Bexley Health Neighbourhood Care GP Hub (BHNC GP Hub) at Erith and District Hospital

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	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

Overall summary

This service is rated as requires improvement overall.

The key questions are rated as:

Are services safe? – Requires Improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires Improvement

We carried out an announced comprehensive inspection at Bexley Health Neighbourhood Care GP Hub (BHNC GP Hub) at Erith and District Hospital on 15 May 2019. This inspection was carried out as part of our inspection programme.

At this inspection we found:

- The service had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes.
- The provider had systems to keep clinicians up to date with current evidence-based practice.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- The provider did not have oversight of health and safety risks in relation to the premises.
- There was limited evidence of quality improvement activity in relation to clinical care and treatment
- There was a lack of management assurance and oversight that proper staff records were maintained and kept up to date.

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

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

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

- Continue to review their arrangements for ensuring staff had up to date training.
- Continue to review their arrangements for the completion of quality improvement activities.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection was carried out by a CQC lead inspector and a GP specialist adviser.

Background to Bexley Health Neighbourhood Care GP Hub (BHNC GP Hub) at Erith and District Hospital

Bexley Health Neighbourhood Care GP Hub (BHNC GP Hub) at Erith and District Hospital operates from Erith and District Hospital, Park Crescent, Erith, DA8 3EE. The service is located adjacent to the Urgent Care Centre in the hospital.

The service is provided by Bexley Health Neighbourhood Care C.I.C, a community interest company and a GP Federation, and is commissioned by Bexley Clinical Commissioning Group (CCG). The BHNC GP Hub at Erith and District hospital consists of two consultation rooms, and a reception area. The Hub has been in operation since January 2015.

The premises are managed by the hospital trust, Oxleas NHS Trust. The service is open from 6.30pm to 8pm on Monday to Friday, and 8am to 8pm on Saturdays and Sundays, 365 days a year.

The BHNC GP Hub service is available to any patient registered to a GP Practice in the borough of Bexley and who consents to their medical record being shared.

Appointments can be booked by the registering GP practice and NHS 111. The BHNC GP Hub service does not offer a walk-in service and all appointments must be pre-booked. GP practices in Bexley can directly book a GP appointment for their registered patients to be seen at the service including same day appointments. Nurse appointments are not available.

The service is commissioned to provide 37,000 GP appointments per annum.

The provider has centralised governance for the service which are co-ordinated by the BHNC board of directors: the managing director and three directors, who are all clinicians, seniors GPs in local practices. The management team are the Chief Operating Officer, Clinical Operations Manager, Head of Quality and Governance, Hub Service Manager and GP Clinical Lead.

Clinical care is provided by Hub GPs, sourced from a clinical workforce agency and all of whom work on a locum basis only.

The non-clinical service team consists of the Head of Clinical Operations, a Service Manager and a team of 12 reception staff members.

The provider is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures and treatment of disease, disorder or injury.

Requires improvement

Are services safe?

We rated the service as requires improvement for providing safe services.

This was because the provider did not have oversight of how health and safety risks identified, which related to their service, were managed, there were gaps in the completion of the provider mandated training topics for staff employed, and there were limitations in the clinical records system which meant information needed to deliver safe care and treatment was not consistently available to relevant staff in an accessible way.

Safety systems and processes

The service had clear systems to safeguard from abuse, but some of their arrangements to keep people safe were not operating effectively.

