Ernest Gardiner Treatment Centre

Quality Report

Pearsall Close
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Hertfordshire
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Website: www.letchworth.com/treatment-centre

Date of inspection visit: 3 January 2017
Date of publication: 22/03/2017

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

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Summary of findings

Letter from the Chief Inspector of Hospitals

Ernest Gardiner Treatment Centre is operated by Letchworth Garden City Heritage Foundation. The service has two designated treatment rooms as well as a communal therapy area. Facilities include physiotherapy equipment and couches where treatment can be provided and blood taken.

The centre provides minor treatments, for example, leg ulcers and therapy services as a community outpatient service only. We inspected the community adult nursing core service.

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 3 January 2017: an unannounced visit to the centre was not required.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we do not rate

We regulate independent community clinics 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:

- The service maintained effective standards of cleanliness and hygiene within the centre. The service had sufficient equipment, which was well maintained.
- Patient records were generally written and managed well. Information about patients was accessible at all times when the clinic was open.
- Staff had an understanding of how to recognise and act on safeguarding vulnerable adult concerns. Staff understood consent and decision making requirements.
- There were always sufficient numbers of staff to ensure that patients received safe care and treatment at all times.
- Pain was assessed and strategies were discussed with patients to manage and minimise their pain.
- Pre-employment checks were undertaken for new members of staff. There were induction arrangements for new members of staff.
- All staff from each discipline were involved in assessing, planning and delivering patient care. Care and treatment provided was patient focused.
- Staff took time to interact with patients, were respectful and considerate. Patients understood the care and treatment they received.
- Services provided reflected the needs of the population served. A free transport service was provided to patients who required transport to the treatment centre. Patients were seen promptly. Feedback about the service acted upon.
- There was a positive culture and good leadership. Staff feedback was sought on a continuous basis through one to ones and team meetings.

Summary of findings

- The service had a documented vision and staff aimed to provide all patients with quality care. There was a governance structure in place and meetings were held regularly.

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

- One incident had been reported as a safeguarding concern but had not been reported internally as an incident.
- The hepatitis B status of staff was not held on their personnel file.
- Some policies did not reflect the latest guidance and others had not been developed. For example, the service did not have a safeguarding children policy and the consent and capacity policy did not reflect the latest guidance.
- Attendance at mandatory training was low for some training courses, in particular health and safety as well as safeguarding children.
- Information about the service's overall outcomes for patients' care and treatment was not collected or monitored and audits did not always follow national guidelines. Patients' feedback was collected.
- Staff competency checks were not undertaken for specific skills or use of equipment.
- Risks faced by the service had not all been identified and recorded on the risk register.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Edward Baker

Deputy Chief Inspector of Hospitals (Central Region)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for adults		We regulate independent community clinics 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: • The service maintained effective standards of cleanliness and hygiene within the centre. The service had sufficient equipment, which was well maintained. • Patient records were generally written and managed well. Information about patients was accessible at all times when the clinic was open. • Staff had an understanding of how to recognise and act on safeguarding vulnerable adult concerns. Staff understood consent and decision making requirements. • There were always sufficient numbers of staff to ensure that patients received safe care and treatment at all times. • Pain was assessed and strategies were discussed with patients to manage and minimise their pain. • Pre-employment checks were undertaken for new members of staff. There were induction arrangements for new members of staff. • All staff from each discipline were involved in assessing, planning and delivering patient care. Care and treatment provided was patient focused. • Staff took time to interact with patients, were respectful and considerate. Patients understood the care and treatment they received. • Services provided reflected the needs of the population served. A free transport service was provided to patients who required transport to the treatment centre. Patients were seen promptly. Feedback about the service acted upon. • There was a positive culture and good leadership. Staff feedback was sought on a continuous basis through one to ones and team meetings.

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- Information about the service's overall outcomes for patients' care and treatment was not collected or monitored and audits did not always follow national guidelines.
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Summary of findings

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Location name here

Services we looked at
Community health services for adults.

Summary of this inspection

Background to Ernest Gardiner Treatment Centre

Ernest Gardiner Treatment Centre is operated by Letchworth Garden City Heritage Foundation (LGCHF). The service opened in July 2013. It is a charitable run service in Letchworth Garden City, Hertfordshire. All services are provided free of charge. The centre serves the local community. The service is funded by LGCHF whose purpose is to maintain and enhance the world's first garden city for the enjoyment of everyone who lives, works and visits there. The LGCHF aims to do this by supporting, funding and promoting activities and projects in order to deliver its charitable commitments for the benefit of the local community.

We inspected the service in December 2016 and at the time of the inspection, a new manager had recently been appointed, and their official registration with CQC was expected to be completed in February 2017.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and a specialist advisor with expertise in community nursing.

The inspection team was overseen by Phil Terry, Inspection Manager.

Information about Ernest Gardiner Treatment Centre

Ernest Gardiner Treatment Centre is a purpose designed single storey building serving the needs of local residents of Letchworth Garden City. It has parking for seven cars including two disabled spaces. It has a dedicated bay for transfer of patients by the provider's minibus.

The treatment centre does not have inpatient beds but provides treatment couches and chairs for patients during treatment. It has facilities to cater for a maximum of 20 patients in either a morning or afternoon session of treatment.

The treatment centre is open Monday to Friday 8am to 4pm. Bank holidays and during the Christmas/new year period the treatment centre is closed.

There are dedicated areas within the building comprising: two treatment rooms for nursing assessments and procedures, an occupational therapy room, a physiotherapy area with a screened off section for one to one treatments and a private consulting room is available.

