Downham Health & Leisure Centre

Inspection report

7-9 Moorside Road
Bromley
BR1 5EP
Tel: 02034881457

Date of inspection visit: 21 and 22 June 2023 and 11 July 2023
Date of publication: 20/11/2023

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Overall summary

This service is rated as Requires improvement overall.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at Downham Health & Leisure Centre. This was the first rated inspection for the service that was registered with the Care Quality Commission (CQC) in 2017. During this inspection we inspected the safe, effective, caring, responsive and well-led key questions.

Downham Health & Leisure Centre is an independent healthcare organisation run by One Health Lewisham (OHL), an integrated community service provider which delivers a number of services for NHS GP practices, across south-east London.

Downham Health & Leisure Centre is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC which relate to particular types of regulated activities and services and these are set out in Schedule 1 and Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Therefore, we did not inspect or report on these services.

The Chief Operating officer of One Health Lewisham is the registered manager. A registered manager is a person who is registered with the Care Quality Commission 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.

Our key findings were:

- The service delivered care and diagnostic procedures from health hubs and from satellite clinics, in spaces run by NHS GP providers.
- There were systems to assess, monitor and manage risks to patient safety. Where these were managed by the service, they generally worked well but they were not consistently effective. For example, not all staff had completed required training to maintain knowledge and skills. We found three members of staff had not completed safeguarding training.
- There was no effective system to ensure that staff employed by host community services, that patients interacted with, had the appropriate skills, knowledge and experience and there were no checks to verify the effectiveness of the system.
- The service had systems and processes to ensure that the premises used to provide services were safe. We visited three host community service sites and looked at equipment and premises, and at documents and found these were generally well managed. However, the provider had no written agreements in place for monitoring host community service risk assessments.

Overall summary

- There were safe procedures for managing medical emergencies including access to emergency medicines and equipment.
- The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence based guidelines.
- We found most recruitment checks were carried out in accordance with regulations (including for agency staff and locums). However, we found some gaps in recruitment records. The provider did not have a written agreement with the host community services that described the recruitment checks expected for staff that interacted with the patients at host clinic sites. There was no mechanism to ensure that this process for ensuring appropriate recruitment checks was effective.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- The service took complaints and concerns seriously and responded to them to improve the quality of care.
- Leaders had the capacity and skills to deliver high-quality, sustainable care. The provider was aware of areas of weaknesses and worked to improve them.
- The service had a culture of high-quality sustainable care.

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

- Carry out an annual appraisal for all staff.
- Train all staff who act as chaperones.
- Continue to ensure policies and procedures are followed, for example the appraisal policy.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Health Care

Our inspection team

Our inspection team was led by a CQC lead inspector**.** The team included a second CQC inspector and a specialist adviser.

Background to Downham Health & Leisure Centre

Downham Health & Leisure Centre head office address is located at Downham Health & Leisure Centre, 7-9 Moorside Road, Bromley, Kent BR1 5EP. One Health Lewisham Limited (OHL) provided some services which are not regulated by the CQC. Therefore, at Downham Health & Leisure Centre, we were only able to inspect the services which were subject to regulation.

Downham Health & Leisure Centre is registered with the CQC to provide the following regulated activities; treatment of disease, disorder or injury and diagnostic and screening procedures, diagnosis and screening procedures and family planning.

CQC inspected Downham Health & Leisure Centre on 21 and 22 June 2023 and on 11 July 2023. As part of this inspection, we visited the south-east London Special Allocation Service (SELSAS) at the main base at Rushey Green Group Practice and visited one of the SAS satellite host practices, to inspect the premises and understand arrangements for the provision of services regulated by CQC including arrangements for emergencies. We did not inspect the NHS GP practices who own or use the premises. We also inspected the Respiratory hub and the Community Dermatology Services (CDS) hub at Marvels Lane Surgery in Lewisham, south-east London.

- The main SAS site is based at the Novum Health Care Partnership Rushey Green Group Practice. SAS care is currently provided from three satellite clinics in Southwark, Bromley and Bexley;

- Dulwich Hospital, Tessa Jowell Health Centre, 72H East Dulwich Grove, East Dulwich, Southwark, London SE22 8EY
- Orpington Health & Wellbeing Centre, 19 Homefield Rise, Orpington, Bromley BR6 0FE
- Queen Marys Hospital, Frognal Avenue, Sidcup DA14 6LT

- The Special Allocation Scheme (SAS) service provided by Downham Health & Leisure Centre (DH&LC) is delivered from dedicated host satellite sites run by NHS GP providers. Leaders at DH&LC told us they do not use any staff at the satellite sites who are employed by the host GP providers. Downham Health & Leisure Service told us they hire a clinical room at the SAS host satellite sites where SAS patients can only be seen by clinical staff who are directly employed by the provider, One Health Lewisham. The SELSAS service is open from 8.30am to 6.30pm, Monday to Friday and provides medical primary care services to people who have been removed from their mainstream GP practice list. When the SAS service is closed patients who need out of hours help can telephone NHS111.

- The Respiratory Hub is delivered across two sites - Marvels Lane Surgery and the Waldron Health Centre in Amersham Vale. The Respiratory Hub provides remote assessment, diagnosis and management of patients with a variety of respiratory needs. It provides spirometry delivered by Association for Respiratory Technology & Physiology (ARTP) trained and trainee spirometry technicians, alongside a specialist respiratory nurse. The Respiratory Hub also provides FeNO breath tests which helps doctors tell if a patient has inflammation in their airways. FeNO stands for fractional exhaled nitric oxide.

