C V S Health Limited

CVS Health Limited (Trinity House)

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	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Summary of findings

Overall summary

This was a focused inspection to make sure the provider had made the necessary improvements to their safety and governance procedures before caring for patients again. This was because after our previous inspection on the 21st June 2021; the CQC took immediate action to limit the serious risks which led to a suspension of the service for eight weeks so that the provider could improve governance and safety checks at the location. At the point of inspection, the service was closed and had applied for dormancy until all systems are implemented embedded and reviewed.

We did not re-rate at this inspection. We looked only at those areas where we had found seven breaches of regulations and wanted to check that the service had improved.

- Systems to monitor self-employed clinical staff training were reviewed to ensure they provided evidence of their mandatory training. The service now provided mandatory training in key skills to administrative staff and made sure they completed it.
- Staff had basic training on how to recognise and report abuse.
- The design, maintenance and use of facilities, premises and equipment had been reviewed to keep people safe. Routine and emergency equipment checks were introduced, and staff trained to complete them. The equipment servicing schedule had been finalised.
- The manager had reviewed and updated the policy for patients at risk of deterioration and trained staff on how to use it. Systems to manage performance and risks issues had been reviewed.
- The service reviewed the management of patient safety incidents, so they were in line with national guidance.
- The service had reviewed policies care and treatment was based on national guidance and best practice.
- Leaders understood the priorities and issues the service faced and had the skills and abilities to make improvements. Managers were now visible in the service.
- Leaders reviewed governance systems and processes to guarantee the service was managed safely and in compliance with the regulations. Opportunities to discuss and learn from the performance of the service were being implemented.
- However:
- There were no formal systems to cope with unexpected events or to limit risks were under review and not fully implemented.
- Systems to limit risks were under review, but not fully implemented
- The providers current CQC registrations statement of purpose includes inaccurate information.

Summary of findings

Our judgements about each of the main services

Service	Rating		Summary of each main service
Diagnostic and screening services	**Inspected but not rated**		Please see main summary

Summary of findings

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Summary of this inspection

Background to CVS Health Limited (Trinity House)

CVS Health Limited (Trinity House) has provided cardiac diagnostic and consultancy services since opening in 2011. The service is owned and managed by a team of partner consultant cardiologists offering a 'one stop' service to private patients who live in Kent and East Sussex. They are based in Eastbourne and services delivered by qualified and experienced local NHS cardiologists and physiologists for the people of Sussex and Kent. We found serious safety concerns during the last inspection in June 2021, so we returned to review improvements made by the service.

The provider offers a wide range of services which include, but are not restricted to, cardiac analysis, electrophysiological studies, coronary angioplasty, cardiac diagnostic testing, and angiograms.

They also provided interventional cardiac pacemaker treatments once a month. This invasive service was carried out off site at cardiac laboratories within two NHS trusts in the Kent and East Sussex area which we did not inspect at this, or our last visit.

The service is registered with the Care Quality Commission (CQC) to provide the following regulated activities:

• Diagnostic and screening procedures;

• Surgical procedures.

• Treatment of disease and disorder.

The main service provided by provider was diagnostic imaging. Surgical procedures were not conducted on-site.

The registered manager of 10 years had deregistered following our last visit, a new manager had been recruited had and was in the process of applying to be registered manager. There was no registered manager at the time of the inspection, although the new manager had submitted the application to the CQC.

This was the second inspection at this location.

What people who use the service say

The CQC had not received any complaints or concerns regarding this service within the last 12 months.

How we carried out this inspection

As this was a focused inspection, we looked at the areas of concern identified in the last inspection.

- Spoke to the manager
- Inspected two clinical rooms
- Reviewed policies, procedures and servicing agreements.

Summary of this inspection

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

We told the provider to make improvements.

- Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.
- The service should ensure it continues to embed internal governance processes for maintaining clear records. (Regulation 17: Good governance 1&2 (a))
- The service should ensure that all clinical staff working at the location receive equipment training on site and keep records to confirm this. (Regulation 12: Safe care and treatment (e) (f))
- The service should consider keeping evidence of staff updates to practice and policies and attendance to meetings.
- The service should ensure that it submits an up to date statement of purpose to the CQC before commencing care of patients. (Registration) Regulations 2009 (Part 4) Regulation 12: Statement of purpose (1)(2)(3))

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic and screening services	Inspected but not rated	Inspected but not rated	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Inspected but not rated	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Diagnostic and screening services

Safe	Inspected but not rated
Effective	Inspected but not rated
Well-led	Inspected but not rated

Are Diagnostic and screening services safe?

Inspected but not rated

Our rating stayed the same

Mandatory training

Systems to monitor self-employed clinical staff training were reviewed to ensure they provided evidence of their mandatory training. The service provided mandatory training in key skills to administrative staff and made sure they completed it.

Administration staff received mandatory training specific to their role. Training included fire safety, information governance, basic life support, duty of candour and chaperone training.

