been no major incidents recorded at the service. The service had a serious incident policy.

Reporting incidents and learning from when things go wrong

Staff recognised incidents and reported them appropriately. 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.

Staff knew what incidents to report and how to report them. Staff we spoke to were able to give examples of incidents where they would be required to make a report. There was a reporting system in place.

There had been no serious incidents or near misses reported at the service.

The service had no never events.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. There had been no cause for the service to utilise the duty of candour policy, but the registered manager stated that patients and families would be informed if anything untoward occurred.

Staff received feedback from investigation of incidents, both internal and external to the service. The service had an incident management policy, this outlined the lessons learned process for recording and distribution of information pertaining to incidents and processes to relevant staff.

Staff met to discuss the feedback and look at improvements to patient care. There was a daily call that reviewed any complaints or incidents that had occurred within the previous 24 hours.

There was evidence that changes had been made as a result of feedback. In the initial setting up of the Merseyside and Region Stoma Service, several recording problems for information were noted. This included the recording of patients who were sadly deceased, but the referral information from the clinical commissioning group had not been successfully processed. A review of the system by the pharmacy team meant that any incorrect codes had been removed and that a clinician had to update the life status of a patient on the NHS Spine, ensuring that the system did not wrongly record patient life status.

Managers shared learning with their staff about never events that happened elsewhere.

The registered manager told us that learning from other services was passed on to staff, in order to maintain an up to date and safe service.

Community health services for adults

Are Community health services for adults effective?

Good 

Assessment of needs and planning of care

Staff worked with patients and families and carers to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.

Staff completed a comprehensive assessment of each patient. We reviewed six sets of care records of patients at the service and noted that physical health assessments had been completed. These could be accessed through the electronic recording system that was linked to the relevant GP. Risk assessments had been updated as and when patients had been assessed by nursing staff.

Staff made sure that patients had a full physical health assessment and knew about any physical health problems. Full physical health assessments were conducted by the GP service prior to referral to the service. Staff monitored physical health when visiting, acting accordingly if they found any problem with physical health by either taking immediate action, such as calling an ambulance, or ensuring the patient was advised to contact their GP or referred for treatment.

Staff developed a comprehensive care plan for each patient that met their physical health needs. The care plans prepared by the nursing staff at the service related solely to the specialist needs involving stoma or urological care. We reviewed six care records and found relevant care plans in place. There was also evidence that each patient had received a copy of their care plan.

Staff regularly reviewed and updated care plans when patients' needs changed. The service conducted appliance user reviews for each patient. Each time a patient required an adjustment to their care, either by the issue of a different medical device or medication, the care plan was amended. This was reviewed and audited. Due to the system in use, the updates became available to GPs.

Care plans were personalised, holistic and recovery orientated. Each care plan was tailored to the needs of the patient, and included all aspects relating to the care provided by the service. During the inspection, we attended and observed a home visit. The nurse discussed some changes to care for the patient, the patient was fully informed and their opinions noted and considered, as were those of the patient's carer.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. With the setting up of the Merseyside and Region Stoma Service, Bullen had enhanced the care that patients using stoma and fistula products received. This was reflected in the comments from patients, carers, and stakeholders in the service.

Staff delivered care in line with best practice and national guidance (from relevant bodies eg National Institute for Health and Care Excellence (NICE)). The products and care provided by the service was led by best practice and supported by different national organisations who assist in the care of stoma, colostomy, urostomy and bladder and bowel problems, all of whom were linked and signposted by the service on their website and in information leaflets.

Community health services for adults

Staff made sure patients had support for their physical health needs, either from their GP or community services. The physical health of the patients was a matter for the patient GP, however, nursing staff could and did act when noting a deterioration in the physical health of patients. This would be in the form of any immediate health assistance, relating to the treatment area the nurse was dealing with, or consideration of emergency treatment at a hospital if deemed necessary. The GP of the patient would be informed of any interventions and recommendations.

Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice. The nurses from the service ensured that there was at least an annual clinic review offered to patients, either at a local clinic close to the patient or at the home of the patient. The Merseyside and Region Stoma Service also provided regular clinics drop-in clinics that patients could attend without appointment, to speak with a specialist nurse. There was also an urgent supply of products that patients could access by telephone, with a prescription being sent to a dispenser of their choice as soon as practicable.

Staff used technology to support patients. The service headquarters had full electronic monitoring and computing equipment to deal with calls from patients. The equipment monitored call times, average waiting times, and other request aspects. The overall performance of the team was projected onto the wall of the service, with real-time updating that allowed immediate action to identify and remedy shortfalls in performance. In the distribution centre of the service, a similar system informed staff of the prescription requirements and products needed, alongside performance monitoring equipment that allowed for staff to identify specific actions.

A team of staff were employed to ensure stoma base plates and other items were cut to the correct size for the individual patient, this output monitored by closed circuit television cameras that could be used to ensure that, if a patient said the wrong item had been provided, evidence was available to the service to ensure that the complaint was dealt with efficiently and correctly. Similar cameras were employed inside the pharmacy, each desk having a camera situated to ensure that prescriptions were properly fulfilled and sent out.

Each nurse had a laptop computer with access to the medical information system that they took with them when visiting patients. These laptops also meant nursing staff could continue to work from home should the need arise.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The clinical governance policy for the service outlined the use of quality improvement initiatives, using noted references to guide the advancement of quality at the service. Clinical and non-clinical audits were also outlined, including number of patients seen in clinic, number of patients seen at home, number of product changes and clinical reasons, number of patients requiring a clinical consultation more than once a year, and patient quality of life indicator results.

Managers used results from audits to make improvements. The audit results were used to drive key performance indicators, this was outlined in the clinical governance policy.

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had (access to) a full range of specialists to meet the needs of the patients. As a specialised service, all nursing staff were fully trained to deal with issues pertaining to stoma, urological and wound care. Nursing staff could also refer patients into further treatment via GPs, such as for psychological input if required.

Community health services for adults

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care. The mandatory training skills for staff were relevant to their role within the service. Specialist training was available if deemed necessary, including a specialist stoma framework that included training from each of the main providers of products used by the service, allowing access to relevant courses ranging from diploma to university level training, with all nursing staff attending an annual specialist conference paid for by the service. There was also a link with a university regarding advanced principles of stoma care. There were competency packs that nursing staff were required to complete, including bladder catheterisation and catheter care, and also assessment of residual urine by use of portable ultrasound equipment.

Managers gave each new member of staff a full induction to the service before they started work. The induction process was detailed, including covering the full mandatory training programme, and this had to be completed before new staff could start work. At the time of the inspection, three new staff were involved in the induction process and were scheduled to complete the process by 19 November 2021.

Managers supported staff through regular, constructive appraisals of their work. There was a clinical supervision policy at the service, outlining clinical and non-clinical supervision. Three models of supervision were described in the policy: management supervision, clinical supervision, and peer (group) supervision. The policy outlined frequency of supervision for staff. Staff told us they received regular supervision.

Managers supported permanent non-medical staff to develop through yearly, constructive appraisals of their work. All non-medical staff at the service had yearly staff appraisals. Staff survey results showed that staff were satisfied with appraisals.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Regular team meetings took place at the service, as well as regular meetings with acute stoma teams employed by clinical commissioning groups. Monthly meetings and weekly mobilisation meetings took place.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Both nursing and sales staff at the service were given access to a national association for urological nurses to improve skills and up to date knowledge of products and advances in the field.

Managers recognised poor performance, could identify the reasons and dealt with these. There was a staff performance protocol in place that included a guide to monitoring, improving and dealing with poor performance. This included a six-month probation period where required, probationary reviews, and set expectations to overcome poor performance.

Multidisciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Nursing staff at the service worked well with acute stoma teams employed by clinical commissioning groups, holding regular meetings and were available to give professional advice when requested. Similar advice was available about urology and wound care. Staff from the service were also actively involved in training for nursing staff from secondary providers.