- The premises landlords conducted safety risk assessments. They had health and safety policies, which were made available to the provider on request. The provider did not have oversight of how risks identified, which related to their service, were managed.
- The provider had systems to safeguard children and vulnerable adults from abuse. Policies relating to this had been recently updated, prompted by a child safeguarding alert. Policies were accessible to all staff. They outlined clearly who to go to for further guidance.
- The service worked with other agencies to support patients and protect them from neglect and abuse. We saw that safeguarding concerns were raised as significant events and reported to appropriate authorities and the service contributed to their investigations and learned from such events. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were in place for clinical and reception staff who worked in the service. (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 mandated that staff received up-to-date training on several topics, including safeguarding and life support appropriate to their role. However, there were gaps in the completion of the provider mandated training topics for staff employed. We saw evidence that managers had followed up on these with the staff concerned, but they had not prevented these staff from working in the service.
- Staff we spoke with during our inspection knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check. However not all reception staff had completed chaperone training as per the service policy.
- The service had an agreement in place for premises management, which was set out in their license agreement to use the premises. The premises landlords had responsibilities for ensuring the facilities and equipment were safe, and we saw they had completed safety checks including a fire risk assessment in January 2019, a cleaning audit in May 2019 and a Legionella risk assessment in January 2018. The legionella risk assessment identified remedial actions requiring less than three months to action, which the service managers were not sure of their status. They had no assurances that the risks identified had been appropriately managed, but the service managers were intending to meet with the landlords to discuss these issues.
- We observed the service premises to be visually clean and tidy. However, they did not carry out their own infection prevention and control audits. Cleaning audits were carried out by the premises' landlords. The provider had recently sought advice on making appropriate Infection Prevention and Control (IPC) arrangements from their CCG IPC nurse. The provider informed us that the nurse had agreed to undertake practical training for all hub staff. The provider plans to undertake an IPC audit in September 2019, and they had discussed these plans with their reception team at a staff meeting.
- We found clinical equipment was maintained according to manufacturers' instructions.
- There were systems for safely managing healthcare waste.

Risks to patients

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

Requires improvement

Are services safe?

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective system in place for dealing with surges in demand. For example, the service had a system for managing inappropriate referrals, and ensuring they were signposted to suitable services.
- The service employed sessional GPs for the operation of the service. The service did not have a formalised induction programme for clinical staff but had recently updated their staff handbook and made this available to all staff. Clinical and non-clinical staff employed in the service were sessional, and most worked in NHS GP practices as their substantive roles.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis. The service maintained a stock of medicines for treating medical emergencies in line with published guidance. They had a defibrillator on site but did not hold medical oxygen. However, they purchased and provided assurance that they had oxygen on their site within a week of our inspection.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.
- When there were changes to services or staff the service assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.
- Individual care records were written and managed in a way that kept patients safe. However, the care records we saw showed that information needed to deliver safe care and treatment was not consistently available to relevant staff in an accessible way. This was due to limitations in the functionality of the patient records system. For example, alerts on the patient records and special notes were not directly visible. A reviewer would have to look in significant medical history section of the patient record. Other limitations of the records system are that searches are difficult to do, even for clinical audits, and there was a time delay of up to 48 hours before consultations were visible on the system.

Appropriate and safe use of medicines

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

- The systems and arrangements for managing emergency medicines and equipment minimised risks. The service did not stock other medicines, medical gases, controlled drugs or vaccines.
- Processes were in place for checking medicines and staff kept accurate records of medicines.
- The service kept prescription stationery securely and monitored its use.
- The service had carried out a medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing. The audit covered the financial year of 2017 to 2018, against the local primary care and community anti-microbial treatment guidelines on urinary tract infections (UTIs), for UTIs in patients presented at the BHNC GP Hubs.
- Staff prescribed medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The service had audited antimicrobial prescribing for patients over the age of 70 with a UTI and found that there was greater clinical adherence to the local antimicrobials prescribing guidelines, than prescribing of an alternative. The audit was not completed, as a second cycle had not been carried out, but the findings of the first cycle showed evidence of actions taken to support good antimicrobial stewardship.

Track record on safety

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture. The service planned to make safety improvements in relation to identified risks.
- There was a system for receiving and acting on safety alerts.

Lessons learned and improvements made

Requires improvement

Are services safe?

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service. For example, following an occasion in April 2019 where the emergency medicines were found to be expired, the service ordered new sets of emergency medicines and a storage box for these. They introduced and implemented an emergency medicines checking template and assigned staff to complete the checks on a weekly basis. We saw evidence that these checks were now being carried out as planned during our inspection.
- The service learned from external safety events and patient safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.
- The provider took part in end to end reviews with other organisations. Learning was used to make improvements to the service. For example, following a child safeguarding concern, the service policies were reviewed and updated, as well as guidance from their commissioners and local authorities.

