City Health Care Partnership CIC - HMP Hull

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**

Overall summary

We carried out an announced focused follow up inspection of healthcare services provided by City Health Care Partnership CIC (CHCP) at HMP Hull to check that the provider had made the necessary improvements. Following our last inspection in July 2021 we found that safe care and treatment; personalised care; and governance systems operated by CHCP at this location required improvement. We issued a Requirement Notice in relation to Regulation 17, Good Governance; Regulation 9, Personalised Care; and Regulation 12, Safe Care and Treatment. We also imposed five conditions on CHCPs registration as a service provider in respect of the regulated activities: Treatment of disease, disorder or injury and Diagnostic and screening procedures.

The purpose of the inspection was to determine if the healthcare services provided by CHCP were meeting the legal requirements and regulations under Section 60 of the Health and Social Care Act 2008 and that prisoners were receiving safe care and treatment. This inspection was carried out alongside Her Majesty's Inspectorate of Prisons (HMIP) during an Independent Review of Progress to monitor how the prison was progressing against the key concerns and recommendations identified at the previous inspection in July 2021.

CQC undertook some of the inspection processes remotely to minimise infection risks due to the coronavirus pandemic.

We do not currently rate services provided in prisons. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

At this inspection we found:

- Patients with long-term conditions were not always being cared for safely in line with national guidance, including the management of their medicines.
- There was effective triage of patients' applications for a healthcare appointment and urgent need was identified and acted upon.
- There was improvement in the management of patients requiring wound care and social care support, however, some patients did not receive this in line with their care plan.
- There were significant backlogs of patients requiring a mental health assessment or awaiting allocation to a staff member's caseload.
- Not all patients who required a care plan had one in place and not all care plans relating to long-term conditions and mental health were personalised in consultation with patients.
- Staffing pressures continued due to the impact of the Covid-19 and recruitment difficulties. The provider had recruited to some roles and continued to employ many recruitment initiatives, however several vacancies remained, and many registered nurse and health care assistant shifts remained unfilled.
- While staff felt supported and had access to peer support, there was little formal management or clinical supervision taking place and such meetings were not always recorded.
- Compliance with Intermediate Life Support (ILS) and National Early Warning Signs (News2) mandatory training was poor.
- Not all actions had been implemented or embedded in practice following recommendations made in Prison and Probation Ombudsmen reports about deaths in custody. For example, in the completion of a monthly audit of the NEWS2 document to review compliance in their completeness and accuracy.
- Not all staff had the required skills to undertake their roles; for example, in the undertaking of specific wound dressings.
- Governance systems and processes had been developed further since our previous inspection but remained insufficiently embedded to assess, monitor and improve the quality and safety of patient care.
- The areas where the provider **must** make improvements as they are in breach of regulations are:

Overall summary

- Consult with patients to determine the care and treatment provided is suitable and reflects their specific needs and preferences and document this in the patient's personalised care record, in relation to long-term conditions and mental health needs.
- Ensure that waiting times for service users requiring a mental health assessment and ongoing mental health care and treatment are reviewed to ensure appropriate access and provision to meet patient need.
- Ensure governance systems are effective in providing oversight of risks to the safety of service users and ensure that action is taken to mitigate such risks. This must include an effective audit programme which identifies areas of risk and identifies measurable actions which are fully implemented and reviewed.
- Ensure that staff receive supervision in line with the provider's own supervision policy and that such supervision meetings are recorded, and any actions are implemented.
- Ensure that staff are compliant with mandatory training, specifically NEWS2 and ILS training.
- Patients requiring ongoing wound care and treatment should receive this in line with their care plan.
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- The areas where the provider **should** make improvements are:
- Continue with their recruitment drive to fill remaining vacant positions.
- Continue to engage with community specialist teams in order to improve the care of patients with long-term conditions.
- Ensure staff receive an annual appraisal.
- Ensure staff have the suitable skills and competencies for their roles.

