Essex Lodge Surgery

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?	Good
Are services well-led?	Good

Overall summary

This service is rated as Good **overall.** (Previous inspection 1 May 2018 – Unrated)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at Essex Lodge Surgery on 10 June 2019 to follow up on breaches of regulations. CQC inspected the service on 1 May 2018 and asked the provider to make improvements regarding a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We checked these areas as part of this comprehensive inspection and found this had been resolved.

The service is an independent health care provider that provides NHS contracted specialist musculoskeletal (MSK) care, chronic pain management, and private slimming clinic services.

Our key findings were :

- The practice provided care in a way that kept patients safe and protected them from avoidable harm.
- Patients received effective care and treatment that met their needs.
- Staff dealt with patients with kindness and respect and involved them in decisions about their care.
- The practice organised and delivered services to meet patients' needs.
- The way the practice was led and managed promoted the delivery of high-quality, person-centre care but some systems or process needed to be reviewed and improved.

The areas where the provider **should** make improvements are:

- Only supply unlicensed medicines against valid special clinical needs of an individual patient where there is no suitable licensed medicine available.
- Review the policy for prescribing weight loss medicines to clarify the criteria and evidence base for initiating, reviewing and discontinuing treatment.
- Review and improve arrangements for fire drills for staff working weekends to ensure staff and patient safety in the event of a fire.
- Review and improve systems to ensure actions to improve safety following significant events, and to identify trends.
- Review, improve and communicate an appropriate whistleblowing procedure to all staff to ensure its clarity and effectiveness.

Dr Rosie Benneyworth BM BS BMedSci MRCGP Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

The CQC inspection team consisted of a CQC lead inspector, a GP specialist adviser, a practice manager specialist adviser, and two members of the CQC medicines team.

Background to Essex Lodge Surgery

Essex Lodge Surgery operates under the provider Essex Lodge I-health Ltd within the premises of Essex Lodge (a GP Practice) and was formed in 2009 to facilitate clinical care delivery from a community based setting. It is situated in a three storey premises which it shares with a GP surgery called Essex Lodge. The Essex Lodge GP practice was granted planning permission to extend the premises. This work was underway at the time of the previous inspection in 2018 and has now been completed. All treatment and consultations provided by Essex Lodge Surgery are undertaken in rooms on the ground floor.

Essex Lodge I-health Ltd is part of a consortium of providers (Barts Health, Homerton Hospital, BMI, Essex Lodge I-health Ltd, East London Foundation Trust, and Patient First Ltd) to deliver specialist musculoskeletal (MSK) care and chronic pain management to patients that belong to NHS Newham Clinical Commissioning Group (CCG). The services are provided under an NHS contract and include physiotherapy, acupuncture, steroid injections, spinal injections that are administered off site in a hospital setting, and chronic pain management including associated counselling and psychotherapy such as cognitive behaviour therapy (CBT).

Essex Lodge I-health Ltd also provides a private slimming service from the Essex Lodge (GP Practice) premises, outside of NHS time weekly on Friday afternoons, and once a month on Saturday and Sunday mornings. This is a private service where patients pay for their treatment. The slimming clinic staff team includes four non-clinical administrators (all with a range of part time hours), one GP and one director of operations. Patients are all welcomed and checked in by slimming clinic staff.

The service is registered with the Care Quality Commission to carry on the regulated activities of maternity and midwifery services, treatment of disease, disorder or injury, surgical procedures, slimming clinics, and diagnostic and screening procedures. This service is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC which relate to particular types of regulated activities and services and these are set out in and of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Essex Lodge Surgery provides a range of non-surgical cosmetic interventions, for example botulinum toxin injection which are not within CQC scope of registration. Therefore, we did not inspect or report on these services.

