# West Cambs Federation CIC

# Acorn Surgery

## Inspection report

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## Ratings

| | |
|---|---|
| **Overall rating for this service** | **Inadequate** |
| Are services safe? | **Inadequate** |
| Are services effective? | **Inadequate** |
| Are services caring? | **Good** |
| Are services responsive to people's needs? | **Good** |
| Are services well-led? | **Inadequate** |

## Overall summary

**This service is rated as Inadequate overall.**

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Inadequate

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Inadequate

We carried out an announced comprehensive inspection at West Cambs Federation CIC, Acorn Surgery as part of our inspection programme. West Cambs Federation is a Community Interest Company and is an independent provider of services to see patients for routine care who are registered with a GP practice across Huntingdonshire and Fenland.

This service is registered with Care Quality Commission (CQC) under the Health and Social Care Act 2008 and provides the following regulated activities:

- Diagnostic and screening
- Family planning
- Maternity and midwifery services
- Treatment of disease, disorder or injury

# Summary of findings

- Surgical procedures.

The regulated activities are available from four registered locations. Patients can be seen at any of these locations:

- Acorn Surgery, Oak Tree Centre, 1, Oak Drive, Huntingdon, Cambridgeshire. PE29 7HN
- Cromwell Place Surgery, Cromwell Place, St.Ives, Cambridgeshire. PE27 5JD
- Cornerstone Surgery, Elwyn Road, March, Cambridgeshire. PE15 9BF
- Buckden Surgery, Mayfield, Buckden. St. Neots. Cambridgeshire. PE19 5SZ.

One of the lead GPs 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 practice is run.

As part of our inspection we asked for CQC comment cards to be completed by clients prior to our inspection visit. In total across the four sites we visited, we received 47 comment cards which were wholly positive about the service and nature of staff and four that were mixed comments one reflecting poor care and three reflecting poor staff attitudes. Other forms of feedback, including patient surveys and social media feedback was generally positive.

**Our key findings were:**

- Patients were supported and treated with dignity and respect. The service offered four locations ensuring the service was accessible to all patients across Huntingdonshire and Fenland.
- The service had recently recruited new members to the management team and had, just before our inspection, employed an external consultant to develop an action plan to improve their service.
  - West Cambs Federation CIC delivered primary care services from existing GP practice premises. They employed clinical and clerical staff who worked in the member practices across Huntingdonshire and Fenland.

However, we also found that:

- The service had not ensured care and treatment was always provided in a safe way to patients.
- People were not adequately protected from avoidable harm and abuse.
- The service was unable to assure themselves that people received effective care and treatment.
- The leadership, governance and culture of the service did not assure the delivery of high-quality care.
- The service could not evidence that all the checks required to employ staff appropriately were in place.
- The service had not ensured all staff had been appropriately trained to undertake the tasks delegated to them.
- The service had not implemented effective systems to ensure appropriate and safe provision of emergency medicines and equipment.
- The service did not have systems and processes in place to ensure that safety alerts were managed or that staff were using appropriate guidelines such as National Institute for Health and Care Excellence (NICE).
- We found there was a lack of policies and procedures that had been written, approved and shared with staff to govern activity and ensure staff were adhering to the same processes.
- The service did not have systems and processes to give assurance that staff would raise, share and record all significant events. There was no clear evidence to demonstrate that any identified learning was shared with the whole practice team.
- The service did not have oversight of the premises from where they delivered services from. For example, they did not have oversight of up to date fire safety, health and safety or infection prevention and control risk assessments.
- As a result of feedback given on the day of the inspection, the provider shared with us an action plan to drive the improvements needed.

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

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

# Summary of findings

- Ensure staff are suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

As a result of these multiple breaches we imposed urgent conditions on the providers registration.

These conditions are that the provider must:

- You must ensure that West Cambs Federation CIC, its employees, servants and/or agents do not carry out consultations in respect of patients' in instances where they do not have full access to a patient's medical records. In the interests of patient safety, should there be an emergency situation in which you feel that you have no choice but to proceed with patient consultation, without access to that patient's full medical records then you must record in each instance where that occurs, as well as recording what the emergency was and why referring the patient elsewhere was not viable alternative.
- You must provide a report to the Commission by mid-day on 2nd August 2019 and again by mid-day on the Friday of each following week. The report must set out the following:

An update on your Action Plan submitted to the Commission on 23 July 2019 with details of:

any progress, completed actions, and how you intend to monitor compliance in respect of those actions moving forward.