Our inspection team

Our inspection team was led by a CQC health and justice inspector supported by a second inspector and a GP specialist professional advisor (GP SPA). This inspection was carried out alongside one Health and Social Care Inspector from HMIP who were also carrying out an Independent Review of Progress (IRP) to follow up on progress made against key concerns identified during the previous comprehensive inspection in July 2021.

How we carried out this inspection

Alongside our HMIP colleague, we jointly conducted a range of interviews with staff and accessed patients' clinical records remotely and on site between 14 and 18 March 2022. We sampled 55 records of patients with various long-term conditions as well as records of patients with other physical and mental health needs. We reviewed the waiting lists for various primary care services, mental health and substance misuse services.

Before this inspection we reviewed a range of information that we held about the service including the provider's action plans in response to our previous inspection. Following the announcement of the inspection, HMIP requested additional information from CHCP which we jointly reviewed.

During the inspection we spoke with:

- Seven nurses across the primary care and mental health team
- One additional member of the mental health team
- Six healthcare assistants
- One GP
- Members of the Drug and Alcohol Recovery Team
- The head of healthcare
- The operations manager
- The general manager
- The service manager
- Members of the pharmacy team.
- A dental nurse
- Two administrators
- Senior managers from a provider commissioned to provide additional strategic oversight

We also spoke with NHS England commissioners.

The provider shared a range of evidence with us. Documents we reviewed included:

- Audits including those relating to a person-centred care audit and a mental health care planning audit
- Quality assurance and governance meetings records
- CHCP transformation plans and meeting minutes
- Root cause analyses and learning from incidents
- Local policies, procedures and standard operating procedures
- Staff rotas
- Staff newsletters
- Service risk register and action plan trackers
- Notes from staff meetings

Background to City Health Care Partnership CIC - HMP Hull

HMP Hull is a local male adult Category B prison serving the East Yorkshire area. The prison is operated by Her Majesty's Prison and Probation Service.

Health services at HMP Hull are commissioned by NHS England. The contract for the provision of healthcare services is held by City Health Care Partnership CIC (CHCP). CHCP is registered with CQC to provide the regulated activities of diagnostic and screening procedures, personal care, surgical procedures and treatment of disease, disorder or injury at HMP Hull.

Our previous comprehensive inspection was conducted jointly with Her Majesty's Inspectorate of Prisons (HMIP) in July 2021 and published on the HMIP website on 2 November 2021. We found breaches of Regulation 12, safe care and treatment, Regulation 9, person-centred care and Regulation 17, good governance. The report from this inspection can be found on the HMIP website at: https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-hull-2/

At the same time CQC carried out a focused inspection that reviewed aspects of service provision under Regulation 12, safe care and treatment, Regulation 9, person centred care and Regulation 17, good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following that inspection, CQC imposed five conditions on the provider's registration for the regulated activities: Treatment of disease, disorder or injury and Diagnostic and screening procedures. Previous breaches of Regulations had been addressed during this inspection. The report from this inspection can be found on our website at:

https://www.cqc.org.uk/location/1-286635113/reports

Following our July 2021 inspection, an additional health care provider were awarded a contract in December 2021 to work in partnership with CHCP and HMPPS to provide strategic support in progressing clinical governance and quality improvement plans. The provider worked alongside their mental health partner and the contract was in place until August 2022. CHCP had given notice on their contract to deliver healthcare services at the prison and the contract would also expire at this time.

CQC conducted a focused inspection in November and December 2020 in response to a serious incident and we found a breach of Regulation 17, good governance. The report from this inspection can be found on our website at:

https://www.cqc.org.uk/location/1-286635113/reports

Inspected but not rated

Are services safe?

Risks to patients

At our last inspection we found that there wasn't an effective system in place for ensuring that a follow up was conducted when patients' clinical observations or test results were outside of normal expected limits. During this inspection, our remote sample of patient records demonstrated improvement in the follow up of patients with diabetes whose clinical observations or test results were outside of normal expected limits.

However, there remained issues and we found examples in patient records with other long-term conditions where action had not been taken when clinical observations or test results were outside of normal expected limits. For example; a patient with hypertension (high blood pressure) who had an elevated blood pressure reading which can present an increased risk of cardiac problems or stroke had not been followed up; and a patient with low vitamin B12 that can present a risk of the development of neurological problems had also not been followed up.