Dr Hardip Nandra is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The specialist musculoskeletal (MSK) and Pain clinic service provides a variable amount of appointments ranging from 100 to 200 per month depending on factors such as the time of year, number of referrals from GPs within the local CCG area. The staff team are employed by either: Barts Health NHS Trust, Essex Lodge I-Health Ltd or East London Foundation Trust. The team includes four GPs (three male and one female) including the lead specialist GP who is the Director of Essex Lodge I-health Ltd. The GPs have a range of special interests in areas applicable to MSK care and chronic pain in areas including rheumatology, orthopaedics, and chronic pain management. In addition, there are two consultant anaesthetists, a Cognitive Behaviour Therapist, four physiotherapists and a physiotherapy team leader. Non clinical staff are a full time director of operations and four administrators that work a range of part time hours.

Service opening hours are Monday to Friday from 9am to 6pm, Saturday 9am to 1pm and once a month Sunday 9am to 12pm.

Approximately five to ten MSK clinical sessions run per week, according to patient need such as the number of patient referrals. On an average week there are likely to be a combination of 10 sessions from:

Musculoskeletal (MSK) and Pain Clinics:

- Monday 2:20pm to 5pm - Consultant anaesthetists' appointments.

- Monday 9am to 2pm – Pain CBT
- Tuesday 9am to 2pm – Pain CBT & Group Sessions
- Tuesday 4pm to 6pm – Physiotherapy
- Wednesday 9am to 3pm – Pain CBT and Group Session
- Wednesday 10am to 1pm & 2pm to 5pm – Chronic pain clinic with a specialist GP.
- Thursday 2pm to 4pm - Chronic pain clinic with a specialist GP.
- Thursday 9am to 12pm - Physiotherapy clinic.
- Thursday 9am to 5pm - Consultant anaesthetists' appointments.
- Thursday 9am to 4pm - Pain CBT
- Friday Alternate Fridays 2pm to 5pm - Specialist GP Orthopaedic appointments alternating with Specialist GP Chronic pain relief and musculoskeletal clinics.
- Saturday 9am to 12pm - Physiotherapy clinic.
- Saturday 9.30am to 12.30pm - Specialist GP clinic.
- Rheumatology clinics run every first and third Saturday morning of the month.

Slimming Service:

- Friday afternoons – 12:30pm to 3:15pm and 5:30pm to 6pm
- Once a month Saturday Morning – 9am to 12pm
- Once a month Sunday Morning – 9am to 12pm

How we inspected this service

During the inspection visit we:

- Spoke with clinical and non-clinical staff including the lead doctor and service manager and reception and administrative staff.
- Reviewed a sample of patient treatment records and documents and policies for the service.
- Reviewed comment cards in which patients shared their views and experiences of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

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

These questions therefore formed the framework for the areas we looked at during the inspection.

Good

Are services safe?

We rated safe as Good because:

Patients were safeguarded and systems were in place to keep patients safe, including emergency equipment, and health and safety including infection control. Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The provider had systems in place to support compliance with the requirements of the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. There was evidence of shared learning across organisation and through dissemination of safety alerts and guidelines.

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- The service conducted safety risk assessments including for Legionella (water safety) and had safety policies which were regularly reviewed and communicated to staff.
- There were no locum staff because staff across all roles covered each other effectively. Staff received safety information from the service as part of their induction and refresher training.
- The service provided services to adults (aged over 18) only and had appropriate systems to safeguard vulnerable adults from abuse. Safeguarding and chaperoning policies were easily accessible to staff. The adult safeguarding policy outlined who to contact for further guidance if staff had concerns about a patient's welfare. The lead specialist GP was the lead member of staff for safeguarding.
- Arrangements at the service ensure they were equipped to work with other agencies if or as needed to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Not all staff working at the location were employed by the provider such as clinical staff employed by other members of the consortium of providers (Barts Health, Homerton Hospital, BMI, East London Foundation Trust, and Patient First Ltd) Barts NHS. Staff employed directly by the provider had relevant employment checks such as ID and references and the provider had taken steps to ensure all other staff working at the location had relevant employment checks, which we saw except for one immunity status check and one ID check for staff not employed by the provider. Management staff told us they were satisfied all relevant employment checks were undertaken as required by staff's employer because all staff were employed by either themselves or a member of the MSK/Pain collaboration that were contracted jointly.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- Immunity status checks had been undertaken for staff as appropriate to their role except May 2018 Public Health England (PHE) guidance () for non-clinical staff, in response to an increase in measles circulation within the UK in 2018 was not implemented. Management staff said they would ask all staff for full vaccination records and ensure that this will be included as a mandatory item for our employment checks over the next few weeks.
- There was an effective system to manage infection prevention and control.
- There was a fire risk assessment and staff were trained in fire safety but not all slimming clinic staff had been involved in a drill due to working weekends and not all staff considered the evacuation of patients. Management staff told us the next fire drill would occur in October 2019.
- The provider ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.
- The provider carried out appropriate environmental risk assessments, which considered the profile of people using the service and those who may be accompanying them.

