GP Care UK Limited Headquarters

Inspection report

2430/2440 The Quadrant
Aztec West
Bristol
BS32 4AQ
Tel: 03333322100
www.gpcare.org.uk

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

Overall summary

This service is rated as Good **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? – Good
We carried out an announced comprehensive inspection at GP Care UK Limited Headquarters as part of our inspection programme.

GP Care UK limited provides rapid access, specialist diagnostic, assessment and treatment services in local health care communities.

During the inspection we reviewed 166 completed CQC patient comment cards of which 161 were positive about the service, two were mixed and three negative. We also spoke to five patients. Feedback described the service as efficient and staff as caring, knowledgeable and respectful.

We rated the service as requires improvement for safe services because:

- Systems and processes to keep people safe were not fully implemented. This included provision of safeguarding children, domestic violence and abuse, and mental capacity act (MCA) training.
- Staff were unclear who they should seek safeguarding advice and support from.
- A process for sepsis identification and management including staff training was not in place.
- Processes to support good governance such as a clinical equipment asset register; documentation to demonstrate cleaning of equipment and, reviews of post-surgery complications including infections were not fully in place.

We rated the service as good for caring, effective, responsive and well-led because:

- Staff dealt with patients with kindness and respect and involved them in decisions about their care.
- The service organised and delivered services to meet patients' needs. Patients could access care and treatment in a timely way.
- Feedback from patients was consistently positive.
- The service encouraged and heard views and concerns from the public, patients and staff and acted on them to shape services and culture.

We saw the following outstanding practice:

- The service had responded to patients who attended the deep vein thrombosis (DVT) clinics and set up a DVT support group. Feedback from the attendees demonstrated the value of the group to encourage healthy living and prevent further medical problems.

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

- Ensure patients are protected from abuse and improper treatment.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out their duties

(Please see the specific details on action required at the end of this report).

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

- Review processes for fire evacuation training at host sites.
- Review medical emergency management at host sites to ensure an appropriate clinician is available to respond.
- Staff including administrators and health care assistants should have training to recognise indicators of acute infection such as sepsis.

Overall summary

- Implement an oversight system for assurance of medical safety alert management.
- Maintain an overarching clinical equipment asset register to document calibration and maintenance.
- Implement a system to document the cleaning of medical equipment following clinic sessions.
- Consider including staff in host site fire evacuation drills.
- Consider a process to record delays in reviews of sonographer diagnosis.
- Review the system to evaluate individual clinician minor surgery histology and post-infection rates in line with good practice.
- Continue to review findings from urology audits in terms of the absence of monitoring of physical symptoms and discharge letters in regard to additional monitoring by a patient's own GP.
- Consider formalising the decision for when private patients refuse to provide details of their own GP when requesting services in relation to Minor Surgery.
- Review audit trails for complaint management to document action completion dates.

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 two other CQC inspectors and a GP specialist advisor.

Background to GP Care UK Limited Headquarters

GP Care UK Limited is a social enterprise providing specialist medical services in the South-West of England. The provider was originally founded by, and are still owned by, over 100 local GPs.

GP Care UK Limited has multiple contracts with NHS commissioners offering NHS patients fast access to diagnostic, outpatient and ancillary healthcare services at convenient community locations. The service treats over 20,000 patients a year mainly in Bristol, North Somerset, South Gloucestershire, Swindon, Gloucestershire and Devon. Care and treatment are provided at a number of clinic locations within these areas including GP practices and hospitals.

The headquarters for the service is: 2430/2440 The Quadrant, Aztec West, Bristol BS32 4AQ. The clinical director is the registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service is registered with the CQC for the registered activities: diagnostic and screening procedures; surgical procedures and treatment of disease, disorder or injury. Regulated activities are carried out from over 18 different clinic locations within each NHS commissioning area. As part of this inspection we visited two clinics provided within GP practices in Bristol. The service operates Monday to Friday between 8am and 6pm. In addition, some clinics are held at varying days and times including Saturdays.

Services provided under contract from NHS clinical commissioning groups include:

- community urology service - A "one stop shop" diagnostic and assessment services that provides NHS patients with fast access to consultant led urology clinics in community locations.
- community deep vein thrombosis ("DVT") Service - Community diagnostic and treatment service for NHS patients with suspected or actual DVTs in community locations.
- community ultrasound service - A community ultrasound services to NHS patients.