Good

Are services effective?

We rated the service as good for providing effective services.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence-based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met.
- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. Where patients need could not be met by the service, staff redirected them to the appropriate service for their needs.
- The service worked to clearly defined clinical pathways and offered guidelines to local practices and the NHS 111 service on the type of clinical indications the GP hubs appointments should be used for. The hub service was for routine GP appointments, two week wait referrals and investigations. The service did not make routine referrals or referrals for specialist services.
- Patients' own GP practices or the 111 service made appointments for them directly with the GP Hub service. If inappropriate appointments were made to the service, such as for services they did not offer including steroid injections or removal of contraceptive implants, the service staff contacted the patient and the GP practice for them to be seen at their practice. The service had clear communications about the scope of services they offered and followed clearly identified clinical pathways and protocols.
- We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

- The service used the information collected for the local Clinical Commissioning Group (CCG) and performance against contractual key performance indicators (KPIs) to monitor outcomes for patients. This information was available on a performance dashboard and monitored on an ongoing basis.
- For the year ending March 2019, the utilisation of available appointments improved over the year and was close to meeting the target of 75% in March 2019. The provider monitored these figures on an ongoing basis and had considered and implemented actions to improve utilisation.
- For the year ending March 2019, the monthly Did Not Attend (DNA) rates were high in the last three months of the period. The provider was aware of these and was working with the local GP practices to ensure the correct clinical pathways were followed, and appropriate patients were referred to the hub service.
- The service used information about care and treatment to make improvements. Information was used by the service to monitor local GP practices' usage and DNA of the hub service. Where necessary, the GP practices were contacted by the service, provided with the information the service held and explained the admission criteria to the hub service.
- The service did not yet have a history of reviewing the clinical effectiveness and appropriateness of the care provided. They had recently agreed a comprehensive programme of quality improvement activity, which included clinical audits.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. However, we saw evidence of staff training gaps.

- All staff were appropriately qualified. Staff were employed through a medical staff agency and they were vetted, had their records and qualifications checked, as part of the process to be listed with the agency.
- The provider had an induction programme for all newly appointed staff. Mandated training topics included safeguarding children and adults, basic and advanced life support and chaperoning. However, the provider had identified gaps in their staff training, were working with staff to get these completed, and had captured the issue on their risk register. We saw evidence that managers had followed up on the training gaps and issued ultimatums to sessional GPs that had not completed mandated training, but some GPs were still used when they have not completed mandated training. The provider had recently purchased additional licenses to provide online training for their staff.

Good

Are services effective?

- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required.
- The provider understood the learning needs of staff and had mandated a set of topics for them to complete if working in the Hub sites. However, up to date records of skills, qualifications and training were not maintained.
- The provider provided staff with ongoing support. This included meetings and appraisals for non-clinical staff. Non-clinical staff were due their appraisals around the time of our inspection, and we saw evidence that the service manager had scheduled these for the staff concerned.
- There was a clear approach for supporting and managing staff when their performance was poor or variable. For example, the service investigated complaints made about care and treatment, and considered learning opportunities for all staff involved.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. Staff communicated promptly with patient's registered GP's so that the GP was aware of the need for further action. Staff also referred patients back to their own GP to ensure continuity of care, where necessary. There were established pathways for staff to follow to ensure patients were referred to other services as required, either directly or through their registered GP practice.
- The service had formalised systems with the NHS 111 service with specific referral protocols for patients referred to the service.
- An electronic record of all consultations was sent to patients' own GPs.
- The service ensured that care was delivered in a coordinated way and considered the needs of different patients, including those who may be vulnerable because of their circumstances.
- There were clear and effective arrangements for booking appointments. Staff were able to make two week wait referrals and referrals for investigations.
- Patient information was shared appropriately. However, due to limitations in the service's electronic records software, the information needed to plan and deliver care and treatment was not always available to relevant staff in a timely and accessible way.