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

- Review and implement systems and processes to ensure significant events and complaints however minor is recorded and ensure there are mechanisms for sharing information and learning with all staff to encourage improvements.
- Implement and monitor systems to keep clinicians up to date with current evidence-based practice such as National Institute for Health and Care Excellence (NICE) best practice guidelines.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

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

# Acorn Surgery

**Detailed findings**

## Background to this inspection

### Our inspection team

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist adviser and a nurse specialist adviser.

### Background to Acorn Surgery

- The provider of this service is West Cambs Federation CIC.
- The registered location is Acorn Surgery, Oak Tree Centre, 1, Oak Drive, Huntingdon, Cambridgeshire, PE29 7HN.
- The website address is: www.westcambsfed.nhs.net
- West Cambs Federation CIC.is an independent provider founded in 2015 and began providing routine GP services for improved access from September 2018. The service is open to 28 GP practices serving a population of approximately 200,000 patients.
- There is a West Cambs Federation Board, West Cambs Federation Executive, Director of Business and Operations. There is a Clinical Operations Manager, Service Manager and various administration staff. They employ four advance nurse practitioners, 23 nurses, 16 healthcare assistants and 24 receptionists. They also utilise 34 GPs and a further two advance nurse practitioners on a self-employed basis.
- West Cambs Federation CIC has three other sites located in the Huntingdonshire and Fenland area. These locations are registered separately with the CQC.
- The service is open between 6.30pm and 8pm on selected weekdays and is open on some weekends. The service displays the opening times for the site on their website and in the patients usual GP practice.

Before visiting, we reviewed a range of information we hold about the service and asked them to send us some pre-inspection information which we reviewed.

During or prior to our visit we:

- Spoke with a range of staff from the service including the registered manager, senior management team, GPs, Nurses, Health care assistants and reception staff.
- Reviewed a sample of records.
- Reviewed comment cards where clients had shared their views and experiences of the service.
- Looked at information the service used to deliver care and treatment plans.

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.

Inadequate

# Are services safe?

## Our findings

**We have rated the service as inadequate for providing safe services because;**

**Safety systems and processes**

**The service did not have clear systems to keep people safe and safeguarded from abuse.**

- The service did not have oversight of safety risk assessments that had been undertaken in the premises they used. There was a lack of safety policies in place to govern activity. The policies that were in place were regularly reviewed and communicated to staff. Immediately following the inspection, the senior management team developed an action plan to review and revise the service level agreement with Acorn Surgery to ensure they gain all the information they required to mitigate risks to patients.
- Staff were given an induction to the premises before they commenced their first shift of work. At engagement events held in May 2019, the staff had requested better inductions, we saw that the service had acted on improving some of the induction and had a check list for those using the premises for the first time.
- The service did not have adequate systems to safeguard children and vulnerable adults from abuse. Not all staff we spoke with were aware who the safeguarding lead was. The service did not have a system and process in place to ensure alerts were in place on the records of patients were there were safeguarding concerns or for those patients who were vulnerable. Immediately following the inspection, the senior management team developed an action plan to review and revise the policy and procedure for safeguarding within their service. The plan included informing staff about the revised policy and ensuring that the lead for safeguarding is known to all staff.
- The was a lack of evidence to show the service carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were not always undertaken when required and the service had not always recorded the details. For example, we found seven GPs and four nurses did not have a DBS recorded. (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).
- The service was unable to evidence that all staff received up-to-date safeguarding and safety training appropriate to their role. They held a training matrix which showed some staff did not have evidence of appropriate training and it did not identify the level of training the staff member had undertaken.
- The service told us that unregistered healthcare professionals acted as chaperones. We did not see evidence to show all staff who acted as chaperones were trained for the role and had received a DBS check.
- Immediately following the inspection, the senior management team developed an action plan to review their oversight to ensure all staff were appropriately trained. The service told us a list of mandatory training would be agreed and evidence to show staff had received the appropriate training obtained. This plan included working with the local practices where staff were also employed.
- There was no evidence to show the service had oversight of infection prevention and control. The service did not have access to any audits undertaken on site and there was no evidence to show they would be aware of issues identified or if they had been acted upon. On the day of the inspection the site was clean and uncluttered. Immediately following the inspection, the senior management team developed an action plan to review and revise the policy and procedure for infection prevention and control.
- The service did not evidence facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. There were no systems at service level to ensure healthcare waste was managed safely.
- The service had not carried out appropriate environmental risk assessments which considered the profile of people using the service and those who may be accompanying them. Immediately following the inspection, the senior management team developed an action plan to review and revise the service level agreement with Acorn Surgery to ensure they gained all the information they required to mitigate risks to patients and staff.