The average age of patients treated at the centre is 70 years old. Mobility aids are provided to meet patients' needs. Services were provided free for patients and referrals came from local GPs.

The following services are provided:

- Full holistic assessment incorporating baseline observations and completing individual treatment plans as required.
- Healthy leg clinic – assessing patients with venous disease, arterial disease and lymphoedema. Doppler tests are completed as part of the holistic assessment. Compression therapy would also be implemented if appropriate. This clinic was held once a week, in addition, patients could attend for outpatient appointments.
- Treatment for patients with active leg ulcers, working in partnership with the local leg ulcer specialist service.
- Wound care including dressings' clinics working in collaboration with local practice nurses.
- Occupational therapy.
- Physiotherapy.
- A phlebotomy clinic was held once weekly. In addition to this clinic, patients could attend early morning for fasting blood tests.

Summary of this inspection

The treatment centre offered rehabilitation through one to one treatment or as part of a group: these were offered Monday through to Thursday. Fridays were dedicated to outpatient services only. During 2016, there were approximately 7,000 patient attendances.

There was one treatment centre, which was registered to provide the following regulated activities:

- Treatment of disease, disorder or injury.
- Diagnostics and screening.

During the inspection, we visited the treatment centre and we spoke with six staff including; registered nurses, allied health professionals, support assistants, and senior managers. We spoke with four patients. We reviewed five sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since registration with CQC.

- In the reporting period October 2016 to November 2016, there were 1,094 day case episodes of care recorded at the service, all of which were paid for by Letchworth Garden City Heritage Foundation.

The service employs three registered nurses, two physiotherapists, one occupational therapist, three support assistants, one receptionist and one housekeeper.

The service's track record on safety during the period January to December 2016 was:

- There had been no never events.
- There had been four clinical incidents all of which were low or no harm.
- There had been no incidents of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA).
- There had been no incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA).
- There had been no incidences of service acquired Clostridium difficile.
- There had been no incidences of service acquired E-Coli.
- There had been no complaints.

Services provided at the treatment centre under service level agreement:

- Clinical and or non-clinical waste removal.
- Interpreting services.
- Grounds maintenance.
- Maintenance of medical equipment.
- Maintenance and upkeep of the building.

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 this service. We found the following issues that the service needs to improve:

- One incident had been reported as a safeguarding concern but had not been reported internally as an incident.
- The hepatitis B status of staff was not held in personnel records.
- Some policies did not reflect the latest guidance and others had not been written. For example, a safeguarding children policy had not been written. The service took action to address this when we raised it as a concern.
- Attendance at mandatory training was low for some training courses, in particular safeguarding children.

However, we also found the following areas of good practice:

- The service maintained good standards of cleanliness and hygiene within the centre.
- The service had sufficient equipment, which was well maintained.
- Patient records were written and managed well.
- Staff had a good understanding of how to recognise and act on safeguarding vulnerable adult concerns.
- There were always sufficient numbers of staff to ensure that patient's received safe care and treatment at all times.
- A contingency plan was in place in the event of unforeseen circumstances.
- All staff were familiar with the duty of candour requirements.

Are services effective?

We do not currently have a legal duty to rate this service. We found:

- Generally, patients had their needs assessed and their care planned and delivered in line with evidence-based, guidance, standards and best practice.
- Pain was assessed and strategies were discussed with patients to manage and minimise their pain.
- Pre-employment checks were undertaken for new members of staff. There were induction arrangements for new members of staff.
- All staff from each discipline were involved in assessing, planning and delivering patient care.
- Information about patients was accessible at all times when the clinic was open.

Summary of this inspection

- Staff understood consent and decision making requirements.

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

- Information about the service's overall outcomes for patients' care and treatment was not collected or monitored and audits did not always follow national guidelines. Patients' feedback was collected.
- Competency checks were not undertaken for specific skills or use of equipment.
- Consent was not always recorded in patient notes and the consent and capacity policy did not reflect the latest guidelines.

Are services caring?

We do not currently have a legal duty to rate this service. We found:

- Staff took time to interact with patients, were respectful and considerate.
- Patients understood the care and treatment they received.

Are services responsive?

We do not currently have a legal duty to rate this service. We found:

- A free transport service was provided to patients who required transport to the treatment centre.
- Services provided reflected the needs of the population served.
- Patients were seen promptly by the service.
- Care and treatment provided was patient centred.

Are services well-led?

We do not currently have a legal duty to rate this service. We found:

- Feedback about the service was listened to.
- There was a positive culture and good leadership.
- The service had a documented vision and staff aimed to provide all patients with quality care.
- There was a governance structure in place and meetings were held regularly.
- Staff feedback was gauged on a continuous basis through one to ones and team meetings.

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

- Service performance was not routinely monitored.
- Risks faced by the service had not all been identified and recorded on the risk register.

Detailed findings from this inspection

Community health services for adults

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are community health services for adults safe?