GP Care UK Limited also provides a range of services to people on a private, self-funded basis from a network of community clinic locations mainly across Bristol, North Somerset and South Gloucestershire. These include:

- minor surgery including the removal of Chalazion/Meibomian cysts. (A Chalazion (or Meibomian) cyst is a fluid filled sac in the upper or lower eyelid, usually caused by the blockage of a meibomian gland),
- pregnancy reassurance scans,
- The Harmony™ Prenatal Test to test for chromosomal abnormalities in an unborn child,
- private pelvic ultrasound for females requiring endometrial screening or Intra Uterine Contraceptive Device (IUCD) assessment,
- abdominal aortic aneurysm ("AAA") screening.
- osteoporosis diagnosis and screening service.
- axillary hyperhidrosis (excessive sweating from the armpits) with Botox injections.

The provider also provides an ultrasound service as a sub-contract at five local prison locations which is out of scope of CQC registration. They were commissioned to provide a day surgery urology service within Gloucestershire (separate CQC registered location outside the scope of this report).

The organisation structure includes a chair and chief executive officer, clinical director, director of patient support services and non-executive directors who work alongside a team of administrative and clinical staff. Administrative staff included analysts and call centre staff. The provider employs local clinicians including NHS consultants, GPs including GPs with specialist interest (GPwSI), specialist nurses and sonographers to work within the service. Clinical staff are appropriately experienced and have either worked or are working in local NHS provider organisations. The service also uses a number of consultants to provide specialist advice and peer reviews to sonographers.

Further information can be found at www.gpcare.org.uk.

How we inspected this service

Before visiting, we reviewed a range of information we hold about the service. We also asked the service to complete a provider information request. During our visit we:

- Spoke with the clinical director who was also the registered manager.
- Spoke to staff including the chief executive officer and a non-executive director.
- Visited the provider's headquarters where their call centre is based.
- Visited two clinic locations and spoke with staff and patients.
- Looked at information the service used to deliver care and treatment.
- Reviewed comment cards where members of the public shared their views and experiences of the clinic.
- Asked the clinical commissioning groups (CCGs) to provide feedback on the services they commissioned the service to provide.

To get to the heart of peoples' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Requires improvement

Are services safe?

We rated safe as Requires improvement because systems and processes and practices that are essential to keep people safe were not fully identified, put in place and communicated to staff.

Safety systems and processes

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

- The provider conducted safety risk assessments. It had appropriate safety policies, which were regularly reviewed and communicated to staff including locums. They outlined clearly who to go to for further guidance. Staff received safety information from the service as part of their induction and refresher training.
- The service had provided training to staff about safeguarding vulnerable adults from abuse. We reviewed staff files and the locations training records. However, the service could not evidence clinical staff had received appropriate levels of training in line with national guidance. Training in domestic violence and abuse was not provided to staff. Following inspection the provider told us appropriate levels of training had taken place. We were unable to corroborate this as relevant documents were not provided.
- Most of the staff we spoke to were unclear who the service's safeguarding lead was and who they should escalate concerns to. We reviewed the providers safeguarding policy which detailed actions for staff if they had a concern.
- During inspection we reviewed training and personnel folders and, spoke to staff. We were told training in the Mental Capacity Act (MCA) (2005) and the Deprivation of Liberty Safeguards (DoLS) was not provided by the service. This meant the provider could not ensure non-clinical staff had a good understanding of these processes to ensure that they could act in a patient's best interest. Clinical staff we spoke to had a good understanding of both and had told us they received training from their main contracted employment. Following inspection, the provider told us appropriate levels of training had taken place. We were unable to corroborate this as relevant documents were not provided.
- We were told safeguarding children training was not provided as part of the service's mandatory training. During the inspection, information to demonstrate safeguarding children training had taken place was not available. Although the service did not provide services to children, staff could encounter children through contact they had with patients or through the clinic locations. This meant not all staff were up to date with steps they should take to protect children from abuse and neglect and the provider was not meeting its legal requirements in terms of ensuring staff had the knowledge and skills to identify abuse and act on concerns. Following inspection, the provider confirmed administrative staff had undertaken safeguarding children e-learning. We were unable to corroborate this information.
- Although clinical staff working in other services should have completed safeguarding children training, the provider did not have a process to ensure training was up to date or at the appropriate level when undertaken elsewhere. Following inspection, we were advised the safeguarding lead had undertaken an updated safeguarding children level 2, MCA and DoLS training which was in the process of being rolled out to staff. We were told safeguarding children level 3 had been undertaken by the clinical lead previously. Documents to demonstrate completion were not provided so we were unable to corroborate the information.
- 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). 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.
- 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. We were told all clinical equipment was cleaned and some equipment calibrated at the end of each clinic session however the service did not keep a documented record of this.
- The provider carried out appropriate environmental risk assessments, which took into account the profile of people using the service and those who may be accompanying them.

