The Footmans Cottage

Inspection report

Castle Park
Frodsham
WA6 6SB
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Overall summary

This service is rated as Good overall.

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? – Requires improvement

We carried out an announced comprehensive inspection at The Footmans Cottage as part of our inspection programme. This location had not been inspected previously since registration.

The provider Bridgewater Family Planning Service Association Ltd offers surgical vasectomy procedures for clients in Merseyside and Cheshire across four clinics based in NHS premises.

The managing director 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.

At the time of the inspection there were no patients attending or receiving regulated services and we were unable to ask them about the service. However, we reviewed some comments from patients the service had received online and one written piece of feedback.

Our key findings were:

- Patients received detailed and clear information about their proposed treatment which enabled them to make an informed decision. This included costs (where applicable), risks and benefits of treatment.
- Peri operative care and advice was clear and post-operative support was available.
- Patients were offered appointments at a time convenient to them and treatment was offered in a timely manner.
- Patients' needs were fully assessed, and care and treatment was tailored to individual needs.
- Clinicians assessed patients according to appropriate guidance, legislation and standards and delivered care and treatment in line with current evidence-based guidance.
- Information about services and how to complain was available and easy to understand.
- There were sufficient staff who were suitably qualified and trained. However, systems for monitoring staff performance and training and development needs should be improved.
- There was not an effective governance framework in place in order to gain feedback or to assess, monitor and improve the quality of the services provided.
- The provider was aware of the requirements of the Duty of Candour.

The areas where the provider **must** make improvements as they are in breach of regulations are:

Overall summary

- The provider must ensure effective governance systems are developed, implemented and monitored to ensure continuous quality assurance and improvement.

You can see full details of the regulations not being met at the end of this report

(Please see the specific details on action required at the end of this report).

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

- Implement and monitor a system for demonstrating staff had received appropriate recruitment checks and required training at appropriate intervals.
- Implement and monitor an effective system for reviewing staff training, performance, learning and development needs.
- Appoint an appropriately qualified infection control lead to support the registered manager.

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

Our inspection team

Our inspection team was led by a CQC lead inspector**.**

Background to The Footmans Cottage

The Footmans Cottage Vasectomy service operates from office premises located in Castle Park, Frodsham, Cheshire, WA6 6SB. They are also known by the provider's name Bridgewater Family Planning Service Association Limited.

They provide vasectomy services to people in Merseyside and Cheshire from four clinic sites which are part of NHS premises. The provider seeks assurance from the host sites that health and safety of the premises is maintained and compliant.

The sites they operate from are:

Victoria Central Health Centre – Mill Lane, Wallasey

Halton General Hospital, Hospital Way, Palacefields, Runcorn

Fingerpost Health Centre, Atlas Street, St Helens

Aintree Teaching Hospital, Lower Lane, Liverpool

These sites were not visited as part of the inspection.

Opening hours/hours of operation:

Monday – Friday 9am – 5pm Office for enquiries

Saturday – 9am – 5pm Clinics

The service is registered with CQC under the Health and Social Care 2008 to provide the following Regulated Activities: Surgical procedures.

How we inspected this service

Before visiting we reviewed a range of information we hold about the service and asked the service to send us a range of information. This included the complaints they had received in the last 12 months, their latest statement of purpose, the details of staff employed to include, their qualifications and proof of registration with their professional bodies. As part of the inspection we reviewed feedback gathered from staff, spoke to the registered manager and reviewed a range of documents.

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:

The service provided care in a way that kept patients safe and protected them from avoidable harm.

Safety systems and processes

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

- The provider conducted safety risk assessments. It had appropriate safety policies, which were reviewed. However, these were not always communicated fully to staff, including bank staff. For example, incident reporting and infection prevention and control policies outlined who to go to for further guidance.
- The service had systems to safeguard children and vulnerable adults from abuse.
- The provider carried out staff checks at 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). At the time of inspection, the provider could not evidence that two members of clinical staff had DBS checks undertaken. Following the inspection evidence was sent to demonstrate these checks had been seen and up-to-date checks applied for. The provider had a DBS policy in place which identified action to be taken on receipt of the DBS check.
- We saw that staff had 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.
- The manager did not have an effective system in place for monitoring safeguarding training to ensure it was kept up to date and at the appropriate level for role.
- The provider delivered services from NHS premises. They sought assurance from the NHS sites that infection prevention and control (IPC) was managed, assessed and reviewed. We saw the IPC audits and reports for the four sites.
- The registered manager was the non-clinical infection control lead in the absence of a clinical professional delivering the role. Plans were in place to appoint a clinical lead for infection prevention and control.
- There were systems for safely managing healthcare waste.
- The provider sought assurance from the NHS premises management that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. The provider told us they reviewed the check lists for emergency equipment when on site and received written assurance, which was also documented in contracts/ service level agreements with the sites.
- The provider was assured that appropriate environmental risk assessments were undertaken and reviewed. We saw examples of risk assessments for the sites used.