Risks to patients

Good

Are services safe?

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for agency staff, if they would be needed in the future, and tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis.
- This is a service where the risk of needing to deal with a medical emergency was low. Emergency medicines and equipment were shared with the GP practice in the same premises and were always accessible including during weekends. There was a defibrillator and oxygen available on the premises, and medicines needed to treat anaphylaxis were available in the treatment rooms. They were in date and had been checked regularly.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place to cover all potential liabilities.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- The service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance if they cease trading.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

The service had reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, including vaccines, controlled drugs, emergency medicines and equipment minimised risks.
- The controlled drugs prescribed for weight loss were stored securely, labelled appropriately, and accurate records of orders, receipt and supply were maintained. The records were checked weekly.
- Medicines for use in the pain service were stored securely, checked regularly and were in date.
- The service carried out regular medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing.
- In the pain clinic, staff administered medicines to patients, made recommendations to the patient's GP and gave advice on medicines in line with legal requirements and current national guidance.
- In the slimming service, processes were in place for checking medicines and staff kept accurate records of medicines. The service did not initiate weight loss treatment for people with a body mass index (BMI) of less than 28 and we saw examples where medicines had not been supplied when the starting BMI was lower than this. Medicines for weight loss were prescribed for some people with a body mass index of between 28 and 30 who did not have additional risk factors and the provider did not provide evidence of effectiveness for this patient group. The minimum starting BMI of 28 was clearly documented but there were no written guidelines which set out additional criteria for reviewing and stopping treatment.
- The medicines this service prescribes for weight loss are unlicensed. Treating patients with unlicensed medicines is a higher risk than treating patients with licensed medicines, because unlicensed medicines may not have been assessed for safety, quality and efficacy. These medicines are no longer recommended by the National Institute for Health and Care Excellence (NICE) or the Royal College of Physicians for the treatment of obesity. The British National Formulary states that 'Drug treatment should never be used as the sole element of treatment (for obesity) and should be used as part of an overall weight management plan'.
- The service provided written information to patients about the medicines supplied and obtained consent to the use of unlicensed medicines.

Lessons learned and improvements made

Good

Are services safe?

The service learned made improvements when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons and acted to improve safety in the service such as ensuring patients records were correctly filed and controlled drugs safe storage and destruction. However, significant events systems and documentation did not indicate changes to systems or processes were considered to prevent recurrence to improve safety or identify trends.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents.

When there were unexpected or unintended safety incidents:

- The service gave affected people reasonable support, truthful information and a verbal and written apology.
- They kept written records of verbal interactions as well as written correspondence.

The service acted on and learned from external safety events as well as patient and medicine safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff. Entering patients in wrong patients records

Good

Are services effective?

We rated effective as Good because:

The service carried out assessments and treatment in line with relevant and current evidence-based guidance and standards. The service responded to referrals in an effective and timely way. Competence and knowledge was recognised as being integral to ensuring that high quality care was delivered by the service. Written consent was understood and implemented the relevant consent and decision-making requirements of legislation and guidance.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance (relevant to their service)

- The provider assessed needs and delivered care in line with relevant and current evidence based guidance. Patients' immediate and ongoing needs were fully assessed. Patients using the slimming service had an initial assessment including medical history, family history of obesity and an identity check.
- Clinicians had enough information to make or confirm a diagnosis and deliver appropriate care and treatment.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients. Patients using the slimming service were weighed at each visit and their blood pressure monitored. These activities were carried out by trained staff who had been assessed as competent. The doctor reviewed the information before supplying medicines. A maximum of 4 weeks supply was given at a time, and patients had a 4 week break after 12 weeks of treatment.
- Staff assessed and managed patients' pain appropriately.