Community health services for adults

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. Staff used the electronic medical information system to ensure that patient care was immediately available to GPs and other healthcare professionals involved in patient care.

Staff had effective working relationships with other teams in the organisation. The service required close collaboration and a strong team work ethic to ensure that patient care was optimised. During the inspection, we saw how each part of the service interlinked, ensuring that each patient was treated quickly and correctly. This was also shown in patient satisfaction figures provided by the service.

Staff had effective working relationships with external teams and organisations. Clinical commissioning groups regularly visited the service for quality assurance purposes, as well as receiving key performance indicator data on a regular basis. In the month prior to inspection, four clinical commissioning groups had visited the service. Contact with stakeholders showed positive opinions of the service, with no problems raised.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff understood the Mental Capacity Act and had a good understanding of at least the five principles. The service did not require staff to complete formal training in the Mental Capacity Act. However, the service did have a mental capacity assessment and guidance checklist, as well as a consent policy. Due to the nature of the service, it was deemed unlikely that Bullen staff would be required to undertake a mental capacity assessment on their patients as this was likely to be completed by the patient's GP practice or secondary care provider depending on the patient's presentation. However, should staff feel that the capacity of a patient had changed, they would pass on this information immediately to the GP or secondary provider.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access. The service policy outlined the key aspects of the Mental Capacity Act, including the guiding core principles, full definition of key roles such as independent mental capacity advocates and lasting power of attorney, how an assessment would be carried out and under what circumstances an assessment might be called for, best interest meetings and a capacity assessment test format. All staff had access to this policy on the service computer system.

Staff knew where to get accurate advice on Mental Capacity Act. Where required, the policy directed staff to the GP practice if questions arose about capacity.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. The policy clearly outlined the need to allow patients to make their own decisions when possible, and the guidance outlined the core principles that should be followed.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. We reviewed six sets of care records, and each record clearly noted there was evidence of informed consent from each patient for decisions relating to their care.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. The mental capacity policy at the service outlined the actions to take

Community health services for adults

about best interest should a patient be considered not to have capacity, and that discussion would be referred to the GP practice or secondary care provider. Under the Merseyside and Region Stoma Service clinical governance policy, the clinical commissioning group would be informed about any concerns the service might have with consent from a patient.

Are Community health services for adults caring?

Good 

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. We contacted six patients from the service. All comments received were very positive, with compliments given about staff and the care received. The Merseyside Region and Stoma Service nurse patient survey results for October 2021 showed that patients were pleased with the service: around 90% of patients rated the service they received from nurses as excellent, the remaining ten percent rated it as very good or good. During the inspection, we were in attendance for a home visit. The carer and patient at the visit were very complimentary about the nursing staff and the service.

The Liverpool Urology Appliance Management Service at Bullen received 83 patient satisfaction survey responses from August to October 2021. Patients were asked if they found any aspect of the service with which they were unhappy, or if they had any suggestions to improve the service. All comments received were positive, almost all responses were happy with the service, with only one respondent suggesting the service create a computer application so they could order for themselves, though this was not a negative comment.

Bullen had a contract with a local NHS foundation trust to provide dispensing appliance contractor urology products, the contract had been extended to August 2022. Bullen issued a patient survey to 180 patients treated within the contract and received 53 responses. 96% of responders felt they were listened to, the others did not answer the question, there were no negative responses. 95% of responders felt they could ask questions, and 95% stated they had their treatment plan fully explained. 67% felt their service from the clinical advisor was excellent, 28% felt it was good or very good, no patient thought the service was very poor.

Staff gave patients help, emotional support and advice when they needed it. We contacted six patients who were receiving treatment from the service, and all patients we spoke to were positive in their response. We visited one patient at home with nursing staff, and the patient and carer both stated that the nurse was supportive, the patient was in contact with the nurse through a computer application that allowed for sending of images if any concerns were raised, and the nurse would immediately respond. We saw the nurse explain possible changes regarding treatment, and that the nurse would train the carer of the patient to assist the patient if necessary.