**Risks to patients**

Inadequate

# Are services safe?

**The systems to assess, monitor and manage risks to patient safety were not adequate.**

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an induction system which involved an introduction to the premises where the staff member would be working. We did not see evidence that any competency reviews were undertaken to ensure staff were fully trained and competent in their role and responsibilities. At the staff events held in May 2019, the staff stated they would like the induction process improved. Immediately following the inspection, the senior management team developed an action plan to design and implement procedures to ensure staff were competent to undertake their role and responsibilities. To ensure the system they implemented was appropriate, the service planned to hold discussions with their Local Medical Committee (LMC) to gain further advice.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. However, the service did not have systems and processes to ensure appropriate emergency medicines were in place and safe to use. We found out of date equipment such as resuscitation masks and cannulas on site. These were removed immediately. The provider took immediate action following our inspection and in their action plan detailed that a risk assessment of the medicines and equipment required would be undertaken and agreed with the practice manager of the site. The service plan to address the issues which included implementation of a check list for staff to use at the beginning of every shift to ensure the equipment and medicines were easily available and fit for use.
- The evidence we saw did not demonstrate that impact on safety was assessed if and when there were changes to the service. For example, we saw that the service had agreed for nursing staff to deliver injections, however, they had not recognised the need for the service to hold patient group directions. This is a national requirement. Immediately following the inspection, the senior management team told us a review of the service delivery plan would be undertaken.
- We found the service did not have evidence to show two clinical members of staff who worked for the service had appropriate indemnity arrangements in place to cover all potential liabilities. Immediately following the inspection, the senior management team developed an action plan to review and revise their human resources provision. Just prior to the inspection, the service had employed an external consultant and an additional administration staff member to review their current situation. The senior management team told us they would contact the clinical staff members concern and obtain evidence of their indemnity.

**Information to deliver safe care and treatment**

**Staff did not have the information they needed to deliver safe care and treatment to patients.**

- Patients were put at risk of harm because care records were not written and managed in a way that kept patients safe. We found evidence of staff not always having access to the care records of patients attending for routine care; staff we spoke with confirmed this. The service had published on their website that it is essential to share your record and that if patients chose not to they will not be able to be seen in the service. The service did not record when a patient was seen without access to the records and therefore were unable to monitor this to identify if training or performance management was needed.
- Immediately following the inspection, the senior management team developed an action plan to implement changes and additional training to ensure patients with the exception of in a medical emergency were only seen with access to the full medical records.
- The service did evidence clear systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Staff told us clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance. Although we were shown a search that had been performed previously, there were no staff present on the day of the inspection to run new searches.

**Safe and appropriate use of medicines**

**The service did not have reliable systems for appropriate and safe handling of medicines.**

- The systems and arrangements for managing medicines, including injections, controlled drugs, emergency medicines and equipment posed risks to staff and patients. Immediately following the inspection,

Inadequate

# Are services safe?

the senior management team developed an action plan to review and revise the service level agreement with Acorn Surgery to ensure they had access to an agreed list of medicines and equipment. The improvements included a check list for staff to confirm that appropriate medicines and equipment was in place at the start of each shift.

- The service relied on the host practice to supply prescription stationery and assumed it was securely stored and that they monitored its use. The service did not have any oversight of the stationery they used.
- The service did not carry out regular medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing.
- The service did not monitor prescribing to ensure staff prescribed and administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.
- Immediately following the inspection and in relation to the issues we identified concerning the safe use of and the monitoring of medicines, the senior management team told us they would discuss this with the CCG medicines management team and implement new policies, procedures and monitoring systems to ensure full compliance.