Risks to patients

Requires improvement

Are services safe?

There were not systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for agency staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. Staff worked across multiple clinic locations owned by other providers such as GP practices. Medicines and equipment to deal with medical emergencies were provided by the service hosting the clinics.
- Staff told us not all locations where clinics were hosted had emergency call bells however the service had an untested process in place to manage emergencies. Although there were always three members of staff on duty during some clinics, there was not a doctor present within the clinic setting. Agreements were in place for a clinician, from the location hosting the service, would be present in a medical emergency however staff told us there was not always an appropriate person present, with the knowledge and skills to manage a medical emergency including the administration of emergency medicines.
- Clinical staff we spoke to knew how to identify and manage patients with severe infections, for example sepsis. However, the service did not provide training to enable non-clinical staff to recognise and respond to acutely unwell or deteriorating patients (who may have sepsis). A process and audit tools were not in place for sepsis identification and assessment including the recording of a patients physiological signs and symptoms.
- Reviews of the minor surgery service included an annual overarching review of post-surgery infection rates and abnormal histology results. However, individual clinician reviews in line with good practice were not evident.
- We saw evidence to demonstrate some clinical equipment calibration had taken place. We were advised there was an asset register to provide assurance that all equipment had been tested however this was not made available to the inspection team Following inspection the service provided an asset register which was dated post inspection. We were unable to corroborate if this was in place during our inspection.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements including professional indemnity in place.
- At clinic locations, staff we spoke to were aware of fire exits and evacuation processes and office-based staff took part in the building owners fire evacuation training however staff were not included in other providers (host sites) fire training. Fire drill training at the office site was provided by the building management company.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- 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.
- The service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

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

- The service kept prescription stationery securely and monitored its use.
- The service did not prescribe controlled drugs (medicines that have the highest level of control due to their risk of misuse and dependence).
- Staff who prescribed medicines such as consultants, GPs and non-medical prescribers gave advice on medicines in line with legal requirements and current national guidance. An audit undertaken identified that four out of 377 discharge letters to patients GPs did not contain information with regards to additional monitoring of some medicines. For example, patients seen in the urology clinics prescribed medicines that may have an effect on those patients with high blood

pressure. Following inspection the service told us they had discontinued prescribing this medicine. Discharge letters asking a GP to prescribe the medicine will advise the need for relevant monitoring.

Track record on safety and incidents

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues including risk assessments for clinics provided at hosted locations.
- 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.
- The service did not have a centralised system for the oversight and management of information from external sources such as the Medicines and Healthcare products Regulatory Agency (MHRA) alerts. Documentation such as clinical governance meeting minutes demonstrated medicine safety alerts were discussed however the service did not have an oversight system to clearly document actions taken.

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. 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. An annual report of all incidents was undertaken yearly. We reviewed the 2018/19 report which showed there were no serious incidents (including unexpected or avoidable deaths or injury). Of the 145 incidents reported 82 were adverse incidents, 62 were near misses and 1 was a corporate incident in relation to health and safety in the office. We reviewed the incidents and found the service had taken satisfactory action.
- Processing errors were responsible for a large proportion of incidents, and we saw the service was taking action to ensure written standard operating procedures and process guides were up to date, standardised and trained out to all relevant staff.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents.
- When there were unexpected or unintended safety incidents the service gave affected people reasonable support, truthful information and a verbal and written apology. They kept written records of verbal interactions as well as written correspondence.