During this inspection, we found most patients with identified mental health needs and medicines received blood tests as required. However, one patient was prescribed lithium carbonate (to treat mood disorder) had not received an annual calcium blood test since July 2020. (A raised calcium level can increase the risk of the weakening of the bones and kidney stones).

We raised our patient concerns with the provider during the inspection who took action to ensure that these, and other patients received the appropriate tests and follow up.

At our last inspection, we found the process to triage applications and allocate patients to the correct healthcare professional was not effective and more urgent issues not always identified. For example, there were long waits to see the GP and managers did not effectively monitor waiting lists to ensure patients who required timely follow up were prioritised. During this inspection, we found systems had been reviewed to improve the effective triage of patients, the allocation of patients to the correct professional, and the ongoing monitoring of waiting lists to ensure patients were seen according to clinical need. For example, administrative processes had been strengthened; the allocations meeting had been restructured to ensure clinical needs were prioritised during the allocation of shifts; patients were seen by a nurse in a virtual ward, triaged and escalated to a senior nurse or GP as required; and a daily safety huddle had been introduced where patients of concern were discussed. Additional GP resource also meant there were no waits to see the GP for routine or urgent care.

At the time of our last inspection, patients on the mental health waiting lists were seen based on the length of time they had been waiting rather than by clinical need which meant there was a risk that patients with more urgent needs may not be prioritised. During this inspection we found that, whilst waiting times for mental health assessment and allocation remained a concern, we were assured that staff prioritised those patients with the most urgent needs.

Waiting lists for other healthcare professionals were not previously being monitored effectively, such as those waiting for an electrocardiogram (ECG). At this inspection we found there was safe monitoring of the ECG waiting list and that no patients waited for an ECG, including those with mental health medicines, which was an improvement.

During a review of waiting lists, we also found long waits for the dentist that had worsened following recruitment difficulties and refurbishment of the dental suite. There were 30 patients waiting for urgent treatment and wait times had risen from one, to five weeks; 31 patients waited for routine treatment with the longest waiting since August 2021; and 117 patients waited to have their application triaged with the longest wait time being 26 weeks. The provider was monitoring the situation and an increase in dental clinics from one to two per week had been introduced to manage the backlog during the week of our inspection. Systems were in place to prescribe patients pain relief or antibiotics as required.

Inspected but not rated

Are services safe?

At our July 2021 inspection, we found that risks to patients with mental ill-health were not always identified and addressed. Staffing vacancies combined with the level of demand for mental health services meant that patients did not receive care and treatment in a timely way which put them at increased risk. At our last inspection, we also found there was a lack of managerial oversight of mental health assessments and caseloads, due to insufficient leadership capacity which meant that risks to patients were not always identified or acted upon.

During this inspection, we found the provider had reviewed the mental health provision and had introduced several changes to address shortfalls in the service. A mental health senior manager had been employed in October 2021; psychiatry support had increased to provide a service two days a week, with a weekly 'virtual' multi-disciplinary meeting, and access to a one-hour telephone support over seven days a week should staff need further advice or support . A new 'stepped care model' had been introduced the week before our inspection; this aimed to support practitioners to make a clinical decision about what the most appropriate treatment would be for the person they were assessing. It was too early to assess the effectiveness of this model at the time of this inspection. Progress continued to be hampered by staff shortages and there were times when the provider could only focus on urgent need.

Mental health waiting lists remained a significant concern and patients again did not receive care and treatment in a timely way which put them at increased risk. For example, 114 patients waited for a primary mental health assessment or allocation; this represented a deterioration from our previous inspection when 79 patients awaited initial assessment and/or allocation. There were 30 patients waiting for step 4 assessment or allocation (patients with the most complex needs) with the longest wait time of 13 weeks. A further 24 patients awaited a step 2 assessment (patients with mild to moderate anxiety/depressive disorders) with the longest wait of six weeks.