We do not currently have a legal duty to rate this service. We found:

Incidents

- Staff understood their responsibilities to report incidents although they were not always reported using the correct template. Incidents reported were discussed at an appropriate committee. All incidents were discussed at the clinical review meeting that all staff attended. Following the inspection, the manager provided evidence that the service was now implementing a system for monitoring quality and safety.
- There was an incident reporting policy in place, which provided an overview of the reporting and investigating process. The centre used paper copy forms to report incidents and the staff we spoke with talked confidently about how they reported incidents and when it was appropriate to do so.
- The service reported no never events in the year preceding the inspection. 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.
- Eight incidents were reported using the 'accident and incident' template during the period 1 January 2016 to 31 December 2016. We also noted there was an additional incident, which had been notified to the local safeguarding authority, however, this had not been officially recorded or reported internally as an incident.
- We reviewed a sample of the incident forms. These had been completed including immediate remedial action. Most of the incidents did not require further follow up action. One of the four forms we reviewed related to a patient fall, the incident form included details of remedial action taken. We saw that incidents were a standing item on the clinical review committee agenda and that individual incidents were discussed. The service had recognised this as an area to improve.
- We asked staff about their understanding of duty of candour. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Duty of Candour is a regulation, which was introduced in March 2015 for independent health care providers. This regulation requires the organisation to notifying the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. A copy of the Royal College of Surgeon's guidance, "Building a Culture of Candour", had been placed on the policy file as a policy was in the process of being drafted. We were provided with evidence that this policy was completed shortly after the inspection took place. Staff had received training on duty of candour as part of the information governance training, although they were not all familiar with the term 'duty of candour'. However, when prompted it was clear that staff understood that they must be open and honest with patients, make an apology and provide support if required and appropriate. None of the reported incidents had met the threshold for Duty of Candour.

Cleanliness, infection control and hygiene

- Effective standards of cleanliness and hygiene were maintained within the centre. We observed the centre to be visibly clean on the day of our inspection.
- Cleaning schedules were on display.
- Weekly cleaning audits were undertaken and 100% compliance was achieved on the most recent audit.
- Infection control and hand hygiene audits were undertaken annually, with spot checks throughout the year. The infection control audits took place in January and February 2016 and the audits covered the toilets and kitchen areas. The audits found there were high standards of cleanliness in the areas inspected, and we saw actions taken following the audit included the replacement of pull cords.
- We reviewed the December 2016 hand hygiene audit findings, which demonstrated that staff had followed a high standard of hand hygiene practice. Hand hygiene facilities were fit for purpose.
- There had been no reported cases of infection outbreaks in the preceding 12 months.
- There was an infection control policy in place, which was approved in September 2015, and due for review in September 2017. The policy included guidance and protocols for hand hygiene, use of personal protective equipment, prevention of occupational exposure, management of blood and body fluid spillage, cleanliness of the environment and equipment, safe handling of linen as well as waste. All staff had signed to confirm they had read the policy.
- There were appropriately colour coded clinical waste bins as well as sharp bins which were stored and used appropriately within the building. We observed that sharps' management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The sharp bins were clearly labelled and tagged to ensure appropriate disposal.
- The clinical waste and sharp bins outside the building were not suitably secure. Bins were not lockable but were stored in a locked, purpose built area. The area used to store bins was not fully contained and could be climbed into by a member of the public. We raised this with the manager who took prompt action and arranged for a padlock to be fitted and we saw evidence of this.
- Clinical waste was collected by a waste management company and consignment notes were signed in accordance with the service's policy.
- All staff were required to complete infection control training. We were provided with data compliance rates for infection control training for the centre; 80% compliance had been achieved. One person was booked to attend in January 2017 and one other member of staffneeded to be booked on a course. The service had not set an agreed target for compliance with training.
- The centre had recently decided to introduce a sticker system to indicate which equipment had been cleaned and the date when this had been done. However, this had not commenced at the time of inspection but all equipment we inspected appeared visibly clean.
- We observed that staff were 'arms bare below the elbows' to enable effective hand washing and reduce the risk of infection. We saw that staff wore personal protective clothing as required and this was available throughout the centre. Hand gel was available in appropriate locations.

  Disinfection wipes were readily available for cleaning hard surfaces and equipment surfaces in between patients, and we saw staff using them.
- There was no evidence on staff files to confirm they had received the required hepatitis B vaccinations or had the required immunity status. Healthcare workers are at increased risk of being infected with the virus due to the exposure to blood and other body fluids and the high contagiousness of hepatitis B.

Environment and equipment

- The design, maintenance and use of facilities and premises kept people safe from avoidable harm. Equipment was maintained and serviced as required. We saw evidence that equipment had been subject to electrical appliance equipment testing and had been calibrated.
- During our inspection, we observed that there was adequate seating and no patients or relatives were standing.

- The service had a defibrillator for use in the event of a cardiac arrest, which had been checked daily to ensure it was safe for use. There were oxygen cylinders available should a patient suffer from breathing difficulties. Staff had completed basic life support training which included training on how to use the equipment.
- We saw that treatment rooms were clutter free and equipment was stored away with single use items such as syringes easily accessible.
- There was sufficient equipment to maintain safe and effective care. The service had an electrocardiography (ECG) machine (an ECG machine is a standard cardiology test used to record the electrical activity of the heart over a period of time), blood pressure and temperature monitors as well as cardio and balance equipment, for example, a treadmill and exercise bike. However, staff had not been competency assessed in how to use medical devices. The newly appointed manager had already identified this as an area of weakness and had begun to make a list of which competencies were required. The new manager was a trained competency assessor.

Medicines

- The centre did not prescribe or administer medicines apart from topical creams (prescribed by a GP). Records were kept of creams applied in the patients' notes. Patients brought their own creams in to their appointments.