The service did not train for clinical staff on site because they relied upon staff to receive their training in their substantive NHS posts and submit their certificates once training was completed. This process had not been effectively monitored in the past. The manager had revised the system for checking compliance to mandatory training in the future.

Since our last inspection leaders had risk assessed services to make sure that clinical staff received the right level of emergency life support training. All staff received basic life support training. For invasive procedures the provider ensured key staff received advanced life support training before services resume.

Safeguarding

Staff had basic training on how to recognise and report abuse. However, the provider safeguarding policy did not reflect national guidance.

The updated “Vulnerable Adults Protection Policy” did not reflect the national Adult Safeguarding: Roles and Competencies for Health Care Staff (2018) guidance. There was no context for safeguarding, current legislation, statutory guidance, relationships with others and internal governance processes for managing safeguards. As a result of our feedback the provider submitted a revised policy which reflected the national guidelines.

A lead for safeguarding had been identified and appointed although they had not received the required level of current safeguarding level 4 training. National guidance says all boards should have access to safeguarding advice and expertise through dedicated designated or named professionals. The new safeguarding lead was responsible for quality assurance, overseeing safeguarding training reviewing the safeguarding policy and safeguarding referrals.

Diagnostic and screening services

The provider had set a target that all staff working at the service had to submit evidence of their required level of safeguarding training by the 8th of October 2021.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment had been reviewed to keep people safe. Routine and emergency equipment checks were introduced, and staff trained to complete them. The equipment servicing schedule had been finalised. There were arrangements to manage clinical waste well.

The service was on the first floor and accessed via stone stairs that housed a stair lift for people with reduced mobility. The environment was clean and maintained. The stair lift had been serviced to ensure it was safe for use.

Sharps bins had not been labelled on the day of our inspection, we told the manager who rectified this. The physiologists working at the service used sharps bins to dispose of safety razors and received training on how to safely dispose razors as part of their professional accreditation. We raised the lack of labelling with the manager who said they would make sure this was done when the service re-opened.

The provider had a clinical waste collection agreement with a third-party company who collected waste on a regular planned basis.

The provider made sure that all medical and diagnostic equipment was serviced in line with the manufacturers' guidelines. The manager kept an asset register of equipment and was responsible for making sure that servicing arrangements were completed to keep people safe.

The manager planned to keep a record of staff training on the use of all diagnostic equipment for staff required to use this as part of staff orientation. However, this had not been implemented and we saw no record of current compliance to staff equipment training.

Staff will be required to follow the manufacturers' guidance on how to use the defibrillator in the event of an emergency when the service re-opens.

The manager had primary responsibility for the routine checking of emergency equipment. . The manager had implemented a process for ensuring recording routine checking of the defibrillator. The manager was responsible for monitoring compliance. The provider informed us that they had sourced an experienced healthcare professional to review the contents of the emergency "grab bag", which is due for completion by 8th October 2021.

The location had an emergency call system installed so that staff could call for help in the event of an emergency. This system had not been used effectively in the past and staff had not received training on how to use the system or how to check that it was in working order. The manager told us of plans to move the call panel to the reception desk and implement a process for checking this once it has been moved. However, there was no completion date for this action.

Assessing and responding to patient risk

The manager reviewed and updated the policy for patients at risk of deterioration and trained staff on how to use it.

Inspected but not rated

Diagnostic and screening services

The manager had reviewed the “Medical Emergency & Resuscitation” policy so that staff had clear guidance on how to deal with emergency situations. The copy we reviewed did not have a review date or include a flow chart the manager had told us was to be displayed in all clinical areas. As the service was not open, we could not be sure all staff had been informed of the changes.

Incidents

The service reviewed the management of patient safety incidents in line with national guidance. Managers had implemented a revised policy and planned to monitor staff compliance once the service re-opened.

Leaders had revised the system for reporting and investigating incidents and ensuring staff learn from them. Staff were aware of the changes to the incident reporting procedure policy, although there were no records to confirm this. The policy had been updated to reflect the Serious Incident Framework 2010 now included adverse events and outlined the serious incident management process. The policy contained an incident referral form, and staff had been told to use this for all incidents. However, as the service was closed, we are not able to check the effectiveness of these changes.

Are Diagnostic and screening services effective?

Inspected but not rated

Evidence-based care and treatment

The service had reviewed policies to provide assurance that care and treatment was based on national guidance and evidence-based practice.

The service provided care and treatment based on national guidance from the British Cardiology Society (BCS), Royal College and National Institute for Health and Care Excellence.

The manager had introduced a process to review current policies and policy review was now included as an agenda item for governance meetings. Records confirmed that 12 policies had been reviewed or were under review. The CVS Board had agreed to review all policies and procedures on an annual basis every September. There were plans for an experienced external healthcare professional to complete peer reviews of the policies.