Good

Are services effective?

We rated effective as Good because staff worked well together and the service was involved in quality improvement activity.

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 (relevant to their service)

- The provider assessed needs and delivered care in line with relevant and current evidence based guidance and standards such as the National Institute for Health and Care Excellence (NICE) best practice guidelines.
- Patients' immediate and ongoing clinical needs were fully assessed.
- Clinicians had enough information to make or confirm a diagnosis.
- We saw no evidence of discrimination when making care and treatment decisions.
- A lead clinician was appointed for each service delivered. They undertook quarterly reviews of each service.
- Standard operating procedures were in place and in line with best practice. For example, we saw procedures for the deep vein thrombosis (DVT) service, booking of patients into clinics and post consultation referral pathways.

Monitoring care and treatment

The service was actively involved in quality improvement activity.

- The service used information about care and treatment to make improvements. For example, they worked with service commissioners to redesign the specifications of the service following analysis of data and performance.
- For one new urology service analyse of data (after six months) of the 455 patients seen demonstrated the service reduced the impact on NHS service providers by freeing up 80 hospital outpatient appointments. The cost analysis showed significant cost savings for the NHS. The new service had also reduced patient waiting times significantly.
- The service undertook monthly performance reviews to analysis the effectiveness of the service. This included reviews on key performance indicators including trends and analysis of performance and RAG (Red, Amber and Green) ratings as a way of indicating quality improvement areas. They utilised data from internal and external information including key performance indicators.
- The service made improvements through the use of completed audits. Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality. For example, audits were undertaken to evaluate clinical care based on NICE guidance. (The national institute of clinical effectiveness NICE provide evidence -based treatment guidance on a wide range of conditions). We saw as a result of a deep vein thrombosis (DVT) service audit the service updated its clinical processes, added in new checks to identify more serious illness such as malignancy and changed the patient pathway in terms of review dates.
- The service encouraged all staff to be involved with audits. This included non-executive board members.
- We reviewed the audit process for review of diagnosis undertaken by a sonographer (a healthcare professional who specialises in the use of ultrasonic imaging). The standardised audit was in line with national recommendations (5% of all requested ultrasounds). The audit January to June 2018 found 99% of patients seen had an acceptable or good quality of image which demonstrated an improvement of 7% from an audit 12 months previously. However we found the service was behind with these reviews. Within the process, the service was not recording the delay in the timing of the review. This meant some patients may experience a delay if additional scanning was required.
- We saw the service continually monitored the services they provided. The provider's deep vein thrombosis (DVT) services undertook 2,000 scans per annum across eight clinic locations. Data about the service showed 500 patients had received a diagnosis of a DVT with reduced waiting times and local access to the service. Patient feedback for the service showed 98% of patients would recommend it.

Effective staffing

Staff did not always have the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff.

Good

Are services effective?

- Relevant professionals (medical, sonographer and nursing) were registered with the appropriate professional council such as the General Medical Council and were, where appropriate, up to date with revalidation.
- The provider had not understood the learning needs of staff with regard to training for safeguarding children, Mental Capacity Act, Deprivation of Liberty Safeguards (DoLS) and sepsis awareness.
- There was no system to record when clinical staff who undertook mandatory training with their main employer completed and updated this training. Following inspection the service provided a documentation of dates of training completion. We are unable to corroborate the information.
- They provided protected time and training to meet their mandatory training programme. Up to date records of skills, qualifications and training were maintained.
- Staff were encouraged and given opportunities to develop. For example, through the institute of leadership and management.
- Staff received monthly feedback on performance. For example, audits of call handler interactions with patients. Staff were asked to self-evaluate their confidence on using processes for the areas they work in which enabled the organisation to identify gaps.
- Competencies were in place for non-clinical staff such as health care assistants (HCA) who perform additional roles, for example, bladder scanning.
- The service had arrangements with senior health care professionals to undertake performance reviews. For example, consultant Radiologists undertook reviews of work completed by sonographers. (A sonographer is a healthcare professional, usually with a radiology background, who performs ultrasounds for diagnosis of clinical illness).
- The service had hospital consultant retainers in place when a second opinion was required.