Monitoring care and treatment

The service was actively involved in quality improvement activity such as completed clinical audits.

The service made improvements through the use of completed audits that had a positive impact on quality of care and outcomes for patients. The service had undertaken two single cycle and three completed (two cycle) audits. For example, an audit on patient's relief of pain following a spinal injection, and any changes in relief of pain by including physiotherapy soon after the spinal injection. In the first audit cycle of 68 patients all patients experienced relief of pain for up to six months. In the second audit cycle of 116 patients it was found by adding physiotherapy relief of pain was maintained for over six months. Another repeated cycle audit showed 114 patients (100%) having spinal injections had received appropriate follow up, and in the second this had been maintained of 176 patients receiving a spinal injection all (100%) were seen for follow up.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- The service had an induction programme for newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The service could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for specialist GPs in orthopaedics, and chronic and acute pain including back pain.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of service development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, clinical supervision and facilitation and support for revalidating GPs. Staff had received an appraisal within the last 12 months.
- All staff were appropriately qualified. Relevant professionals (medical) were registered with the General Medical Council (GMC) and were up to date with revalidation.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained including for slimming clinics. Staff were encouraged and given opportunities to develop.
- The service did not provide immunisation or ongoing reviews of patients with long term conditions.

Coordinating patient care and information sharing

Staff worked together, and worked well with other organisations, to deliver effective care and treatment.

Good

Are services effective?

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services and when appropriate. Information was shared between services, with patients' consent, using a shared care record and clinicians could access patient's hospital records such as x-ray results to inform clinical decision making. Similarly, when a service clinician prescribed a repeat medicine for a patient this information was immediately accessible to the patients own GP to avoid delays in patients receiving medicines they needed, including to relieve pain.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history.
- Staff told us they had not delivered care and treatment to any patients in vulnerable circumstances, but it would not be a barrier.
- Patient information was shared appropriately (this included when patients moved to other professional services), and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way. There were clear and effective arrangements for following up on people who had been referred to other services.

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice, so they could self-care. Patients using the slimming and other services were given leaflets and advice about exercise and healthy eating.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support such as repeat prescribing arrangements to ensure continuity of care, and referrals to a local physical exercise scheme (gym membership program).
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs. Including to secondary care.

Consent to care and treatment

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 but this had not been applicable in the scope of its care to patients so far.

Good

Are services caring?

We rated caring as Good because:

During our inspection we observed that members of staff were courteous and helpful. Staff we spoke with demonstrated a patient centred approach to their work. In addition, completed CQC comment cards were very positive and indicated that patients were treated with kindness and respect. Curtains and screens were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them. Information leaflets were available in easy read formats, to help patients be involved in decisions about their care.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect and patients were seen in a consultation room.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

Patients had timely access to the service. Results of the services latest customer satisfaction survey indicated that patient satisfaction levels were high. The service responded to complaints promptly and thoroughly.

Responding to and meeting people's needs

The service organised delivered services to meet patients' needs. It took account of patient needs and preferences.

- The service was set up in response to patient needs within the local population profile and in collaboration with its consortium partners and was commissioned by the local CCG as part of the National MSK (musculoskeletal). More recently approximately six months prior to our inspection the provider had added private slimming clinics to its services and CQC registration.
- The provider understood the needs of their patients and improved services in response to those needs. Slimming clinic sessions were changed from evenings to weekends in response to patient feedback.
- The facilities and premises were appropriate for the services delivered.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- The service was set up in response to patient needs within the local population profile and in collaboration with its consortium partners and was commissioned by the local CCG as part of the National MSK (musculoskeletal). More recently approximately six months prior to our inspection the provider had added private slimming clinics to its services and CQC registration.
- The facilities and premises were appropriate for the services delivered.
- There were a variable number of clinics provided which was tailored according to patient need such as GP referrals.
- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Referrals and transfers to other services were undertaken instantaneously and electronically through the joined up IT system.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- The service had a complaints guidance leaflet and a complaints policy and procedures in place.
- Information about how to make a complaint or raise concerns was available and staff treated patients who made complaints compassionately. However, the service responses to patient's complaints did not inform patients of any further action that may be available to them should they not be satisfied with the service response. Management staff told us they usually explained escalation steps in a face to face / telephone call to the patient and would now include this within its complaint response letter to patients.
- The service learned lessons from individual concerns and complaints, it did not analyse trends but acted on individual complaints to respond to patients and improve the quality of care where applicable. For example, after a patient had disagreed with a clinical decision. The service acknowledged and investigated the patients concerns and found the decision was the appropriate course of care and treatment, which they explained to the patient and they accepted.