Helping patients to live healthier lives

- The service was not able to provide continuity of care to support patients to live healthier lives in the way that a GP practice would. However, we saw the service demonstrate their commitment to supporting patients to manage their own health and promotion of health and well-being advice.
- Where appropriate, staff gave people advice, so they could self-care.
- Staff we spoke to showed a good knowledge of local and wider health needs of patient groups who may attend the GP Hub service. GPs told us they offered patients general health advice within the consultation and if required they referred patients to their own GP for further information.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Good

Are services caring?

We rated the service as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- We received 32 completed Care Quality Commission comment card, where patients shared with us their experiences of the service. Of the comments cards we received, 30 were entirely positive, and two had mixed comments. The areas for improvement identified in the feedback were the need for greater promotion of the service and more comprehensive patient counselling and advice for steroid inhaler technique.
- The Bexley CCG supported BHNC in gathering patient feedback through their Mystery Shopper Scheme, focussing on the hub service at Erith hospital. They had received 20 responses through the scheme since October 2018, all of which were positive about the service. Common themes in the feedback received were promptness of the service, helpful staff, good care and treatment experiences.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care:

- Interpretation services were available for patients who did not have English as a first language. The patients' own GP service who booked them into the hub service would inform them of this need. Information leaflets were available 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 enough time during consultations to make an informed decision about the choice of treatment available to them.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Staff respected confidentiality at all times.
- 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.
- The service monitored the process for seeking consent appropriately.

Good

Are services responsive to people's needs?

We rated the service as good for providing responsive services.

Responding to and meeting people's needs

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

- The provider understood the needs of its population and tailored services in response to those needs. Appointments were made into the service by the patients' usual GP service or NHS 111. Slots were reserved for the NHS 111 service at the weekends, when they were most likely to have the highest need to refer into the hub service.
- The provider considered improvement opportunities in response to unmet needs. The service was considering introducing telephone consultations to patients who did not attend (DNA) their appointments.
- Care pathways were appropriate for patients with specific needs, for example patients who needed acute, episodic care, rather than long term conditions management.
- The facilities and premises were appropriate for the services delivered.
- The service made reasonable adjustments when people found it hard to access the service. For example, there was disabled access and car parking at the hospital site.

Timely access to the service

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

- Patients were able to access care and treatment at a time to suit them. The service operated from Monday to Friday from 18:30 to 20:00, and on Saturdays and Sundays from 08:00 to 20:00.
- The appointment system was accessed by Bexley GP practice or NHS 111 staff on behalf of patients. The service did not see walk-in patients and a 'Walk-in' policy was in place which clearly outlined what approach should be taken when patients arrived without having first made an appointment, for example patients were told to call NHS 111 or referred onwards if they needed urgent care. All staff were aware of the policy and understood their role with regards to it, including ensuring that patient safety was a priority. Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs.
- Waiting times, delays and cancellations were minimal and managed appropriately. The practice used an electronic rota system to plan sessional staff availability in advance.
- Referrals to other services were undertaken in a timely way. The service made two week wait referrals and referrals for investigations. It was not within the service's scope of provision to make routine patient referrals or referrals for specialist services.
- It was not within the service's scope of provision to transfer patients to other services.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. One complaint was received in the last year. We reviewed the complaint but found that it was not responded to in a timely way. Although the complaint was immediately acknowledged the complainant did not receive a full response for close over five weeks. The service cited the lack of availability of the sessional GP the complaint related to leading to delays in their investigation and subsequent response to the complaint.
- Issues were investigated across relevant providers, and staff were able to feedback to other parts of the patient pathway where relevant. For example, if an inappropriate appointment was made into the service, they explained to patients why their appointment needed to be cancelled, and the staff made sure they reiterated the scope of their service to the referring service.
- The service learned lessons from individual concerns and complaints. They had not received enough complaints to allow them to carry out analysis of trends.

Requires improvement

Are services well-led?

We rated the service as requires improvement for leadership.

This was because the provider did not have oversight of how health and safety risks were managed; and had not fully addressed staff training gaps and the limitations of their clinical records systems.