An additional 41 patients were awaiting allocation to the caseload of mental health staff which was a similar number to those awaiting allocation at our July 2021 inspection (50). There had been no treatment/therapy provision during the previous six months for patients who required step 3 (patients with severe depression/anxiety disorders) and step 4 treatment. Groupwork had also not resumed due to staff resource.

We found during our inspection that support for patients with complex mental health needs who were accommodated in the wellbeing unit was insufficient. Meeting minutes from the daily huddle showed that a staff member from the mental health team was not in attendance on each occasion as required. The provider confirmed this was due to staffing issues. Psychiatry services were available seven day a week however, and an additional psychiatrist had been recruited to meet patient needs.

Appropriate and safe use of medicines

At our July 2021 inspection we saw evidence where some patients with known abnormal readings were not followed up appropriately to ensure their medicines were prescribed and monitored safely. During this inspection, we also saw evidence where patients with known abnormal readings were not followed up appropriately to ensure their medicines were prescribed and monitored safely.

During our review of patient records at this inspection, we found two examples when action had not been taken to review and amend prescribed medicines where required. For example, a patient's record had not been amended to stop prescribed medicines in accordance with a cardiologist's recommendations. The provider updated the patient's records during our inspection.

At the July 2021 inspection, we identified that patients who were prescribed high risk medicines were not always monitored to ensure they were not adversely affected by the medicines, placing them at potential clinical risk. We found

some improvement during this inspection in that there was a reduced number of patient records identified where there was a concern; however, similar concerns were identified in some patient records. For example, patients who were prescribed anti-coagulant medicines to prevent blood clots were not always reviewed in line with best practice to ensure correct prescribing and monitoring.

Our sample of patient records identified two patients who were overdue their annual medication review. For example, a patient on the asthma long term condition's register had not received an annual medicine use review since 3/11/2018 that was not in line with guidance. The provider booked the patients for a review when we brought the patients to their attention. Where medicine reviews had taken place, we found several that had not been consistently structured which was not in line with National Institute for Care and Excellence (NICE) guidance and could increase a risk of a prescribing error.

Lessons learned and improvements made

In December 2021, an additional provider was awarded a contract to provide strategic support to CHCP to help progress their clinical governance and quality improvement. The provider worked alongside their mental health partners at the time of our inspection and corroborated with CHCP to identify what was working well and which areas were a priority for development.

CHCP had a quality and clinical governance team who worked with local leaders and provided support to embed improvements. They had developed a comprehensive action plan which was closely monitored, and this showed there had been some improvements in the delivery of care since our July 2021 inspection. For example, improvement had been made in the clinical triage and allocation of patients to the correct waiting lists, and patients were now prioritised based on clinical need. Furthermore, a review of GP and ECG waiting lists had significantly reduced wait times; and a new stepped model of care had been introduced the week of our inspection to support with clinical decision making regarding the appropriate treatment for patients with mental health needs. It was too early to measure the impact of this at the time of our inspection however, and wait times for mental health services remained too long.

Whilst progress continued to be made in the care of patients with long-term conditions, staff shortage had temporarily hampered progress, and we found there continued to be issues with the care of some patients with a long-term condition. For example, in ensuring care plans were in place and personalised in collaboration with the patient.

The provider continued to ensure that core services, such as medicines administration and reception screening, were prioritised during periods of staff shortages. Whilst there was evidence of several further initiatives introduced to support with recruitment and retention, staff shortages continued to impact on the opportunities the provider had to embed improvements.

Lessons again were not always learned from investigations into the deaths in custody that had occurred since the inspection in 2018. We saw some recommendations were repeated in subsequent investigations, meaning the required improvements had not been made. For example, recommendations relating to the care of the deteriorating patient such as with the completion and documentation of all observations required for an accurate NEWS2 score, and a review of the training needs of health care staff, had not all been fully actioned and embedded.

Inspected but not rated

Are services effective?