Good

Are services well-led?

We rated well-led as Good because:

The leaders had the capacity and skills to deliver high quality, sustainable care and were aware of and receptive to making necessary improvements which they had done since our previous inspection. The provider had a clear vision to deliver high quality care and promote good outcomes for patients. Processes for managing risks, issues and performance were effective. There was a positive and professional working culture at the service. Staff stated they felt respected, supported and valued. The service took on board the views of patients and staff and used feedback to improve the quality of services.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Vision and strategy

The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The service monitored progress against delivery of the strategy.

Culture

The service had a culture of high-quality sustainable care.

- Staff felt respected, supported and valued and the service focused on the needs of patients.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when for example when responding to incidents, significant events and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed and demonstrated openness, honesty and transparency during our inspection. However, the whistleblowing policy directed staff to raise their concerns in writing to the providers most senior leader and lead clinician, and in the event this person was the subject of staff concern directed staff should inform their immediate superior, but there was no immediate superior. All reporting and escalation stages of the whistleblowing process were ring-fenced to one organisational leader and there was no reference to any external reporting body. We brought this to the attention of management staff that told us the staff structure chart shows two alternative persons employed by other organisations for the slimming clinic and the MSK/pain service; that they had since spoken to a third external person that stated they would step in if required, and the policy had been reviewed accordingly.
- There were processes for providing staff with the development they need. This included appraisal and career development conversations. Staff received regular annual appraisals in the last year and were supported to meet the requirements of professional revalidation where necessary. Clinical staff were considered valued members of the team. They were given protected time for professional time for professional development and evaluation of their clinical work.
- There were positive relationships between staff and teams and a strong emphasis on the safety and well-being of staff.
- The service actively promoted equality and diversity and staff felt they were treated equally.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

Good

Are services well-led?

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities.
- Leaders had established proper policies, procedures and activities to ensure safety.

Managing risks, issues and performance

Processes for managing risks, issues and performance were generally effective but some needed to be reviewed.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. However, the policy for prescribing weight loss medicines needed a review to clarify the criteria and evidence base for initiating, reviewing and discontinuing treatment. The process for staff immunity status checks needed to be reviewed considering Public Health England (PHE) guidance.
- The service had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions.
- Leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had commenced to underpin sustainable high care and outcomes for patients.
- The provider had plans in place and had trained staff for major incidents. However, no fire drills had been practiced by staff working weekends to ensure patients and staff safety in the event of a weekend fire.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The service involved patients, staff and external partners to support high-quality sustainable services.

- The service encouraged and heard views and concerns from the public, patients, staff and external partners and acted on them to shape services and culture such as through focus group meetings for patients and their carers.
- Staff could describe to us the systems in place to give feedback. For example, regular one to one and staff meetings. We saw evidence of feedback opportunities for staff and how the findings were fed back to staff.
- The service was transparent, collaborative and open with stakeholders about performance.

There was evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement such as completed cycle audits.
- The service made use of reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- There were systems to support improvement and innovation work. For example, staff told us the MSK/Pain service was staff told us the service was the first and only collaborative in the UK delivering the full care pathway for patients. The collaboration had developed data sharing agreements that allowed clinicians, with patient's consent, to see the information they needed to see without delay to allow prompt and best informed clinical decisions on patients care and treatment.