Records

- Patient records were generally written and managed well. Patients' notes were completed on paper records and stored on site in a locked office.
- Some basic patient information was stored on the service's basic electronic system. This was a historic information system. At the time of inspection, the new manager was researching the possibility of using a more modern system, which would allow complete patient records to be recorded electronically.
- We reviewed five sets of patient records who attended the centre. Notes were mostly in good order, information was easy to access and we found they were legible, accurate, and up to date; however, some could have included additional information. For example, the wound of one patient had been photographed as it healed and the photographs were stored on file but improvement had not been documented in their notes, which meant their records were incomplete. Referral letters, past medical history and discharge summaries were on the patient file. The service had completed a record keeping audit in December 2016, overall the audit reported compliance with the standards expected from the service.
- An audit on patient confidentiality and data protection was carried out in October 2016. The audit was completed to ensure the confidentiality of patients' notes and data was upheld and maintained. Findings reported 100% compliance with the service's standards.

Safeguarding

- Guidance was in place and training undertaken for safeguarding vulnerable adults but not children.
- The treatment centre had a safeguarding adults policy in place that reflected national legislation and local requirements. The service did not have a policy on safeguarding children from abuse. Although children were not treated by the service, child protection concerns could still be evident, either because of children accompanying a relative, or through disclosure to a member of staff. The newly appointed manager recognised that there was no safeguarding children's policy in place. We discussed this and as an interim measure, the manager obtained a copy of the county council's policy and shared this with staff until a service specific policy could be written and approved in early 2017.
- Staff received training and had a good understanding of their responsibilities in relation to safeguarding of vulnerable adults. The staff we spoke with were able to explain safeguarding arrangements, and when they were required to report issues to protect the safety of vulnerable patients.
- There had been one concern regarding another service, which required a safeguarding referral during the previous 12 months, and we saw that a referral had been made to social services.

- An audit was undertaken in July 2016 to assess each member of staffs' understanding and knowledge about safeguarding. The audit concluded staff had a good awareness of safeguarding concerns and protocols.
- All members of staff had a card attached to their ID badge, which informed them of relevant safeguarding contact details. Information was also on display in appropriate locations within the unit as well as in the safeguarding adult policy.
- In 2016, the centre reported 100% of staff had up to date training in adult safeguarding but only one member of staff was up to date with safeguarding children training level two. We raised this with the manager who immediately made arrangements for staff to complete the required level of safeguarding children's training; we were provided with evidence this had been done.
- All members of staff had an up to date disclosure and barring check (criminal record check), relevant checks had been undertaken prior to employment for each staff file we reviewed.

Mandatory training

- There were systems in place to provide mandatory training to all staff. This was monitored by the manager, although attendance at some courses was better than others.
- There were ten mandatory training courses which were made up of on-line and face to face sessions in; safeguarding adults level two, mental capacity act, basic life support, infection control, information governance, patient handling, conflict resolution, equality and diversity, safeguarding children level two, fire safety and health and safety.
- We saw that some mandatory training courses had been better attended than others. For example, mental capacity act training had been completed by 100% of staff but health and safety training had not been completed by any member of staff. The overall completion rate was 64% for all mandatory training courses: a target had not been set by the service. The new registered manager was aware of this and had already started to take action by identifying which staff were overdue some training courses and we were provided with evidence that staff had been booked to attend.

Assessing and responding to patient risk

- A nurse reviewed all referrals into the clinic and assessed if patients were suitable to attend. All patients accepted into the clinic were low risk. Patients who had suffered a stroke had been subject to an assessment by the discharging service to ensure they met the criteria of the treatment centre.
- Risk assessments were completed for patients at their first appointment and this was assessed on each subsequent attendance.
- If a patient's condition deteriorated and they were no longer suitable for treatment at the centre they would be referred back to their local GP.
- If a patient became unwell or deteriorated whilst attending the centre, staff would undertake basic first aid and dial 999.

Nursing staffing

- Staff levels were suitable to ensure that patients' received safe care and treatment at all times.
- There was one qualified nurse appointed to run clinics who was supported by one healthcare assistant. The manager and deputy manager of the service were also qualified nurses and able to provide cover or support if required. There were no nursing vacancies.
- There was an induction programme for all new staff including agency staff when appointed which involved completion of a checklist to ensure the new member of staff had been appropriately orientated to the service. We saw evidence of this.
- Nurse clinics followed the same weekly schedule with clinic lists held daily Monday to Friday. We were told that capacity was managed well and that staffing arrangements were adequate to meet the needs of patients.
- We saw that all registered nurses employed had a valid nursing registration, to confirm nurses that nurses were eligible to practise within the UK.

Community health services for adults

- Multidisciplinary handover meetings were held each morning between all staff including nursing and therapy staff. Each patient who was booked to attend an appointment that day was discussed at the morning meeting to ensure consistency of approach.

Therapy staffing

- Staff levels were suitable to ensure that patient's received safe care and treatment at all times.
- There was one occupational therapist who was supported by an assistant occupational therapist. There were two physiotherapists who had the support of an assistant.
- One of the physiotherapy positions was vacant and cover was being provided by a long-term agency worker until the post could be recruited to. The position had been previously advertised but had not been filled and was due to be advertised again in January 2017.
- We were told that if therapy staff were sick or on leave, agency cover would be provided or clinics cancelled or rescheduled. We were informed that during the previous 12 months, only one patient had needed to be cancelled due to unavailability of staff and we were provided with evidence of this
- There was an induction programme for all new staff including agency staff when appointed which involved completion of a checklist to ensure the new member of staff had been appropriately orientated to the service. We saw evidence of this.
- Multidisciplinary meetings were held each morning between nursing and therapy staff. Each patient booked to attend an appointment that day was discussed at the morning meeting.