**Track record on safety and incidents**

**The service did not have a good safety record.**

- There were no risk assessments in relation to safety issues.
- The service did not monitor and review activity to help it understand risks.
- Immediately following the inspection, the senior management team developed an action plan to implement systems and processes to ensure oversight and monitoring of safety systems required to ensure patients and staff were kept safe.

**Lessons learned, and improvements made**

**The service did not evidence that they learnt and made improvements when things went wrong.**

- There were inadequate systems for reviewing and investigating when things went wrong.
- We were told that a system for recording and acting on significant events was available. However, the service had not recorded any events and therefore were not able to evidence that lessons were learnt, and improvements made.
- Staff we spoke with understood their duty to raise concerns and report incidents and near misses however most told us they had not needed to report any incidences. They told us they would deal with minor incidences as they happened but did not record these.
- The service was unable to demonstrate they were fully aware of and complied with the requirements of the Duty of Candour.
- The provider encouraged a culture of openness and honesty. However, the service had not recorded any complaints or feedback or significant events however minor.
- The service did not act on and learned from external safety events as well as patient and medicine safety alerts. There was no mechanism in place that was effective to disseminate alerts to all members of the team including sessional and agency staff. Immediately following the inspection, the senior management team developed an action plan to implement systems and processes to ensure oversight and monitoring of safety alerts.
- Three staff events had been held in May 2019 and were attended by 45 of the 108 staff on at least one occasion, feedback from the meetings included staff saying they would like more regular meetings or support groups.

Inadequate

# Are services effective?

(for example, treatment is effective)

## Our findings

**We have rated the service as inadequate for providing effective services because;**

**Effective needs assessment, care and treatment**

**The provider did not have systems to keep clinicians up to date with current evidence-based practice. We saw evidence that clinicians did not always fully assess needs or deliver care and treatment in line with current legislation, standards and guidance such as National Institute for Health and Care Excellence (NICE) best practice guidelines.**

- The service did not always access the patient's full medical records and therefore, the immediate and ongoing needs of patients was not always fully assessed.
- Clinicians did not always have enough information to make or confirm a diagnosis.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed patients' pain where appropriate.

**Monitoring care and treatment**

**The service was not actively involved in quality improvement activity**.

- The service did not demonstrate they had the knowledge, systems or processes to obtain information about care and treatment to make improvements. For example, we did not see the service monitored medicines prescribed, staff competency, use of best practice guidelines and consultations. The service had undertaken one audit (November 2019) of some clinical records which showed some poor performance of staff. They had not recorded any feedback given to staff and had not repeated the audit. The service was unable to evidence that they had made improvements through the use of completed audits.
- Immediately following the inspection, the senior management team informed us that they would review the policy and procedure in line with discussions they planned to have with the CCG medicines management team.

**Effective staffing**

**The service did not have oversight to ensure the staff had the skills, knowledge and experience to carry out their roles.**

- The service was unable to evidence that all staff were appropriately qualified. We did not see evidence to show nursing staff had been trained in cervical screening or that staff who reviewed patients with long term conditions had received specific training and they could not demonstrate how they stayed up to date.
- The service had an induction programme for all newly appointed staff. However, this lacked detail to show that staff had been deemed competent to undertake their role and responsibilities.
- The service had checked that relevant professionals (medical and nursing) were registered with the General Medical Council (GMC)/ Nursing and Midwifery Council and were up to date with revalidation. However, there was no system in place to regularly review this.
- The service told us they had been operating since September 2018 and were planning a programme of appraisals and reviews.
- Immediately following the inspection, the senior management team developed an action plan to implement systems and processes to ensure oversight and monitoring of staff. This included a review of their infection and prevention and control policy and procedures, recruitment and training oversight and needs of staff. They detailed they would develop an audit programme following discussion with the Local Medical Committee.

**Coordinating patient care and information sharing**

**The service was unable to clearly evidence that staff worked together to deliver effective care and treatment.**

- Before providing treatment, staff at the service did not always ensure they had adequate knowledge of the patient's health, any relevant test results and their medicines history. We saw examples of patients being treated for routine care without the full records being accessed.
- Staff told us patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service. We saw discharge letters sent to the patient's own GP practice.