Coordinating patient care and information sharing

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

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate. For example, the service aimed to improve commencement of medicines by a patient's own GP from 90% of patients prescribed blood thinning medicines prior to appointment so to improve quality outcomes for patients. We saw a GP training session was planned to improve GP knowledge regarding pre-referral treatments required.
- Before providing treatment, clinicians at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history. We saw examples of patients being signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment.
- All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service. However, there was a not a formalised process detailing actions staff should take if privately funded patients refused to provide their own GP details.
- Patient information was shared appropriately (this included when patients moved to other professional services), and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way. There were clear and effective arrangements for following up on people who had been referred to other services.
- Data for the service showed that a patient's own GP was provided with a summary of care and treatment within two days of being seen. For the urology clinic we saw the provider consistently achieved a 100% completion rate which was more than the target rate of 96%.
- We spoke to the service where a clinic was held and whose patients were referred to the provider. They spoke positively about GP Care UK Limited telling us they had no complaints and the service was smooth and efficient.

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice so they could self-care.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support.
- Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Good

Are services effective?

- The service had established a monthly deep vein thrombosis (DVT) support group for patients. The group provides support for management of the condition and encouragement to prevent further blood clots through healthy living. The group had 60 members and they fed back monthly to the service. Feedback included the positive support they received from the group and the effective local service they received when first referred by their own GP.

Consent to care and treatment

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

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Clinicians we spoke to told us, where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The service monitored the process for seeking consent appropriately.
- Although the provider had never had concerns regarding obtaining consent there was not a formal process in place in case patients who funded their treatment privately refused to provide GP details.

Good

Are services caring?

We rated caring as Good because the service involved and treated people with compassion, kindness, dignity and respect.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received.
- Feedback from patients was positive about the way staff treat people. They told us they felt listened to.
- 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 observed staff interactions with patients during clinical procedures. Staff we observed gave patients enough time to discuss procedures and concerns and were very kind and caring.
- We reviewed the quarterly patient survey (July to September 2019) for two clinical commissioning group areas and saw of the 1,771 patients who responded to the survey, 100% said they were treated with dignity and respect.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

- Interpretation services were available for patients who did not have English as a first language. Information leaflets where necessary were available in easy read formats, to help patients be involved in decisions about their care.
- Patients told us through CQC comment cards, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Good

Are services responsive to people's needs?

We rated responsive as Good because the service was responsive to and met people's needs. They did this by listening to patient feedback and amending services to improve patient access. Their DVT clinic had won a number of innovation awards. (Deep vein thrombosis (DVT) is a potentially life threatening medical condition caused by a blood clot in the vein).

Responding to and meeting people's needs

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

- The provider understood the needs of their patients and improved services in response to those needs. For example, following feedback on quarterly patient surveys, the service reviewed and updated location maps and directions. They also reviewed the locations in Gloucestershire following poor patient feedback regarding facilities at these locations. This resulted in changing locations so standards of facilities were of good quality.
- The facilities and premises which hosted clinics were appropriate for the services delivered.
- Reasonable adjustments had been made so that people in vulnerable circumstances or those with sensory disadvantages such as those who required an interpreter could access and use services on an equal basis to others. A text message service was used to remind patients of booked appointments.
- We reviewed patient surveys. The survey for two clinical commissioning group areas for July to September 2019 showed 99% of patients would recommend the service. Between 92% and 94% of patients (dependent on type of clinic) were satisfied with the service they received.
- We received 166 CQC comment cards of which 161 were positive, two were mixed reviews and three negative about their experience using the service. In addition we spoke to four patients who were positive about the service and staff they spoke to.
- Monthly performance meetings and the leadership team's governance dashboard included patient feedback, concerns and complaints.
- The DVT support group, set up as a pilot, had continued due to positive patient feedback and support received. The group allowed patients the opportunities to share experiences, coping strategies and support each other to improve lifestyles and reduce further medical concerns.
- At the DVT support group sessions patients were asked to complete patient feedback. The service took account of the patient feedback and as a result adjusted clinic times to meet the needs of different populations. For example, early morning and Saturday clinics.
- The provider had won awards for their innovative DVT service twice and were currently nominated for a healthcare excellence award.

Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment booking system was easy to use.
- Data for the DVT clinic (September and October 2019) showed:
- 96% of the 257 patients received a call within two hours of referral to the service.
- Patients who abandoned calls were well below the 5% abandonment rate.
- 90% of urgent referrals were seen in the clinic within 24 hours. (Those not seen were due to patient choice) and 100% of non-urgent referrals were seen within the 48 hour target.
- Clinics had a 97% booking rate with empty appointments available for urgent referrals.
- Clinic non-attenders (DNA) had reduced from 3% to 2%.
- Data for the urology service demonstrated patients received appointments within set timescales. For example, in October 2019 the service rate for patients seen within 28 days was 98% which was above the 96% target.
- Referrals and transfers to other services were undertaken in a timely way. The service had a standard operating procedure in place to refer patients who required urgent surgery or complex radiography.

Good

Are services responsive to people's needs?

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. Staff treated patients who made complaints compassionately.
- The service informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint.
- The service had complaint policy and procedures in place. They had an appropriate process to manage complaints about the service. We reviewed this and found complaints were satisfactorily handled. Actions taken were clearly documented however dates of completion of actions were not always evident.
- The service learned lessons from individual concerns, complaints and from analysis of trends. It acted as a result to improve the quality of care. This included an annual review of patient and contractor complaints. For 2018/19 the service received 46 complaints of which 26 were from patients or their carers which relates to less than 1% of the total number of patients seen during this period.
- We saw, as a result of complaints, the service made improvements. For example, they developed in-depth patient guides for different services provided.

Good

Are services well-led?

We rated well-led as Good because

- **the service listened to feedback and concerns from patients and staff and implemented changes as a result.**
- **There was a focus on innovations to improve the quality of care and treatment.**

Leadership capacity and capability

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

- Leaders 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.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service. For example, they encouraged staff to attend a nationally recognised leadership management programme.
- The senior leadership team worked within the same office. Staff told us they were all accessible, took time to listen to them and they were able to approach them with concerns or feedback.

Vision and strategy

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

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- The service developed its vision, values and strategy jointly with staff and external partners (where relevant).
- The mission statement for the service: to reduce hospital waiting lists and patient waiting times by increasing the availability of rapid access specialist diagnostic, assessment and treatment services in local health care communities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The service monitored progress against delivery of the strategy. The provider undertook a shareholders survey every three years to ensure their views formed part of ongoing strategy reviews.
- The service demonstrated they aligned staff to the business objectives, mission and goals. For example, they recently held a workshop with a poetry company for staff to focus on what patients need. As a result, staff wrote a poem on caring aligned to the company's values which was available on their website for the public to view.

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.
- Staff told us they were able to raise issues and this was acted on. For example, staff raised that there was not adequate heating at the head office and this was rectified swiftly.
- Staff also told us that when they fed back to the management team that there were more demands for certain clinics, additional clinics had been put on to meet demands.
- The service focused on the needs of patients.
- Leaders, managers and staff acted on behaviour and performance consistent 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 told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed. The service had access to a Freedom to Speak Up Guardian.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. Clinical staff were considered valued members of the team. They were given protected time for professional development and evaluation of their clinical work.
- The service had core expected values and behaviours for the organisation and their staff. These, along with the

services objectives and vision, were incorporated into performance reviews. The organisation's values were rated for each individual staff member to identify areas of development.
- There was a strong emphasis on the safety and well-being of all staff. For example, the service had provided staff with wellbeing and mindfulness sessions. There was a plan in place to train some staff as mental health first aiders.
- 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.
- Staff had received unconscious bias training to enable them to identify any bias which may affect the way patients are treated.
- There were positive relationships between staff and teams.

Governance arrangements

There were areas where systems of accountability to support good governance and management were not fully implemented, leading to gaps in assurance.