Emergency awareness and training

- A contingency plan had been developed in the event that services were interrupted due to unforeseen circumstances and staff were up to date with fire safety training. Staff were expected to complete fire safety training every two years. Staff were up to date with this, and were due to complete their update training in February 2017.
- The contingency plan listed some examples or possible events, which may affect service provision. This included, severe weather, staffing levels, heating failure or power failure. In most circumstances, clinics would be cancelled. We were told that if there was a flood or severe weather that patient appointments would be cancelled. The service provided was run by a charity and aimed to support local NHS services. Therefore, in the event of a major incident or disaster, patients would be referred back to the NHS.
- Fire drills were undertaken every six months, these were organised by the administrator. We were informed by the manager that these worked well and all staff and patients had been evacuated from the building in accordance with set procedures and timescales.

Are community health services for adults effective?
(for example, treatment is effective)

We do not currently have a legal duty to rate this service. We found:

Evidence-based care and treatment

- Generally, patients had their needs assessed and their care planned and delivered in line with evidence-based, guidance, standards and best practice.
- A standard pre-assessment form was completed for all patients prior to accepting them for treatment. Patients were not discriminated against because of age, disability, gender or gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation.
- There were documented policies and guidance for some aspects of patient care and treatment provided by the service. For example, there were policies for blood pressure monitoring and blood glucose monitoring, healthy leg clinical guidelines and ear syringing which were up to date and in accordance with national guidance. However, the service had not documented their own procedures for therapy services, for example, caring for someone with a brain injury or caring for patients who had suffered a fall. The manager had identified this, and staff had copies

of national guidance available until the manager had documented internal policies and procedures. Documenting guidance had been included as part of the action plan.

Pain relief

- Patients' pain was assessed and documented. The clinic did not prescribe or administer medication for pain relief.
- All patients who attended the service had their pain assessed in accordance with a national recognised pain scale. We saw that the patients' own description of their pain was recorded in their notes.
- Causes of pain as well as strategies to minimise the level of pain experienced were also documented. Patients were referred back to their GP or another service if necessary for ongoing pain relief management.

Nutrition and hydration

- The service did not provide meals to patients, as they only attended for a short time. Assessments were carried out regarding nutritional status when required. Referrals to GPs were made when required.

Patient outcomes

- Information about the service's overall outcomes for patients' care and treatment was not routinely collected or monitored. Audits of some aspects of treatment took place, although this was not always in line with national guidance. Patients' feedback was collected.
- All multi-disciplinary and therapy patients had individual goals set and these were reviewed on a weekly basis. The centre followed National Institute of Health and Care and Excellence guidance that was relevant to the individual patient's condition. Goals were reviewed to ensure patients progressed in accordance with their treatment plan. Progress for individual patients was also recorded in a diary; however, there was no formal monitoring of overall performance for treatment outcomes. The manager had identified this and planned to undertake audits on patient outcomes.
- The centre also followed Royal College of Nursing guidance for leg ulcer healing rates with an overall aim to see improvement within six weeks. The ulcers on patient legs were photographed and measured at each review. Data on leg healing rates were not monitored for the service as a whole. The manager had identified this and planned to gather data going forward.
- Patients who received therapy or nursing services were treated and offered follow-up appointments as required until the patient had met their goals or their wound had healed. Data was not routinely collected on the length of time therapy took for certain conditions or how long wound / ulcer management continued for. Timeframes and milestones for improvement were not set. The manager explained that this was because the service could continue to treat patients as required and that they were not restricted to a prescribed number of appointments. This meant that if treatment provided was ineffective, this may not necessarily be identified and acted on to improve patient care.
- Audits were undertaken on leg ulcers. Doppler (a Doppler ultrasound measures the amount of blood flow through arteries and veins, usually those that supply blood to your arms and legs) clinic notes were reviewed in line with the local adapted healthy leg ulcer notes and local leg ulcer service standards. The audit demonstrated an overall compliance of 96.7%, Agreed action was to continue to maintain and improve this standard. Audits failed to capture the clinical elements of care, for example, audit questions included: "Has the wound assessment form been regularly reviewed and updated?" and "Are the Doppler review forms filed in chronological order?". The audits failed to consider whether the correct care had been provided in line with national guidance. For example the Royal College of Nursing, 'The management of patients with venous leg ulcers' audit guide recommends assessing elements of care such as, which dressings were used, whether skin care preparation was used and, how long the ulcer took to heal.
- The audits undertaken by the treatment centre lacked clinical focus. The newly appointed manager had

recognised this as a weakness and had already considered improving the audits based on national guidance. Audits on physiotherapy and occupational therapy were being planned for 2017.

Competent staff

- Recruitment checks were in place to ensure that staff employed by the service had the right qualifications, skills, knowledge and experience to do their job and this was monitored on a continual basis. All professional staff were registered with their respective national body, for example the Nursing and Midwifery Council or the Health and Care Professionals Council.
- Competency checks for specific skills were not undertaken, for example, on use of equipment or how to correctly dress a wound. The newly appointed manager had already identified this as an area of weakness and had begun to make a list of which competencies were required. The new manager was a trained competency assessor.
- Pre-employment checks were undertaken and we saw that all members of staff had a valid and up to date DBS check (criminal record check), two references and were registered with the appropriate professional body if necessary, for their role. Membership was checked for all registered members of staff to ensure this remained up to date.
- Induction arrangements were in place, a standard checklist was used to act as a prompt. This included orientating the new member of staff and informing them about processes as well as allocating time for the staff member to read policies and procedures.
- We reviewed the files for three members of staff and found that all staff members had completed their annual appraisal and personal development plan to help identify their learning needs.
- Employees were supported to attend external training or events which were relevant to their role.
- One to one meetings had been held with each individual periodically throughout the year, although these were not routinely undertaken regularly.
- The service employed 10 members of staff and daily meetings were held, staff told us they could discuss any concerns with their manager at any time if they wanted to.