Inadequate

# Are services effective?

## (for example, treatment is effective)

- The service did not show us they had risk assessed the treatments they offered. They had not identified medicines that were not suitable for prescribing if the patient did not give their consent to share information with their GP. For example, medicines liable to abuse or misuse, and those for the treatment of long-term conditions such as asthma.
- Patients were able to attend for cervical cancer screening, however, there was no system in place to ensure that all results were received by the service or the patient's own GP.
- Immediately following the inspection, the senior management team developed an action plan to ensure staff always accessed the medical records of patients and to implement systems and processes to ensure safe and effective prescribing. They told us this would be in consultation with the CCG medicines management team.

**Supporting patients to live healthier lives**

**Staff told us they were 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.
- 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 did not always obtain consent to care and treatment in line with legislation and guidance.**

- The service did not monitor the process for seeking patient's consent to the sharing of their medical records appropriately and staff did not always access the patient's full medical records and staff did not always access the patient's full medical records. We discussed this with staff we spoke with who told us that reception staff in the patient's own GP practice had not ensured that sharing of records consent was obtained and recorded. The service did not have systems and processes in place to monitor this or to take alternative action to gain patient consent. Following the inspection, the senior management team took action and re issued guidance and training to ensure staff could record consent. The service had liaised with member practices and their own staff to ensure staff booking the appointments had the skills and knowledge to perform the tasks required.
- 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?

## Our findings

**Kindness, respect and compassion**

**Staff treated patients with kindness, respect and compassion.**

- Feedback from patients was positive about the way staff treat people. We received 47 wholly positive cards, these highlighted caring staff. We received two comment cards with negative feedback about staff attitude.
- 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. Information leaflets were available in easy read formats, to help patients be involved in decisions about their care.
- Patients told us through comment cards, 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.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.

**Privacy and Dignity**

**The service respected respect 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?

(for example, to feedback?)

## Our findings

**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 improved services in response to those needs. The service provided evening and weekend appointments across Huntingdonshire and Fenland.
- They had four sites across the area where patients could see and clinical staff such as GPs, advance nurse practitioners, nurses and healthcare assistants.
- The facilities and premises were appropriate for the services delivered. However, the service did not have oversight to ensure any issues would be highlighted and addressed.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others.

**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, diagnosis and treatment, although the clinical staff did not always access their medical records.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- The service offered routine care only, but staff we spoke with told us that if a patient with a deteriorating condition arrived at the service they would prioritise their care and treatment.
- Patients reported that the appointment system was easy to use.
- Referrals and transfers to other services were undertaken in a timely way.

**Listening and learning from concerns and complaints**

**The service told us they took complaints and concerns seriously, however, the service had not logged any complaints and therefore we could not assess if they responded to them appropriately to improve the quality of care.**

- Staff we spoke with told us they would deal with any negative feedback at the time and if a patient wished to complain further they would email the managers.
- Information about how to make a complaint or raise concerns was available.
- The service told us they would inform 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 a complaint policy and procedures in place. The service was unable to evidence that learned lessons from individual concerns, complaints and from analysis of trends had been acted upon as they had not recorded any complaints.

# Are services well-led?

Inadequate

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

## Our findings

**We rated well-led as Choose a rating because:**

**Leadership capacity and capability**

**Leaders did not have the capacity and skills to deliver high-quality, sustainable care.**

- Leaders did not demonstrate they had the knowledge about issues and priorities relating to the quality and future of services. They had recently employed new members of the senior management team who had recognised significant risks and had developed an action plan with the support of external consultants. On the day of the inspection, we did not see enough evidence to ensure the clinical leadership was in place to drive these improvements.
- Staff told us some leaders were visible and approachable. Staff told us they had confidence in the new senior management team to make the changes needed.
- The provider did not have effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.
- Immediately following the inspection, the senior management team shared with us an action plan that covered the areas of concern we highlighted during the inspection.

