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

Inspection report

Park Crescent
Erith
DA8 3EE
Tel: 02082981965
www.bhnc.org.uk

Date of inspection visit: 24 May 2021
Date of publication: 03/08/2021

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?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Overall summary

This service is rated as Requires improvement overall. (Previous inspection 06 2019 – Requires improvement)

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at Bexley Health Neighbourhood Care GP Hub (BHNC GP Hub) at Erith and District Hospital on 24 May 2021. This inspection was carried out as part of our inspection programme and to follow up on breaches of Regulation 12 Safe care and treatment and Regulation 17 Good governance.

How we carried out the inspection

Throughout the pandemic CQC has continued to regulate and respond to risk. However, considering the circumstances arising as a result of the pandemic, and in order to reduce risk, we have conducted our inspections differently.

This inspection was carried out in a way which enabled us to spend a minimum amount of time on site. This was with consent from the provider and in line with all data protection and information governance requirements.

This included:

- Conducting staff interviews using video conferencing and questionnaire
- Reviewing patient records to identify issues and clarify actions taken by the provider
- Requesting evidence from the provider
- A short site visit

Our findings

- The service had risk management arrangements in place, although some were only recently established.
- The service took a responsive approach in dealing with safety incidents, learning from them and using them to improve their processes, but the preventative element to incidents management was not in place.
- The service did not routinely review the effectiveness and appropriateness of the care it provided. This meant they could not be consistently assured that care and treatment was delivered according to evidence- based guidelines.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

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

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Overall summary

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included an Out of Hours GP specialist adviser, and a second CQC inspector.

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 Northumberland Heath Medical Centre, Hind Crescent, Erith, Kent DA8 3DB. 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 Northumberland Heath Medical Centre is located within the Erith and Distirct hospital site, and consists of one consultation room and a reception area. The Hub has been in operation since January 2015.

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 GP practice where the patient is registered or NHS 111.

The service is commissioned to provide 37,000 GP appointments per annum for a patient population size of 240,000. The BHNC GP Hub service does not offer a walk-in service and all appointments must be pre-booked. The service includes assessment, investigation, diagnosis, treatment (including issuing a prescription) and referrals.

The provider has centralised governance for the service which are coordinated by the BHNC board of directors: the managing director and three directors, who are all clinicians as senior 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 sessional GPs that work locally and provide regular sessional shifts.

The non-clinical service team consists of leaders responsible for each area of the business such as finance, human resources, operations and clinical performance reporting to the Chief Operating Officer. A team of reception and administrative staff members support the administration of services, and the service receives external support from the primary care network.

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 there was a lack of proactive review and monitoring of clinical activities.

Safety systems and processes

The service had made some improvements in relation to safe systems and processes since our last inspection. However, some of their arrangements to keep people safe still needed further improvement.

- The provider conducted safety risk assessments. It had safety policies, including Control of Substances Hazardous to Health and Health & Safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction and refresher training. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The provider had systems to safeguard children and vulnerable adults from abuse. Safeguarding level 3 training is one of the provider's mandatory training courses for its clinicians, and the service supplied evidence that clinicians were up to date with this training.
- The service worked with other agencies to support patients and protect them from neglect and abuse. 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 undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The service mandated that staff received training on topics appropriate to their role. The provider had arrangements to ensure that staff training was monitored and kept up to date.
- Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control (IPC). We observed the service premises to be visually clean and tidy. The Head of Nursing was the IPC lead and there was an IPC policy in place that included additional precautions and instructions in relation to the COVID-19 infection prevention. IPC audits had been completed for the premises during May 2021, but these did not mention specific precautions and assurances around COVID-19.
- The provider ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.
- There were health and safety risks management arrangements in place. These included policies, risk assessments and service plans for premises and equipment.
- Fire drills were carried out by the site landlords, and had not take place during 2020 due to the COVID pandemic. The provider informed us that as a mitigation, they ensured all their staff completed fire safety and health and safety training. They also informed their staff of fire procedures as part of their staff induction.
- We saw evidence that the service had recently established and was maintaining a risk register as of February 2021. Entries on the risk register were discussed at the service's clinical governance meeting held on 14 May 2021. The meeting minutes showed this was their first meeting and was planned to take place monthly.

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. Since January 2021, the service has also started completing performance reports showing practices their usage of the Hub service which they have found has increased uptake.
- There was an effective induction system for temporary staff tailored to their role. The service had a staff handbook, which made this available to all staff, and induction processes were followed when new staff joined the service. Clinical and non-clinical staff employed in the service were sessional, and most worked in local 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 and medical oxygen on site, which may be needed as part of treatment of medical emergencies.
- 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 had the information they needed to deliver safe care and treatment to patients.

- 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. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.

Appropriate and safe use of medicines

The service had systems for appropriate and safe handling of medicines, but these were not always effective.

- The provider had systems and arrangements in place for managing medicines, including medical gases, and equipment, for treating medical emergencies. The provider did not stock other medicines, controlled drugs or vaccines. The provider did not have a paediatric pulse oximeter, which is used to check blood oxygen levels, but have agreed to order these for their Hub sites.
- The service kept prescription stationery securely and monitored its use.
- The service had carried out medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing. In 2019, they carried out prescribing audits of antibiotics for the treatment of urinary tract infections (UTIs), and anxiolytics and hypnotics. Both audits are due to be repeated this year to check that the changes they made in response to its initial findings have had a positive impact on patient outcomes. The provider also planned to carry out the first cycles of prescribing audits into Warfarin prescribing and anti-depressant medications later this year.
- The service had also carried out regular medicines prescribing audit to ensure prescribing was in line with set financial budgets. The provider concluded that the latest available data (up until November 2020) demonstrated that the actual spend at their GP Hub locations is low compared to the set budget which was related to reduced footfall and demand related to the pandemic year and lockdown situations.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The service had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.