Multidisciplinary working

- All necessary staff from different teams were involved in assessing, planning and delivering patient care.
- The service provided some nursing and therapy services, including physiotherapy, occupational therapy for falls prevention and stroke care as well as some other neurological disorders, nursing staff provided leg ulcer and wound management care and treatment. All patients who attended the service (excluding patients attending for phlebotomy draw) were discussed at the daily multi-disciplinary meeting each morning or afternoon, prior to their visit.
- Staff worked closely with external parties, including GPs, care homes and social services to ensure any concerns were discussed and communicated effectively; we saw evidence of this in the records we reviewed. Clinical staff also co-ordinated and communicated with administrative staff to ensure appointments were booked as required.

Access to information

- Information needed to deliver effective care and treatment such as care plans, case notes and risk assessments were available to staff as required.
- Most of the information was available in paper records, the service had not switched to a fully encompassing electronic system. An electronic system was used to record basic patient information such as their names and addresses. This meant that if the paper records destroyed, there was no back up. GPs were sent a summary of the treatment plan following the patient's first appointment as well as a discharge summary. GPs were also notified of any concerns. The manager was researching the possibility of purchasing a more modern patient record system; a timeframe had not been established, as the manager was new into post.

Community health services for adults

- When patients moved between services, the information needed for their ongoing care was shared appropriately and promptly. The service used internal postal services so that information could be sent to GPs securely.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff generally understood consent and decision making requirements, although the policy was not reflective of current guidance and patient records did not consistently include a record of when consent had been obtained.
- The service had a patient consent policy in place, which outlined how consent was defined, assessed, when it was required and who from. However, the policy was not based on guidance issued by the Department of Health and had referred to the Mental Capacity Act 2005 (MCA). The policy had not distinguished between a person that may lack capacity due to a permanent or temporary impairment in the functioning of their mind or brain. Some of the language used within the policy was inconsistent with up to date guidance, for example, referring to a patient as being 'incompetent', which meant that guidance was not patient centred.
- We were told that patients were only accepted for treatment if they had capacity, this was because the centre was not adequately secure and did not have the staffing levels to ensure patients who lacked capacity could be adequately cared for.
- Patients who attended the service for stroke rehabilitation or other neurological services were assessed by another local rehabilitation centre for their suitability prior to acceptance by the treatment centre. Patients referred by their GP were initially assessed through medical history provided by their GP as well as a telephone interview, which incorporated a two-step assessment of their capacity.
- The staff we spoke with had a good understanding of how to assess a patient's capacity and were able to describe the steps required to make an assessment. All staff had completed mandatory training on the Mental Capacity Act 2005. However, we reviewed a sample of patient records and found that consent to treatment, whether written or verbal, was not consistently recorded in the patients' notes. The manager had recognised this as an area for improvement.

Are community health services for adults caring?

We do not currently have a legal duty to rate this service. We found:

Compassionate care

- Staff took the time to interact with patients and those close to them in a respectful and considerate manner.
- All of the patients we spoke with were complimentary of the staff and the compassionate care they provided.
- Staff showed an encouraging, sensitive and supportive attitude to patients.
- We observed positive interactions between staff and patients and patients told us they always felt supported and listened to.
- Staff ensured that where possible peoples' privacy and dignity was always respected. Examinations occurred in private rooms, with the door closed to ensure patient privacy and confidentiality was protected.
- The clinic conducted a patient satisfaction survey every quarter. For the quarter July 2016 to September 2016 a total of 20 responses were received. All patients reported that they felt comfortable asking questions about their treatment, that staff were friendly and that their dignity was respected at all times during their visit to the service.

Understanding and involvement of patients and those close to them

- Staff communicated with patients so that they understood their care, treatment and condition. The patients we spoke with confirmed that information was given to them in an easy to understand format. They also told us that they felt able to ask questions if they needed any further information to help them understand.

Community health services for adults

- Staff recognised when patients needed additional support to help them understand and be involved in their care and treatment and enabled them to access this. Staff allowed patients' relatives to come into the examination room, to act as an advocate, if necessary.

Emotional support

- We saw positive interaction between staff and patients during our inspection. Patients appeared relaxed and comfortable in their surroundings.
- Patients told us that staff had enough time to provide them with adequate emotional support.
- If staff had concerns about a patient's mental wellbeing, they spoke with their GP or care home after gaining as appropriate and after gaining consent and we saw evidence of this.
- Staff ensured that the atmosphere in the clinic was calm and patients and relatives could ask questions.
- We observed one patient who appeared visibly anxious about waiting for their appointment. Staff interacted with the patient and asked them how they were and what they had been doing over the Christmas period in order to help them feel more relaxed.

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

We do not currently have a legal duty to rate this service. We found:

Service planning and delivery to meet the needs of local people

- The services provided reflected the needs of the defined population served and ensured flexibility, choice and continuity of care. Referrals came from local GPs.
- The treatment centre was funded by a local charity and therefore service planning did not involve primary care commissioners. The manager had recently been invited to attend the clinical commissioning group meetings to see how the service could further enhance local NHS clinics.
- The manager had recently met with some local GPs to make them aware of the services provided.
- Stakeholders made up the membership of the treatment centre's clinical review meetings, including a local GP and community nurse. The focus was on the function of the treatment centre but stakeholders also had the opportunity to comment on how the service could be enhanced.
- A GP from a local practice had recently suggested they would like to facilitate a falls prevention group and this under discussion.
- The facilities and premises were appropriate for the services that were planned and delivered. Comfortable seating was available, including a chair and couch for larger patients.
- Parking was available directly outside the centre.
- The centre had the capacity to see more patients and had recently started educating local GP services to promote the different treatment options offered by the service.