- Structures, processes and systems to support good governance and management were mostly in place. However, during inspection, key staff were not available which may have led to the provider being unable to fully demonstrate compliance. We found areas where systems to support good governance should be improved. For example, documentation for clinical equipment management including an overarching asset register and recording of cleaning. A process for sepsis identification. And recording of delays in the review process for ultrasounds within patient records.
- During the inspection process the service provided additional information to support improvements to processes. We have been unable to corroborate this.
- The service utilised a governance dashboard for oversight and assurance of risks, clinical governance, key performance indicators and compliance with regulations.
- The governance and management of partnerships and joint working arrangements promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities
- Leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. As part of these processes they undertook visits and audits at host locations to ensure the location and their staff were complying with legal requirements. We saw up to date risk assessments were in place for all their locations.
- The service undertook an annual audit of their accounts with external auditors. This went above contractual requirements.
- Information governance was in line with NHS guidance on data security.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an overarching process to identify, understand, monitor and address current and future risks.
- The service had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change services to improve quality. However, audits of post-surgery infection rates and abnormal histology results did not take place.
- The provider had plans in place and had trained staff for major incidents.
- Daily exception reporting was in place to review any breaches and incidents.
- Monthly operations and performance meetings took place such as the risk and continuous improvement group and clinical governance committee. They included in-depth monitoring and oversight of the governance and management of the service.
- We saw the service responded quickly and appropriately to risks. For example, an issue with IT connectivity at clinics led to contingency plans and future proofing connectivity to reduce risk.

Appropriate and accurate information

The service acted on appropriate and accurate information.

Good

Are services well-led?

- 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 sufficient access to information.
- The service used performance information which was reported and monitored and management and staff were held to account.
- Monthly meetings with commissioners took place and the service provided monthly performance reports.
- 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.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- The service encouraged and heard views and concerns from the public, patients, staff and external partners and acted on them to shape services and culture. They undertook quarterly patient surveys using qualitative and quantitative data. Any concerns noted in the results or within a verbal or written complaint were reviewed and actions taken. For example, a female patient raised a concern seeing a male clinician with a male chaperone. As a result, the service reviewed clinic staffing and ensured any clinic with female patients had a female member of staff present at the location.
- Staff could describe to us the systems in place to give feedback. We saw evidence of feedback opportunities for staff such as the annual staff survey and how the findings were fed back to staff. Results from July 2019 showed more than 95% of employees believed the organisation looked after their health and wellbeing. More than 75% of staff believed the culture was open and honest and 80% believed their teams were well managed.
- The provider implemented changes as a result of feedback. For example, following feedback on the suitability of the office premises including staff wellbeing whilst working there the service was due to move to a new premises in 2020.
- The provider took steps to improve staff wellbeing through provision of wellbeing training. They were in the process of providing mental health first aider training to staff.
- The service was transparent, collaborative and open with stakeholders about performance. They met with commissioners and provided monthly performance reports.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement. We saw learning from a serious incident had led to changes to staff inductions, learning sessions for staff and changes to the process for monitoring the quality of clinical care.
- 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.
- There were systems to support improvement and innovation work. For example, the provider was in the process of completing an ISO 9001:2015 standard. (The standard is used by organizations to demonstrate their ability to consistently provide products and services that meet customer and regulatory requirements and to demonstrate continuous improvement).
- We saw the provider worked with local NHS commissioners to provide pilot urology services in two areas to improve patient access to urology clinics and reduce financial impact. Both pilots resulted in contracts to provide this service.
- The provider demonstrated they focused on improvements and innovations including future business aspirations to drive local community care and ensure access to diagnostics was available locally. For example, their DVT service which we saw was under a continuous review.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:** **The registered person had failed to establish systems to prevent abuse. In particular:** • Staff had not received safeguarding training relevant to their role. For example, safeguarding children, safeguarding vulnerable adults and, domestic violence and abuse. • Staff we spoke to were unclear who the service's safeguarding lead was and who they should escalate concerns to. **This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** **The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular:** • Training in the Mental Capacity Act (MCA) (2005) and the Deprivation of Liberty Safeguards (DoLS) was not provided by the service. • The provider did not have a process to ensure safeguarding training was up to date or at the appropriate level when undertaken elsewhere.

This section is primarily information for the provider

Requirement notices

- The service did not provide training to enable non-clinical staff to recognise and respond to acutely unwell or deteriorating patients (who may have sepsis).
- There was not a system to demonstrate when clinical staff had undertaken mandatory training through their main employer.

This was in breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.