Requires Improvement

Are services safe?

- Processes were in place for checking medicines and staff kept accurate records of medicines. However, we found that a reported incident highlighted that better processes needed to be implemented to check consistency in clinicians'' records on consultations and medicines prescribed. The incident highlighted that ongoing audit processes were not in place to check that clinicians prescribed in line with published guidelines. Clinicians prescribing practices were only checked when they first joined the service during their probationary period.

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 that led to safety improvements.
- There was a system for receiving and acting on safety alerts.
- Joint reviews of incidents were carried out with partner organisations, local GP practices, in relation to care and treatment provided by sessional clinicians.

Lessons learned and improvements made

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. The service had recorded two significant events within the last 12 months. These were recorded, investigated and acted upon. In one incident where the service had to deal with a medical emergency, they followed established protocols, but also reviewed their equipment and medicines held for such situations afterwards to determine if they remained enough and agreed they were.
- The service learned from external safety events and patient safety alerts. The service used an information sharing, compliance, and workforce management platform for updating colleagues about the content of safety alerts.
- 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 complaint relating to the clinical care of one of their clinicians the service suspended the clinician pending an investigating and carried out an audit of the clinicians' sessions. Their investigation also highlighted that there was a gap in the routine review and audit of clinician's sessions following their probationary period. We found that there was no formal system for sharing learning across the service, as incidents often involved, related to and included individual clinicians only. The service had recently started holding clinical governance meetings, which included discussion about audits, and they informed us the minutes of these meetings were shared on their information sharing, compliance, and workforce management platform. However there was no evidence that the issue of the lack of routine review and audit of clinicians' sessions had been addressed

Requires Improvement

Are services effective?

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

This was because there was a lack of quality improvement activities

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.
- The provider monitored the utilisation of appointments on an ongoing basis and had considered and implemented actions to improve utilisation.
- The provider monitored Did Not Attend (DNA) rates for appointment attendance. Since the COVID pandemic, the service clinicians typically conducted appointments via telephone. They found that this significantly reduced the DNA rates for appointments. The service also maintained capacity to carry out face to face appointments.
- 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 have a history of reviewing the clinical effectiveness and appropriateness of the care provided. This lack of quality improvement activities was also identified at our last inspection in May 2019. At this inspection, we found that the provider 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.

Requires Improvement

Are services effective?

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff. This covered specific and relevant topics for their roles.
- 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.
- 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. Staff told us they were given protected time for learning.
- The provider provided staff with ongoing support. This included meetings and appraisals for non-clinical staff.

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. Most recently, following a complaint about a Hub GP's poor record keeping and prescribing practice, they are considering introducing ongoing periodic review and audit of clinicians'' care and treatment.

- Non-clinical staff told us they felt supported by the management, that any concerns they raised were listened to. However, they highlighted that they had not received annual appraisals in the last 2 years and would like more meetings with the managers.

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 patients' 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 supported the healthcare system by providing additional access to manage 'on the day demand' for GP appointments.
- The service demonstrated their commitment to supporting patients to manage their own health and promotion of health and well-being advice.

Requires Improvement

Are services effective?

- Where appropriate, staff gave people advice, so they could self-care.
- Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

The service 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.
- The service gave patients timely support and information.
- We did not gather patient feedback during this inspection, due to the COVID-19 pandemic.
- No concerns or compliments had been received by the local CCG or Healthwatch teams about this service.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available.
- Due to the COVID-19 pandemic, patients were not being seen in the service, but appointments were provided by telephone.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Staff always respected confidentiality.
- 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. Since the COVID-19 pandemic, telephone appointments have been provided wherever appropriate.
- 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 6.30pm to 8pm, and on Saturdays and Sundays from 8am to 8pm.
- 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. The service had not received any complaints in the last year.
- 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.

Good

Are services responsive to people's needs?

- The service learned lessons from individual concerns and feedback. They had not received any complaints to allow them to carry out analysis of trends.

Good

Are services well-led?

We rated the service as good for leadership.

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. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- 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 leadership team within the service had changed significantly since our last inspection. A recently appointed Chief Operating Officer was in place, with oversight of all the provider's operations, including those out of the scope of this inspection and their CQC registration. The provider was going through a restructure and reallocation of roles and responsibilities to suit staff strengths and expertise.

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.
- 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. However, the staff we communicated with told us they had not received appraisals in the last two years.
- 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

Good

Are services well-led?

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- 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.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for 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 when we last inspected in May 2019. At this inspection, we found their clinical audit activity had not progressed to the extent of being able to evidence the impact on quality of care and outcomes for patients. They cited changes in staffing among the challenges they had to progress in this area.

- The providers had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- 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.
- At our last inspection 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. Since our last inspection, the provider has met with records system provider, who had provided additional training to the staff team on the correct ways of using the system to obtain the required information.

Engagement with patients, the public, staff and external partners

Good

Are services well-led?

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

- 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 has provided telephone consultations to patients during the pandemic.
- The service was transparent, collaborative and open with stakeholders about performance.

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. The service had plans to complete a programme of quality improvement activities.
- 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 were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **There was a lack of effectively established and operated systems and processes to demonstrate good governance.** **We found:** • There was limited evidence of quality improvement activity in the service. • The provider had not implemented processes to check consistency in clinicians' records of consultations and medicines prescribed. **This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**