Access and flow

- Patients had timely access to initial assessment, diagnosis and treatment and ongoing appointments. The national referral to treatment target (the length of time between initial referral and treatment starting) was 18 weeks. The clinic performed better than this, with an average referral to treatment time of seven weeks. The service had recently started to monitor waiting times, following the appointment of the new manager.
- As far as possible, patients accessed care and treatment at a time to suit them. Appointments were booked over the telephone with the administrator. Appointments were offered Monday to Friday in morning or afternoon sessions. The administrator worked with the patient to find a suitable time for the appointment.
- Appointments were generally booked on a first come first serve basis. Due to the flexibility of appointment times and available capacity, same or next day appointments were usually available if a patient had concerns.

- Appointments were rarely cancelled. Data for November 2016 reported that there were 248 booked appointments: no appointments had been cancelled by the centre.
- 34 appointments were not attended or cancelled by the patient, 9% were not attended and 4% were cancelled in advance by patients. If patients failed to attend, a member of staff called them to re-book the appointment.
- We were told that appointments were rarely cancelled because cover could usually be arranged to cover planned leave or sickness absence. If there was a long term issue which affected patients, they would be referred back to their GP. The service was entirely funded by a charity and its aim was to alleviate pressure from local NHS services.

Meeting people's individual needs

- Services were planned and delivered to take account needs of the patients, although it was not designed to meet the needs of all patients in the community who had complex needs and vulnerabilities who used the service..
- We were told that patients were only accepted for treatment if they had capacity, this was because the centre was not adequately secure and did not have the staffing levels to ensure patients who lacked capacity could be adequately cared for. Patients who attended for stroke rehabilitation or other neurological services were assessed by another local rehabilitation centre for their suitability, prior to acceptance by the treatment centre. Patients referred by their GP were initially assessed through medical history provided by their GP as well as a telephone interview which incorporated a two-step assessment of their capacity.
- A free minibus service was available to patients. The minibus service was run and largely paid for by the Heritage Foundation, with one minibus purchased by another local charity. This enabled patients who may have struggled to attend appointments to receive free transport directly from their home to the centre.
- Patients who attended the treatment centre were informed prior to their first appointment that all staff who work at the centre were female and that if they preferred to receive treatment from a male member of staff they could be re-referred to another service.
- The main area where patients were encouraged and supported to partake in physical rehabilitation activity, such as using cardio or balance equipment was in an open plan area. This meant that other patients, relatives as well as staff not directly involved in the provision of treatment were able to observe. Prior to patients attending their initial appointment, they were sent a letter which informed them of the open plan arrangement and they were given the opportunity to be treated by another service provider if they preferred.
- The service did not accept people who lived with dementia or did not have capacity to make their own decisions. If patients' needs changed, they would be referred back to their local GP.
- All patients were offered a warm drink and biscuits on arrival for their appointment and had the opportunity to sit with other patients and staff in a designated area if they wanted to.
- All areas of the clinic could be accessed by wheelchair users and there were disabled toilets available.
- The service had a mobile induction loop available (an induction loop is a sound system in which a loop of wire around an area in a building produces an electromagnetic signal received directly by hearing aids used by people who are partially deaf) for people with hearing impairments, if required.
- The service had taken reasonable steps to ensure that patients with disabilities were able to access the service and necessary adjustments to the environment had been made. Patients were informed prior to their first appointment that all employees were female and that should they prefer to be treated by a male member of staff they should be referred back to their GP to be treated at another service.
- An inclusive access audit had been undertaken by an external consultant. The audit highlighted some areas for improvement and we saw evidence that action had

been taken or that it was in progress. For example, the audit identified the need for some door handles and light switches to be in contrast colour to the door / wall and we saw that this work had been completed.

- The clinic had access to a telephone translation service, although we were told this was very rarely required.
- Chairs were available in the waiting room and a treatment couch for larger patients, although we were informed that these were not usually required.
- Patient information leaflets were available and on display in the centre. Leaflets were in English but could be translated if required.
- Patients were able to find further information or ask questions about their care and treatment. The telephone number for the service was on all letters sent to patients which they could call if they had any questions or concerns. The patients we spoke with were aware of this, and said they would call if they had any questions.
- The reception at the treatment centre was in close proximity to the main entrance. Patients were not always able to speak to the receptionist without being overheard. However, no information regarding the patient was shared at this point. Only the patient's name and appointment time was given, thus reducing the risk of any breach of confidentiality.

Learning from complaints and concerns

- A complaints' policy was in place and patients knew how to make a complaint if they needed to. The policy outlined the internal complaints process, where complaints should be sent and what to do if the patient was not satisfied with the response to their compliant.
- From January 2016 to December 2016, the centre had not received any formal complaints.
- We were told that complaints were rarely made and that usually if a verbal complaint was made, this would be resolved immediately by the member of staff involved or the service manager.
- Information about how to make a complaint was displayed on the notice board in the main corridor within the centre. The patients we spoke with told us they had not needed to make a complaint and that if they did, they would speak to a member of staff in the first instance.

Are community health services for adults well-led?