Staff supported patients to understand and manage their own care treatment or condition. We saw evidence of this on a home visit, also when an inspection team member listened into calls to the service.

Community health services for adults

Staff directed patients to other services and supported them to access those services if they needed help. As part of the welcome call employed by the service, each new patient was contacted shortly after referral and fully briefed on how the service would be assisting the patient with their care. This included signposting the patient to charities and organisations that may be of assistance in transition to their new care regime, or to advise if the patient needed other assistance.

Patients said staff treated them well and behaved kindly. The staff patient survey results showed that patients were very happy with the service.

Staff understood and respected the individual needs of each patient. We reviewed six sets of care records that showed each patient had an individual care plan, and that this was adhered to and updated when required.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and staff. Every patient was made aware of the complaint process and how to make a complaint to or about the service. Explanatory leaflets indicated that the service was regulated by the Care Quality Commission and gave the website address for patients to use to contact the Commission.

Staff followed policy to keep patient information confidential. Patient details were maintained on a secure electronic system.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates. Staff informed and involved families and carers appropriately.

Involvement of patients

Staff involved patients and gave them access to their care plans. We reviewed six patient care records and noted that every patient had received a copy of their care plan. The inspection team contacted patients who told us they were aware of what they required and what service were being provided. Patients could contact the service at any time and speak to a contact handler and raise concerns or ask to be contacted by a nurse to discuss their treatment. The average time to respond to a call in October 2021 was nine seconds.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Explanatory leaflets produced by the service could be reproduced in another language, braille or in audio format: the leaflet contained a contact number to the service to arrange different information formats.

Patients could give feedback on the service and their treatment and staff supported them to do this. A customer satisfaction survey was available to all patients, or carers if the patient was deemed not to have capacity. There was a meeting every morning that included discussion on any complaints about the service received in the previous 24 hours.

Staff supported patients with advanced decisions on their care. The mental capacity assessment guidance in place at the service clearly outlined how to consider advanced decisions should any patient have made such a decision in relation to their care.

Community health services for adults

Involvement of families and carers

Staff supported, informed and involved families or carers. We spoke to the carer of a patient during the inspection on a home visit, and they stated that they had full involvement in care and decisions regarding treatment of their relative. The nurse had offered training to assist the carer in looking after the patient.

Staff helped families to give feedback on the service. A customer satisfaction survey was available to all patients and carers, and the service could be contacted at any time to give feedback.

Are Community health services for adults responsive?

Good 

Access and waiting times

The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. Staff followed up patients who missed appointments.

The service had clear criteria to describe which patients they would offer services. There were no strict criteria for referrals to the service, other than the requirement of treatment for stoma, urology or wound care. Existing patients who required stoma services in the region were automatically registered onto the Merseyside Region and Stoma Service system in the first instance, but patients did have the option to decline the service, at which point the service would inform the clinical commissioning group, as policy dictated.

Patients on the Liverpool Urology Appliance Management Service were also automatically registered with the service.

The service met target times for seeing patients from referral to assessment and assessment to treatment. For the Merseyside and Region Stoma Service, patients were contacted within two days of referral to the service, as per contract. For the Liverpool Urology Appliance Management Service, as part of the key performance indicators, the service was required to contact the patient within five days of the referral/registration with the service. The NHS trust contract held by the service to supply urology products/packs included the requirement for the service to contact the patient on the same day they receive the referral, all trial without catheter episodes must be completed within three to five days (if referred from accident and emergency department), with a maximum timescale to complete a trial without catheter of ten days. The key performance indicators for this contract showed that 93% of 73 visits had taken place within the time frame (August to October 2021), the remaining seven percent (five patients) missed due to patients being admitted to hospital, being unable to be contacted, or requiring an urgent appointment (appointment was brought forward).

Staff saw urgent referrals quickly and non-urgent referrals within the agreed target time. Any urgent referrals were seen within contract limits, as were non-urgent referrals. This was verified by key performance indicator information that was shared with clinical commissioning groups and contract holders.