At our last inspection we found there continued to be issues with the management of patients with long-term conditions. Follow up actions were not always taken when readings were outside of the expected normal range and patients were not always prescribed the correct medicines and medicines were not always monitored as required. At this inspection we found some improvement in the management of patients on the diabetes long term conditions register; however, there continued to be issues with the management of patients with other long-term conditions. Follow up actions were not always taken when readings were outside of the expected normal range, medicines were not always monitored as required, and some patients had not been followed up for an annual long-term condition review.

At the July 2021 inspection, there wasn't an effective system to help ensure patients with a severe mental illness received a physical health check in line with NICE guidance. Where the mental health team had requested that their patients received an ECG and blood test, these had not always been scheduled or carried out. During this inspection, we found improvement and saw these were being done in line with National Institute for Health and Care Excellence (NICE) guidance.

At the last inspection we found patients who required regular wound care did not always receive this care and treatment in line with their care plan. At this inspection we found some improvement, however; not all patients received care in line with their care plan. For example, one patient record showed a patient did not have their wound dressings changed at the required set frequency which put them at risk of further deterioration or infection. There was no member of staff on duty with clinical competency to complete the specific dressing that was required on three occasions. The provider confirmed a visiting tissue viability nurse was now completing a weekly clinic and was also upskilling staff members.

During the last inspection, not all patients in receipt of a social care package received the assessed level of support they required to maintain their personal care. At this inspection we found most patients in receipt of a social care package received the assessed level of support to maintain their personal care.

At the last inspection, we found that the majority of care plans were still based on a generic care plan template and had not been personalised in consultation with patients. This meant patients were at risk of receiving care that was not appropriate or did not meet their needs. At this inspection, whilst some care plans we reviewed had been updated in consultation with the patient, we continued to find plans that had not been personalised in consultation with patients. Furthermore, we found three out five patient records who were prescribed anti-psychotic medication had no care plan in place and none of the four patients on the palliative/end of life care register had an end of life care plan in place. There was no evidence that a discussion regarding DNACPR (do not attempt cardiopulmonary resuscitation) had taken place with the four patients on the palliative/end of life care register. This meant there had been no consultation with the patients to determine if the care and treatment was suitable and reflected their specific needs and preferences.

Monitoring care and treatment

At our previous inspection we found that audits were not always carried out in a timely way and that audits did not always lead to improvement in patient care. During this inspection we found that not all expected clinical audits were included in the cyclical audit programme, and that audits again did not always lead to improvement in patient care.

In response to our July 2021 inspection, the provider had revised their audit programme to monitor progress against identified areas for service improvement. However, a NEWS2 audit was not included on the provider's audit schedule despite Prisons and Probation (PPO) reports dating from 2018 to 2021 that made repeat recommendations regarding the management of the deteriorating patient. This meant the monitoring of care and treatment was not effective in ensuring care was delivered in line with NICE guidance.

Inspected but not rated

Are services effective?

The provider confirmed a NEWS2 audit had been completed following our inspection and that the audit had been added to the schedule. However, whilst there was an action arising from the audit to ensure staff were compliant with NEWS2 training, there was no target date for its completion. Given the poor compliance with NEWS2 training, this meant the audit may not be effective in improving the delivery of safe and effective patient care in a timely way.

The audit schedule included a mental health care planning clinical audit and person-centred audit to ensure that care plans relating to long-term conditions and mental health were personalised in consultation with patients. Whilst the audits captured plans improve performance, we again found the linked action plans did not always contain timebound or measurable actions and accountability for implementing each action was not clear.

Many of the audits included in the schedule had been completed in February or March 2022 which meant at the time of our inspection there had been limited opportunity to provide assurance that improvements were being made or to measure their impact

Effective staffing

As at our July 2021 inspection, the service had staffing vacancies across the primary care and mental health teams and was continuing with recruitment campaigns in order to fill these vacancies. A designated HR manager was on site to support staff and further initiatives had been implemented to help with recruitment and retention, such as with the payment of a retention premium. During our inspection, managers confirmed several posts had been recruited to with start dates awaited; nevertheless, 33% of mental health nurse/health care assistant (HCA) shifts and 36% of physical health registered nurse/HCA shifts were unfilled during the previous six months. There were early signs of improvement in recruitment during February 2022 and most staff we spoke with described feeling more optimistic and supported than at our last inspection. A member of the mental health team described things as 'much better' since the July 2021 inspection and this was attributed to having a full-time senior leader on site.