**Vision and strategy**

**The service did not have a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.**

- The service had a vision and strategy to deliver high quality care

**Culture**

**The service did not have a culture of high-quality sustainable care.**

- Staff we spoke with felt respected, supported and valued.
- Leaders and managers did not have the systems and processes in place to show that they would recognise behaviour and performance inconsistent with the vision and values.
- We were unable to assess if openness, honesty and transparency would be demonstrated when responding to incidents and complaints as the service had not recorded any.
- Staff told us they could raise concerns, however, there was no evidence to show any had been raised or responded to.
- The service did not have processes for providing all staff with the development they needed. The service had been operating since September 2018 and the service had yet to put in a programme of reviews and appraisals.
- The service failed to demonstrate there was a strong emphasis on the safety and well-being of all staff. The service did not have any oversight of the premises the staff worked in.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff felt they were treated equally.
- There were positive relationships between staff and teams.
- Immediately following the inspection, the senior management team shared with us a detailed action plan that covered the areas of concern we highlighted during the inspection.

**Governance arrangements**

**The governance systems were inadequate and had led to concerns about the safety of patients.**

- There were no defined structures, processes and systems to support good governance and the management responsibilities were not clearly set out, understood and effective.
- Leaders were not clear about their roles and accountabilities.
- Leaders had not established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- Immediately following the inspection, the senior management team shared with us a detailed action plan that covered the areas of concern we highlighted during the inspection. This plan included looking at an electronic system to share the policies and procedures with staff to enable easy access.

**Managing risks, issues and performance**

# Are services well-led?

Inadequate

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

**The systems to manage risk, issues and performance were inadequate and had led to concerns about the safety of patients and staff.**

- There was no effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The service did not have processes to manage current and future performance. Performance of clinical staff could not be demonstrated through audit of their consultations, prescribing and referral decisions. The service had undertaken one audit of some consultations (November 2018), this showed some poor performance of staff. The service had not recorded any feedback given to individuals or repeated the monitoring process.
- One clinical audit had been undertaken and there was not enough information yet to show a positive impact.
- Leaders did not have oversight of safety alerts, there were no recorded incidents or complaints/feedback however minor.
- The provider had plans in place and staff worked across various sites and would be able to deal with major incidents.
- Immediately following the inspection, the senior management team shared with us a detailed action plan that covered the areas of concern we highlighted during the inspection.

**Appropriate and accurate information**

**The service did not always have appropriate and accurate information.**

- We saw no evidence to show quality and operational information was used to ensure and improve performance.
- There was no evidence to show quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service told us they used performance information which was reported to the Clinical Commissioning Group but did not monitor and manage leaders and staff to hold them to account.
- On the day of the inspection, we found the staff available were not trained to undertake any data searches of the clinical system. We did not see evidence that there were any regular searches performed to enable the service to manage and monitor care and treatment provided.
- The service told us there were plans to address identified weaknesses and had employed external consultants to work with the new management team. However, we saw a lack of evidence to show the clinical leadership, capability and capacity would be in place to ensure care was safe and effective.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.
- Immediately following the inspection, the senior management team shared with us a detailed action plan that covered the areas of concern we highlighted during the inspection. This plan included looking at an electronic system to share the policies and procedures with staff to enable easy access.

**Engagement with patients, the public, staff and external partners**

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

- The service had recently undertaken visits to all the sites and had held three staff meetings to encourage and hear views and concerns from staff. For example, the service held some staff engagement events where staff raised some concerns; for example, they wanted the induction process improved and asked for extra training to discharge patients effectively.
- Staff reported this was a positive event and had requested more meetings. Changes that had been made were to improve the access for patients at this site. Because the building was used by other services, patients rang a bell to gain access to the reception area. An additional receptionist was employed to ensure there was no delay in the patient entering the building and to ensure safety of both patients and staff. Staff had highlighted some shortfalls in the rota system of shifts, the service had made changes to accommodate staff preferences.
- The service had a process of recording patient feedback via the family and friends test. The data showed a high percentage of patients were satisfied. 164 responses were received of that 96% of patients were likely or extremely likely to recommend the service.

**Continuous improvement and innovation**

# Are services well-led?

Inadequate

## (for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

- The service failed to demonstrate that continuous improvement and innovation was in place.

This section is primarily information for the provider

# Enforcement actions

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**Care and treatment was not provided in a safe way to patients.** |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**There was a lack of systems and process in place to ensure good governance in accordance with the fundamental standards of care.** |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>**The provider failed to evidence that staff were suitably qualified, competent, skilled and experienced persons were deployed to meet the fundamental standards of care and treatment.** |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br>**Recruitment procedures were not fully established and operated effectively to ensure only fit and proper persons are employed.** |