Staff tried to contact people who did not attend appointments and offer support. All patients were contacted at least once a month to ensure that they were receiving the correct appliances, with follow up calls should there be no response. The service had access to GP records and could check if the patient had moved or been admitted to hospital.

Community health services for adults

Patients had some flexibility and choice in the appointment times available. Staff would visit patients at times that were convenient to the patient. The key performance indicators showed that for the Merseyside and Region Stoma Service, the average time for a telephone call to be answered by the service was nine seconds, the performance indicator allowing up to 20 seconds, and this had been maintained for the month of October 2021, just prior to inspection.

Staff worked hard to avoid cancelling appointments and when they had to, they gave patients clear explanations and offered new appointments as soon as possible. Cancellations were very rare at the service, even during the lockdown periods. Patients were contacted thirty minutes before a visit to confirm attendance and viability of visit.

Appointments ran on time and staff informed patients when they did not. Nursing staff had their own key performance indicators, these included having to complete five home visits a day, seven clinic visits, or ten virtual visits, and the recording of these visits were completed in real time with the patient.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

The service had access to a full range of rooms and equipment to support treatment and care. Patients were no longer seen at the service, the two clinic rooms were well maintained but not in use at the time of the inspection, Clinics were held at specific sites under the auspices of GPs or providers. The service design and layout for the running of the service was efficient, thoughtful, practical, and considered all aspects of ongoing infection and prevention controls and wellbeing for staff.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. Patients were either seen at home or at clinics, where patient access needs would be considered by other providers. Communication needs were considered, with information leaflets available in other languages, braille or audio. Should there be any other consideration, the service would do all it could to manage the situation to the benefit of the patient.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Staff signposted patients in their initial welcome calls to services or charities that were deemed suitable or likely to be of assistance to patients. Patients were told how to complain, and the service had a full complaints policy.

The service had information leaflets available in languages spoken by the patients and local community. These were available if required, as well as in braille or in audio format.

Managers made sure staff and patients could get hold of interpreters or signers when needed. The service would do everything they could to ensure patients were both understood and informed in a manner that was acceptable to all.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Community health services for adults

Patients, relatives and carers knew how to complain or raise concerns. Complaints could be made by telephone, email or letter. The complaints and compliments policy clearly outlined the way in which a complaint (defined as “an expression of dissatisfaction”) would be handled. Details of how to complain were given to every patient and was also available on the relevant website.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke to told us they knew how to handle a complaint, how to report it, and the policy details on timing of responses. We viewed the complaints register during inspection, noting there had been 24 complaints regarding the recent Merseyside and Region Stoma Service, all had been dealt with through the complaint process, all related to problems with the initial set up of the service, requiring small adjustments to the system. There had been only one other complaint at the service provided to the NHS trust regarding catheter care, but this was actually a third-party complaint and did not relate to the service. Since registration in 2017, there had been only two complaints received by the Care Quality Commission.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We tracked two complaints to the service, following the complaint process fully. We saw that the complaints originally related to the start of the Merseyside Region and Stoma Service, that the matters were resolved, patients were kept informed, the six clinical commissioning groups had all been informed, and that the lessons learned had been acted upon within the service.

Managers investigated complaints and identified themes. The complaint investigation system was robust and followed. The complaint policy clearly outlined the responsibilities and actions required when dealing with complaints.

Patients received feedback from managers after the investigation into their complaint. Patients were kept informed of the progress and outcome of a complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. There was a lessons’ learned file maintained, this could be accessed by staff. We saw that the matters that had been flagged during the initial set up of the Merseyside Region and Stoma Service had been resolved and staff were aware of them.

The service used compliments to learn, celebrate success and improve the quality of care. Compliments, and the recording of compliments, was outlined in the complaints and compliments policy. The monthly key performance indicators for the Merseyside and Region Stoma Service recorded compliments and comments from patients, this was circulated among the six clinical commissioning groups. The Liverpool Urology Appliance Management Service key performance indicators included a section on patient experience, with eight different quantified records.