The impact of Covid-19 continued to affect staffing levels across the service and sickness absence meant there were occasions when the service was operating below the planned staffing levels. Efforts were made by managers to fill gaps in the rota through the use of regular bank and agency staff and we observed that the interim head of health care stepped down to undertake clinical work during our inspection.

Health care assistants were required to complete 'stop back' shifts on a fortnightly basis which meant they started work at 7am and did not finish until all first night screenings and other allocated tasks were complete. Some staff told us it was not unusual to still be on site until 9 or 10pm and one member of staff stated, "How can this be safe?" The provider told us new initiatives were under review to reduce the risk of staff working beyond their contracted hours.

CHCP had identified the need to increase staff skills and training and a transformation plan had been agreed to develop nurses who had worked within the prison environment for several years to become more aligned with community practice nursing and clinical skills. Support from a community tissue viability nurse had recently been made available.

Whilst many staff had completed most training considered to be mandatory for their role, compliance with critical training was poor. NEWS2 training had been completed by 27% of eligible staff and intermediate life support compliance was 54% as at 11 March 2022. However, some but not all staff were booked on to future training sessions.

At our three previous inspections we saw supervision of staff had not been embedded into the service and, at this inspection, we found this was still the case. Most, but not all staff, told us they felt supported by their manager and colleagues but again there had been little formal supervision taking place. The healthcare provider commissioned to

Inspected but not rated

Are services effective?

deliver strategic support to CHCP had offered staff formal supervision; however, there had been limited acceptance of this offer. Additionally, the provider told us senior managers/clinicians and the head of workforce had offered peer and group supervision; however, there was no evidence that these had been recorded against individual staff members supervision records. Progress was being made with identifying clinical supervisors for the mental health team. Staff did have access to group supervision and peer support and in daily huddles for immediate support, however; this was not assessed as an appropriate means to ensure effective clinical support and oversight. Additionally, many staff told us they had also not received an appraisal in 2021.

There had been no substantive pharmacy manager in post since October 2021 and staff told us gaps had arisen since some pharmacy technicians had moved to the wings to administer medicines. This meant there was often no pharmacy technician to support with managing the high number of open tasks on the electronic patient record system each day. Staff told us they worked beyond their contracted hours to complete their roles and reported the significant daily workload increased the risk of error. Whilst huddles had been introduced within the pharmacy team, some staff told us they did not feel included in the wider healthcare team and they reported communication from the senior leadership team did not always reach them.

During our inspection we asked the provider to evidence that they were assured staff were competent for their roles, for example, in taking bloods and wound care skills, however; we did not receive information to evidence compliance with competency frameworks

Inspected but not rated

Are services well-led?

Leadership capacity and capability

Since our previous inspection, an additional health care provider had been awarded a contract to work in partnership with CHCP to provide strategic support in progressing clinical governance and quality improvement plans. The provider worked alongside their mental health partners, and City Health Care Partnership (CHCP) operational and governance leads met fortnightly with them as a strategic alliance.

There had also been change in the leadership team since our last inspection: CHCP had successfully recruited to the role of a senior operations manager, and the primary care lead had 'stepped up' from their role to act as interim head of healthcare (HoHc) three weeks prior to our inspection to cover in their absence. Whilst the interim HoHc had extensive clinical experience, they had yet to become familiar with all requirements of the role. Additionally, they were required to continue to provide some clinical care due to staffing shortfalls, meaning they could not fully focus on more strategic work.

While there had been additions to the clinical and operational leadership team, we found some management arrangements were disjointed, which meant lines of accountability were not always clear. There was a significant number of clinical and operational leaders on site and, due to the recent leadership change, we observed there was a lack of understanding by some staff regarding lead roles and responsibilities. For example, one member of staff told us they were uncertain who their current line manager was following the change.