Risks to patients

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. The provider had identified that there were staff shortages in key clinical roles and had commenced plans to recruit.
- Staff had received training in managing medical emergencies.
- There were appropriate indemnity arrangements in place, including public, employer and professional liability.
- There were suitable medicines and equipment to deal with medical emergencies situated at the premises where the vasectomy service operated from. The provider sought assurance from the NHS sites that emergency equipment and medicines were stored appropriately and checked regularly. The provider had their own anaphylaxis kits which they took on site. These were stored securely and checked regularly.

Good

Are services safe?

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 patient's own GP was informed of the procedures performed.

Safe and appropriate use of medicines

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

- The provider stocked and used a very small number of medicines. They had anaphylaxis kits which they took with them to the clinic sites used. Local anaesthetic used was stored, documented and managed safely.
- The service does not prescribe Schedule 2 and 3 controlled drugs (medicines that have the highest level of control due to their risk of misuse and dependence). Neither did they prescribe schedule 4 or 5 controlled drugs.
- Staff did not prescribe, administer or supply any other medicines to patients.

Track record on safety and incidents

The service had a good safety record.

- There were risk assessments in relation to safety issues, such as fire and general health and safety risks.

Lessons learned and improvements made

There was little evidence of the service having learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. However not all staff understood their duty to raise concerns and report incidents and near misses.
- There were adequate systems for reviewing and investigating when things went wrong, however incidents were not fully analysed, or reported on with identified actions documented. The service had documented one incident in the last 12 months. This had not been analysed or action identified to minimise the risk of it happening again.
- The service had a system in place to receive, assess and disseminate safety alerts to relevant members of the team where appropriate.

Good

Are services effective?

We rated effective as Good because:

People received effective care and treatment that met their needs.

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)

- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed patients' pain during the procedure where appropriate.

Monitoring care and treatment

There was limited quality improvement activity evident.

- The provider completed reviews of post-operative events and reviewed the results annually. However, there was no evidence of other quality improvement activity such as clinical audits, or any improvements made as a result of such activity.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles, however systems for ensuring access to training and appraisals needed improvement.

- All staff were appropriately qualified. Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC)/ Nursing and Midwifery Council (NMC) and were up to date with revalidation.
- Staff completed core mandatory training; however, records were not fully maintained or up to date. The provider told us they would be implementing a training matrix record for all staff and evidence was sent following the inspection to demonstrate this was in progress.
- The provider had not carried out staff appraisals, but staff were still encouraged and given opportunities to develop on an ad hoc basis.

Coordinating patient care and information sharing

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

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate. For example, the patient's own GP.
- All patients were asked for consent to share details of their consultation/treatment with their registered GP when they used the service.
- 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.

Good

Are services effective?

- Care and treatment for patients in whose circumstances made them vulnerable was coordinated with other services. We saw an example of a patient with hearing difficulties and their care was coordinated with the help of a sign language translator.

Supporting patients to live healthier lives

- Where appropriate, staff gave people advice so they could self-care, for example in post-operative care and support.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

- Staff understood the requirements of legislation and guidance when considering consent and decision making.

Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Good

Are services caring?

We rated caring as Good because:

People received care and treatment in a caring manner

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service had received a very small amount of feedback from patients on the quality of clinical care received. The limited feedback we saw from patients was positive about the way staff treat people.
- Staff told us they understood patients' personal, cultural, social and religious needs, they were understanding and had a non-judgmental attitude to 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 or who had accessibility needs, such as those who were deaf.
- One recent patient feedback we reviewed told us that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- 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:

Services were tailored to meet the needs of individual patients and were accessible.

Responding to and meeting people's needs

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

- The provider understood the needs of their patients and delivered services in response to those needs.
- 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.

- Patients had timely access to initial assessment, test results and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- The appointment system was easy to use.
- Information sent to other services was undertaken in a timely way.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately.