However, there was no time frame for the completion of the review of the “Quality Control – echo operating and governance policy” or the “Mental Capacity Act” policy.

Leaders planned to revise their strategy for completing annual audits of safety and quality in October 2021 and records confirmed this. The manager planned to monitor the patient satisfaction survey, the echocardiogram quality and the catheter laboratory indications for procedures mapped against national guidance, outcomes and complications. The service has agreed to update CQC when the plan is completed.

Inspected but not rated

Diagnostic and screening services

Are Diagnostic and screening services well-led?

Inspected but not rated

Our rating of well-led stayed the same.

Leadership

Leaders understood the priorities and issues the service faced and had the skills and abilities to make improvements. Managers were now visible in the service so that staff and patients were supported.

Leaders responded to our last inspection by recruiting a new manager who had a track record in healthcare risk and governance. The leadership team decided to extend the initial suspension of the service so that stakeholders and the CQC could be assured that the service had completed all necessary action to comply with the regulations and provide safe and effective care and treatment. The board had applied for dormancy of the service whilst they implemented changes to improve safety. However, it was unclear when they planned to restart undertaking regulated activities. Dormancy is when a provider is registered with the CQC but not carrying out the regulated activity.

Leaders recognised the current challenges and had been pro-active in communicating with the CQC. However, during this inspection we found that certain aspects of our initial requests had not been fully or correctly implemented. For example, the safeguarding policy did not fully reflect current guidance, policies did not have a review date and there was no written evidence of staff being informed of the current challenges or changes. It was unclear if the service had retained its original self-employed clinical staff or whether a new recruitment program was underway.

The service organisational structure was led by a managing director who was also the medical director. They had the knowledge, skills and qualifications to oversee the service. The board had three consultants including the managing director. All consultants held medical protection certificates which is a type of indemnity insurance for doctors.

After our last inspection the leadership team had changed. The service did not have a current registered manager. This was because they had recently appointed a new manager and their application to the CQC to become the CQC registered manager was currently being processed. The new manager had completed an initial review of the service and fed back their findings to the board.

The manager recommended that the board met more frequently to review the service and implement the changes required to bring the service in line with the regulations set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A formal agenda had been introduced that included governance and assurance, strategic issues and quality, people, finance and performance.

The manager was aware of their responsibilities and was on site most days to oversee the running of the service. They told us that the service would not re-open until they had completed a full review and all actions had been implemented and staff updated.

However, the provider's current CQC statement of purpose was out of date because it included the names of people who no longer worked for the provider. We bought this to the attention of the manager who redrafted the document and planned to submit this to the CQC when they received confirmation of their CQC registration.

Inspected but not rated

Diagnostic and screening services

Governance

Leaders reviewed governance systems and processes to guarantee the service was managed safely and in compliance with the regulations. Opportunities to discuss and learn from the performance of the service were under review.

During our original inspection we found multiple failures in governance that indicated a lack of ongoing supervision of the regulated activities. We told the service it must ensure that it takes prompt action to address several significant concerns identified during the inspection relating to governance systems and process and risk management to ensure the quality and safety of service.

The board met fortnightly and the manager submitted agenda items prior to the meetings so that leaders had good insight into the current challenges. The manager had submitted an action plan to the CQC. Board minutes confirmed leaders reviewed the actions and discussed the importance of reviewing governance processes on a routine basis to ensure compliance to regulations.

The manager introduced a policy review panel and planned to review all policies on an annual basis. All policies had been printed and stored safely so that staff could access them if digital systems were unavailable. Reception staff had been told about the changes although there was no record of this.

After our last inspection we told the service it must review its system for Disclosure and Barring Service checks. The provider action plan confirmed that internal digital staff files did have a section for checking DBS certificates, but these had been misfiled in the past. The service planned to ensure staff had either a CVS specific or "portable" DBS certificate which is transferable from service to service.

Management of risk, issues and performance

Systems used to manage performance and risks issues had been reviewed and escalated to reduce their impact in the future. There were no formal arrangements to cope with unexpected events although, systems to limit risks were under review.

Managers were aware of the risks and had regular meetings to review and update the risk register. Stakeholder and board minutes reviewed current risks related to financial sustainability and the liability of the property lease for the building. The manager introduced a list of actions to assure us that the service was fully monitoring the risks and looking at approaches to reduce these.

There was no evidence of a formal business continuity plan.

After the last inspection we told the service it must ensure that the incident reporting process was reviewed and must implement a process in line with national guidance so that learning can be shared and acted upon. The manager planned to ask all staff working at the location for a workable solution to ensure all staff could attend meetings about the service. Meetings will be recorded and include feedback about outcomes from incidents, policy and practice updates in several formats. This was because historically staff meetings were ad-hoc and self-employed staff rarely attended staff updates. They were going to source a workable solution, for example remote digital meeting software and a closed social media group for staff discussion. However, there was not a system to record attendance to meetings.