The leadership team continued to strive towards achieving improved outcomes in patient care and significant progress had been made against the improvement plan in one out of five key areas. However, the high number of new prison receptions, exacerbated by ongoing staff deficits, meant leaders had been unable to embed all required changes across the service and some plans remained in their infancy.

Culture

Following some initial challenges, the provider had forged relations with the additional commissioned provider in support of their strategic aims. Most staff said they had been kept well informed of the changes and spoke positively about the slight upturn in recruitment and way forward. The newly implemented safety huddle meeting and stepped model of care were viewed positively by staff in support of their roles. Whilst some staff spoke negatively of the extended hours worked to meet patient need, most staff told us there was a 'close knit' and supportive team.

Governance arrangements

At our previous inspection we found there was a governance structure in place which had been adapted in response to our previous inspection findings. However, at the previous inspection identified risks were not always acted upon in a timely way.

Action plans that were linked to the results of audits did not always contain timebound or measurable actions and accountability for implementing each action was not clear. Again, during this inspection we found action plans did not always contain timebound or measurable actions, such as the mental health care planning clinical audit and person-centred audit linked action plans.

Inspected but not rated

Are services well-led?

Identified risks highlighted in PPO report recommendations from 2018 to 2021 had not been addressed, such as in ensuring systems and processes provided assurance that NEWS2 guidance was implemented regarding the management of the deteriorating patient. Furthermore, governance systems had not ensured compliance with mandatory critical training.

Processes and systems had significantly improved to ensure clinical oversight of various waiting lists in primary care and mental health services. This meant patients were prioritised for appointments according to clinical need. However, there remained large numbers of patients on various mental health waiting lists and, whilst a new model of care had been implemented the week of our inspection, it was too early to evidence its impact on the management of patients waiting for care and treatment.

Additionally, systems again had not been effective in ensuring the delivery of supervision or appraisals in line with policy and had not ensured staff were always competent to deliver the required treatment and care.

Managing risks, issues and performance

CHCP was aware of the risks to the quality of the service provision and maintained a risk register. Action had been taken to drive forward improvements following our previous inspections, such as: systems to ensure the consistent clinical triage and prioritisation of patients, an increase in GP and psychiatric hours, a review and significant reduction in GP waiting times, additional support from a general manager, and in the completion of audits in line with the audit schedule. However, the continued impact of Covid-19 and the staffing pressures this created meant it had continued to be difficult at times to make the required progress in fully addressing risks. Whilst there was mostly sufficient capacity within the leadership team to ensure risks were managed, the recent backfill in the HoHC position meant they continued to be required to provide clinical cover on the rota.

Continuous improvement and innovation

Our remote samples of patient clinical records found some improvement in that there was a reduction in the number of high-level concerns we were required to bring to their attention. Nevertheless, we continued to identify a range of risks relating to long-term conditions management which we bought to the attention of the provider who took action to ensure these patients received the appropriate care, treatment and follow up. During our previous inspection we raised a similar range of issues relating to long-term conditions management. CHCP provided assurances that lessons had been learned from this and felt that improvements had been made. However, we found that similar issues persisted which showed that, whilst progress had been made, further improvement was required to ensure consistency in the delivery of safe care.

CHCP demonstrated that continuous improvement had been made in the clinical triage and management of patient waiting lists. The provider also continued to initiate new systems to effect change; however, it was too early at the time of our inspection to provide assurance that there had been continuous improvement in a number of areas.

Since our last inspection, the provider had continued to provide regular action plan updates to NHS England commissioners and CQC regarding their action plans.

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.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The systems to assess, monitor and improve the quality and safety of the services provided were not operated effectively. Enforcement action we took: We imposed conditions on the provider.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users did not reflect their preferences because the provider had not carried out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user. The provider had not designed care or treatment with a view to achieving service users' preferences and ensuring their needs are met. Enforcement action we took: We imposed conditions on the provider.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way to service users because risks to the health and safety of service users were not always assessed and all reasonably practicable steps had not been taken to mitigate risks. Enforcement action we took: We imposed conditions on the provider.