Staff were aware of the compliments; we saw communications between management and staff ensuring that compliments were related to staff and recorded in relevant locations.

Are Community health services for adults well-led?

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Community health services for adults

Staff we spoke to knew who the most senior managers in the organisation were and stated that, as they were on site, they were a visible presence. Senior management were approachable. During the inspection, we interviewed the chief executive, the managing director and the finance director, and it was clear that they were actively involved in not just the running of the service but in ensuring that their staff were happy in their roles. The company was a family concern, a fourth-generation owned family business, and the chief executive and the managing director were part of the family who owned the company, a company that had been established in 1858.

The registered manager told us that leadership opportunities were available to her and other members of staff.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

There were company values displayed throughout the service, values that were known by staff we interviewed. We were told that staff had been involved in the creation and foundation of the company values, and that they felt they reflected the key objectives of the service.

The registered manager told us that team objectives were based on the values.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff we interviewed told us that they felt valued and respected. Staff told us that the service was "a busy, but happy" place to work. We were told that the work could be stressful, but that staff were well supported by management to ensure wellbeing for all was in place. The registered manager stated that they had been very well supported in their 11 years with the company.

We were told that the relationship between all teams within the service was good, as well as relationships outside of the service. Stakeholders told us that they had no problems with the service, that it was a positive relationship.

There were no cases of bullying or harassment reported at the service. There was a whistle-blowing process at the service, staff were aware of the policy and would use it if they felt it was necessary. We were told that staff could raise concerns without fear of victimisation.

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 used key performance indicators to drive performance, as well as keeping relevant stakeholders and contracted services informed of progress. The key performance indicators for the Merseyside and Region Stoma Service were sent to each of the six clinical commissioning groups who commissioned the service from Bullen. The spreadsheet report factored in a quarterly summary, patient feedback, inbound and outbound call performance, a monthly summary, and a breakdown of information for each of the six clinical commissioning groups. The indicators included the number of patients registered, the number of prescriptions issued, the number of new referrals, the number of patients contacted within the five-day referral to contact window, and any serious incidents.

Community health services for adults

The Liverpool Urology Appliance Management service key performance indicators were categorised into five groups of data: operational, clinical, financial, quality of life, and patient experience. The data collected was very specific and was shared with the clinical commissioning group. The key performance indicators for the NHS trust contact was relevant, the data again being shared with the relevant party.

The use of a projection system in the service headquarters allowed for constant real-time monitoring of performance, and this allowed for planning to be adapted accordingly and for specific targeting of performance.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The electronic monitoring and information system used at the service allowed for access to GP data on patients, and real-time updating of records. Each nurse had a laptop computer that was able to access relevant information and allowed for easier access to GP and secondary care providers to alert them of any changes required in treatment or problems encountered.

The service had a risk register that staff could submit items to, through their line manager or the senior management team. There were no examples where financial pressures compromised care.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Key performance indicators included performance data and were analysed accordingly.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

The service worked closely with partners to ensure that the commissioned health care was meeting the needs of the population. There were over 27,000 patients receiving levels of care from the service, and performance data showed that the service was efficiently and effectively acting on their behalf. Stakeholder comments on the service were positive, and extensions of ongoing contracts were driven by positive outcomes.

The registered manager took part in weekly meetings with the managing director and finance director, as well as taking part in other monthly and board meetings. The registered manager felt that they could give feedback leading to service development, and that senior management was always open to suggestions on how to improve the service.

Learning, continuous improvement and innovation

The registered manager felt that the creation of the Merseyside Region and Stoma Service, under agreement with six clinical commissioning groups, was an example of continuous improvement and innovation. The centralised system allowed for targeted investment and continuity of treatment under the management from Bullen, and frequent quality assurance meetings with the clinical commissioning groups allowed formal recognition and identification of correct treatment within the budgetary constraints of the contract.

Community health services for adults

The registered manager believed that patient service improvement meant health business growth. The service was merging a NHS commissioned service for 5000 patients.