We do not currently have a legal duty to rate this service. We found:

Leadership and culture of service

- The manager for the treatment centre was new into post. They had applied to be the registered manager with CQC and this was expected to be completed by February 2017. The manager was supported by a deputy who had held their position at the centre for a number years. The manager had started to identify some gaps in the service, which were similar to those we found during the inspection. The manager was taking steps to ensure action was taken, for example, to improve training attendance and ensure policies and procedures were up to date.
- The manager was accountable to Letchworth Garden City Heritage Foundation (LGCHF), a charitable organisation who owned the centre. One of the directors for the LGCHF held regular meetings with the manager to ensure the service functioned as intended.
- The manager was an experienced nurse who had previously worked within another leg ulcer service.
- We observed the centre had with clear leadership with clear definition of roles and responsibilities. The manager and deputy manager were both on site during operational hours, the deputy manager also worked clinically.
- The staff we spoke with told us they felt very well supported and if they had concerns, they could speak with the manager or the deputy manager at any time.
- We observed positive interactions between managers and staff.
- We observed the manager greeting some of the patients as they entered the building, the manager

knew the first names of all of them and asked how they were. The patients appeared to be pleased to be met by them and greeted the manager in a warm and friendly manner.

Vision and strategy for this this core service

- The vision for the service was to, "Provide free health care for our local community in our unique treatment centre, where patients are given the time they require to address their individual needs in a safe and friendly environment". The service was funded by LGCHF whose purpose was to maintain and enhance the world's first Garden City for the enjoyment of everyone who lived, worked and visits there. The LGCHF aimed to do this by supporting, funding and promoting activities and projects in order to deliver its charitable commitments for the benefit of the local community.
- The manager told us there was a strategy to increase the number of patients treated at the clinic by making GPs more aware of what the service had to offer. The manager had already met with some local GPs and planned to meet more. Mouse mats for PCs had been produced which detailed the full service provision and these had been distributed to GP surgeries to help create awareness about the centre.
- The new manager had identified there was no business plan in place; the manager had identified some areas of weakness within the service, including the lack of a business plan. As a result, an action plan had been developed which included this as an area for action. There was an annual budget and the manager worked within the constraints of the agreed budget.
- All staff spoken with said they were committed to providing a positive patient experience.

Governance, risk management and quality measurement

- There was a governance structure in place within the centre. A clinical review committee (CRC) had been established to oversee the quality and management of the service. This reported to the LGCHF Board of trustees.
- The CRC was responsible for monitoring patient and carer experience, risk management, education and training, clinical audit, openness and evidence based care. The committee met every three months and was attended by staff who worked at the service as well as a trustee from the charity and head of charitable services, representatives from GP practices and other community services were also invited.
- Review of meeting minutes confirmed discussion was held around audits, incidents, patient feedback, staff training and recruitment updates. From the data reviewed as part of this inspection, it was apparent that deliverables were positive and that patients were seen promptly and good progress was made with patient treatment. However, the committee did not include discussion around performance of the service, including outcomes for patients. If this was not discussed, staff may have been unaware of how they were performing compared to other services: this acted as a benchmark to identify poor performance or encourage staff to continue to improve by sharing positive results. We also saw that audits were not undertaken in line with national guidance, for example the leg ulcer audit.
- Safeguarding was not a standing agenda item at the Clinical Review Committee meetings, but it was discussed at regular team meetings. This meant that there was a potential risk staff may not share concerns with each other or ensure safeguarding remains a focal point of ensuring patient safety.
- There were systems in place to identify risks. There were ten identified risks on the service's risk register. The register had been reviewed in September 2016 and each identified risk had been scored according to the likelihood of it materialising as well as the potential impact. Mitigating controls were recorded for each risk. Risks included lone working, complications due to injury, patient falls, and availability of medical records. The risk register was discussed at the CRC.
- We identified some additional risks as part of the inspection, which had not been recorded on the register, for example, policies not reflecting the most up to date guidance. The manager was new into post and had identified many of the issues and was working towards addressing each of these.

Public engagement

- Patient feedback was obtained to shape and improve the service. Patient surveys were conducted every quarter to gauge their feedback on the care provided

and enable changes to be made. The quarter 3 survey largely reported positive results. Most patients reported the service was safe and clean with adequate equipment and staff numbers and that staff clearly explained the treatment options and care provided. Some patients were unaware that they could refuse treatment if they wished to. An action plan had been developed to address weaknesses. Actions included, 'to make patients more aware of the role of the Care Quality Commission', 'direct or sign post patients onto other health and social care services' and 'improve communication with regard to patients recognising that they can refuse treatment at any time'. We also noted that some feedback related to improved accessibility. As a result the provider commissioned an external consultant to review accessibility to the treatment centre and a full report was produced and actions undertaken.

Staff engagement

- Staff feedback was obtained to shape and improve the service.
- A formal staff survey was not undertaken, as there were 10 employees who worked for the service.
- All staff were given the opportunity to comment on how the service was run during the monthly team meetings as well as at their one to one meetings and annual appraisals.

Innovation, improvement and sustainability

- The service had recently produced and distributed mouse mats for personal computers (PCs) to the local GP services to raise awareness of care and treatment offered at the centre.
- There was an agreed annual budget and we were told that the manager ran the service within the constraints of the budget.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- To ensure that all staff complete incident report forms.
- To ensure that all staff provide evidence of their hepatitis B status and copies of these are stored in staff personnel files.
- To ensure policies are in place for aspects of care and treatment provided and that they reflect the latest national guidance.
- To ensure staff complete mandatory training courses.
- To ensure a local child protection policy is in place.
- To collect and report on patient outcomes as a matter of routine.
- To ensure that staff are competency assessed for use of equipment as well for certain procedures.
- To ensure that performance is routinely monitored.
- To ensure that all risks faced by the service are recorded on the risk register.