- Information about how to make a complaint or raise concerns was available.
- The service had complaint policy and procedures in place. They informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint.
- The service had procedures in place to review and learn lessons from concerns and complaints.

They had only had one complaint in the last 12 months, and this was dealt with appropriately.

Requires Improvement

Are services well-led?

We rated well-led as Requires improvement because:

There was not an effective governance framework in place that demonstrated quality assurance, improvement or auditing of systems and processes.

Leadership capacity and capability;

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

- The provider was aware of the issues and priorities relating to the quality and future of services. They understood the challenges they faced with staff absences and were planning to increase staffing to include succession planning for the future clinical leadership of the service.
- The provider/registered manager was visible and approachable.

Vision and strategy

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

- There was a clear vision and set of values.
- The service had realistic strategy and supporting business plans to achieve priorities.
- Staff understood the vision and values. However, from staff questionnaires, feedback indicated not all staff were aware of their roles and how they could help in achieving the vision and values.

Culture

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

- Staff felt respected, supported and valued.
- The service focused on the needs of patients.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us in the completed questionnaires they felt they could raise concerns with the manager/provider however they were not fully aware of policies, procedures and support in how to do this.
- The service promoted equality and diversity. Staff had received equality and diversity training through their professional roles.

Governance arrangements

There were no clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were lacking. Improvements were needed and an effective governance framework was not operational.
- Staff were not clear about their roles and accountabilities, for example some staff could not describe/or did not think it was part of their role or responsibility in relation to infection prevention and control or health and safety.

Requires Improvement

Are services well-led?

- Policies, procedures and activities were in place. However, these needed a program of review and revision in order to ensure they were up to date and reflected current regulations and guidelines. Policies and procedures were not widely distributed to all staff. The provider did not have practices or systems in place to assure themselves that staff had read and understood them, and they were operating as intended.
- The provider had oversight of safety alerts, incidents, and complaints.
- The service did not have processes in place to manage current performance. Performance of clinical staff could not be demonstrated as audit of their consultations did not take place. Appraisals of staff had not taken place in the last two years.
- Staff meetings were held infrequently. Not all staff attended these meetings and minutes were not circulated with the relevant information or actions needed.

Managing risks, issues and performance

There were processes for managing risks, however there was no clarity or monitoring of performance.

- There were some processes in place to identify, understand and monitor risks including risks to patient safety. Risk assessments of environment and fire risks were undertaken.
- Clinical audit did not take place and there was no clear evidence of action taken to improve quality as a result of audit. A review of post-operative events was undertaken annually.
- The provider had a business continuity plan in place, however there was no evidence that staff had been trained for major incidents.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- The service reported on, and provided performance information to their stakeholders
- The service submitted data or notifications to external organisations as required.
- There were 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 did not involve patients, the public, staff and external partners to support high-quality sustainable services.

- The service did not have robust mechanisms in place to gather and assess feedback, views and concerns from patients, staff or external partners. There was no evidence of views and concerns contributing to service improvements.
- Patient feedback mechanisms were lacking, a very small number of returns were gathered from satisfaction surveys sent out last year. The provider was currently thinking of ways to develop more meaningful ways to gather views.
- Staff had limited means in place to give feedback. Not all staff attended meetings and minutes were not widely distributed. Staff appraisals had not taken place for two years. The provider/registered manager did meet with staff on an informal basis during clinic sessions and told us this was an opportunity for feedback and information giving.
- Processes for providing all staff with the development they need was lacking. Staff had not received regular annual appraisals in the last two years. Development opportunities were given ad hoc without formal documented discussions and relating to service needs.

Continuous improvement and innovation

Requires Improvement

Are services well-led?

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

- The service could not give any examples of incidents and complaints where learning was shared and had been used to make improvements.
- There was a lack of development and review of individual and team objectives, processes and performance.
- There was a lack of audit processes or program in place to demonstrate service and quality improvement.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** • There were not effective governance systems or processes in place to assess, monitor and improve the quality of the services provided. • There was no evidence of learning from significant incidents or complaints. • Staff were not clear in understanding their roles and responsibilities and how to report concerns. Staff appraisals had not taken place regularly. • There were no effective systems in place to seek and act on feedback from relevant persons, including patients and staff, for the purposes of continually evaluating and improving service. • There was no effective audit plan or program in place. • There was a lack of effective processes in place for staff communication, review and monitoring the effectiveness of policies and procedures and for staff involvement in quality improvement.