Leadership capacity and capability

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

- Leaders had the experience, capacity and skills to deliver the service strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable.
- Senior management was accessible throughout the operational period, with an effective on-call system that staff were able to use.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service. The senior management team in the service had been recently established and comprised the Chief Operating Officer, the Head of Clinical Operations, the Head of Quality and Governance, and GP Clinical Lead. Each member of the management team had clear roles and responsibilities reporting to the Chair of the Board, who was also the CQC Registered Manager. The management team reported directly to the directors.

Vision and strategy

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

- There were organisational aims and objectives, which were set out in its Statement of Purpose. The service had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy of the organisation and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The provider planned the service to meet the needs of the local population.
- The provider monitored progress against delivery of the strategy.

Culture

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

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. The provider had a policy to provide annual staff appraisals to their non-clinical staff team. Non-clinical staff appraisals were being arranged around the time of our inspection. Clinical staff were supported to meet the requirements of professional revalidation where necessary.
- There was a strong emphasis on the safety and well-being of all staff.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management. But they did not yet have assurances that these operated effectively.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective.
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.

Requires improvement

Are services well-led?

- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control. However, we noted limitations in the provider's management of infection prevention and control risks.
- Leaders had recently established proper policies, procedures and activities to ensure safety. However, they did not yet have assurances that they were operating as intended. For example, they had agreed a programme of clinical audit in May 2019, and their staff handbook had been recently updated and distributed to all staff.

Managing risks, issues and performance

- The provider had processes to manage current and future performance of the service. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of patient safety alerts, incidents, and complaints.
- Leaders also had a good understanding of service performance against contractually agreed performance indicators. Performance was regularly discussed at senior management and board level. Performance was shared with staff and the local CCG as part of contract monitoring arrangements.
- The provider had recently agreed a programme of quality improvement activities through clinical audit. Therefore, they did not yet have evidence of the impact on quality of care and outcomes for patients.
- The providers had plans in place and had trained staff for major incidents.
- The provider did not have a fully effective process to identify, understand, monitor and address current and future risks including risks to patient safety. This was because some risks were managed by the premises landlords and the provider did not have an established process for maintaining an oversight of those that related to and affected their service.

Appropriate and accurate information

The service acted on appropriate and accurate information. But there were improvements needed in the clinical records system.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had enough access to information.
- The service used performance information which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service submitted data or notifications to external organisations as required.
- The service used information technology systems in the delivery of care, and to monitor and improve the quality of care. However, we noted there were limitations in the clinical records system which meant that staff did not consistently have the information they needed readily available to deliver safe care and treatment to patients. In addition, the system limited their ability to conduct clinical audits.

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.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- The service had listened to patients and made some improvements. For example, patients had asked for more publicity about the GP hub service. The provider worked with GP practices to ensure the service was advertised and the scope of the service was properly communicated.
- The service was transparent, collaborative and open with stakeholders about performance. Staff worked together to reduce the DNA rate. The service followed up with the patients' usual GPs when they did not attend an appointment. The service was also considering providing telephone consultations to patients who did not attend.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the service.

Requires improvement

Are services well-led?

- Staff knew about improvement methods and had the skills to use them.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** **Care and treatment was not provided in a safe way for service users.** **In particular, we found:** • There were gaps in mandated staff training and the service did not consistently have assurances that sessional clinicians had completed all the necessary checks and training prior to providing clinical sessions in the service. • The arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not operated effectively, in relation to premises management • There were limitations in the clinical records system which meant that staff did not consistently have the information they needed readily available to deliver safe care and treatment to patients. **This was in breach of Regulation 12(2) (c), (d) and (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** **There was a lack of effectively established and operated systems and processes to demonstrate good governance.** **In particular, we found:**

This section is primarily information for the provider

Requirement notices

- There was a lack of management oversight of health and safety risk management, particularly in relation to the premises.
- There was limited evidence of quality improvement activity in the service
- There was a lack of management assurance and oversight that proper staff records were maintained and kept up to date.

This was in breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.