- Community Dermatology Services (CDS) is a GP led service delivered across two sites in Lewisham, by a team of locum GPwER (General Practitioners with Extended Roles). It does not currently offer minor surgery. At this inspection, the dermatology service was not providing any minor surgery but planned to employ a dermatologist to undertake minor surgery procedures. Patients registered with a Lewisham GP practice can be referred to the community dermatology service.

The provider website is https://www.onehealthlewisham.co.uk/services

How we inspected this service

Before we inspection we reviewed information already held by CQC and information submitted by the provider for the inspection. We spoke to stakeholders who commission the service.

During the inspection, we received feedback from people who used the service, interviewed staff, made observations and reviewed documents.

To get to the heart of patients' 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:

- The service delivered care from satellite clinics in South East London, in spaces run by NHS GP providers. The service had systems and processes to ensure that these premises were safe, but they were not consistently effective.
- The service had systems to keep people safe and safeguarded from abuse, but it was not clear whether they were consistently used. Not all staff received up-to-date safeguarding and safety training appropriate to their role.
- At the main SELSAS service based at Rushey Green Group Practice, patients received care and treatment from clinical and non-clinical staff employed by the host NHS GP provider, Novum Health Partnership. SAS patients interacted with non-clinical staff in the reception area at the practice. The service had no written agreement with the host GP provider that described the recruitment checks and training expected. Leaders did not have a mechanism in place to check that this process for ensuring appropriate staffing was effective.

Safety systems and processes

The service had systems to keep people safe and safeguarded from abuse, but these were not consistently effective.

- The service had systems to safeguard children and vulnerable adults from abuse.
- 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. We found most recruitment checks were carried out in accordance with regulations (including for agency staff and locums). However, we found some gaps in recruitment records. For example, we looked at recruitment records for six members of OHL staff. There was a record of one reference for one locum GP employed by OHL. There was a record showing a second reference was requested but this was never received and there was no record of a risk assessment done in the absence of the second reference. A second reference request was made following our inspection and a copy of a second reference was sent to us. There was no record of a CV with full employment history documented for this clinical member of staff either. Following our inspection, managers sent us a copy of the CV with full employment history.
- There was no record of references for one member of staff employed by OHL to deliver spirometry at Marvels Lane. Following our inspection, a reference was requested, and copy sent to the inspector.
- 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).
- Providers have a responsibility to ensure that all staff with whom patients interact as part of the delivery of care have received appropriate recruitment checks and safety training. At the main SELSAS service based at Rushey Green Group Practice, SAS patients received care and treatment from clinical staff employed by the host GP provider, Novum Health Partnership. Patients also interacted with non-clinical staff from the main host practice, in reception areas. The provider Downham Health & Leisure Centre did not have a written agreement with the host GP provider that described the recruitment checks and training expected for staff that interacted with the SELSAS patients. There was no mechanism to ensure that this process for ensuring appropriate staffing, was effective. We raised these concerns with the provider Downham Health & Leisure Centre and following our inspection, they told us they had reflected on our feedback and taken action to change their processes of recording recruitment checks and updating staff training records. For example, the provider (DH&LC) told us they had put a data sharing agreement in place with the Special Allocation Scheme (SAS) service, so that the provider can legally host information about their employment records, including training, qualifications, recruitment checks and immunisation status.

Requires Improvement

Are services safe?

- Not all had staff received up-to-date safeguarding and safety training appropriate to their role. We looked at five staff files and found gaps in mandatory safeguarding training. One member of staff employed by One Health Lewisham and two members of staff employed by two different host community services, had not completed required safeguarding training at appropriately frequent, regular intervals to maintain knowledge and skills. The provider shared a copy of a training matrix to log mandatory training for all staff who interacted with the service's patients.
- Staff who acted as chaperones were trained for the role and had received a DBS check. However, we found there was no record of chaperone training for one member of staff who acted as a chaperone at the respiratory hub service at Marvels Lane. Following our inspection, the service provider sent us evidence of completed chaperone training for this member of staff.
- During our inspection of the SELSAS service, there were no SAS patients booked in for a face-to-face appointment. We were therefore not able to see how SAS patients interacted with staff employed by the host provider, at the Tessa Jowell Health Centre satellite site. Downham Health & Leisure Centre leaders told us that they do not use any staff at the satellite sites who were employed by the host GP provider and all clinical staff attending SAS satellite sites were directly employed by One Health Lewisham. Leaders informed us that most consultations with SAS patients were undertaken by telephone. However, if after initial triage, a face-to-face appointment was considered necessary, an appointment was booked for the patient at one of the satellite sites. Patients attending an appointment at a satellite site were directed to the reception area and immediately met by the security staff and a clinician. Leaders told us that SAS patients were only treated by a clinician employed by One Health Lewisham. The provider, One Health Lewisham, had a contract with a security company which provided security industry licenced staff, to support the SAS services.
- The service had systems in place to assure that an adult accompanying a child had parental authority.
- 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.
- There was an effective system to manage infection prevention and control. Infection risks to staff and people using the services were assessed and managed.
- At this inspection there were arrangements to protect staff and patients from the risks of legionella bacteria. Staff showed us evidence of monthly temperature checks made at the provider's location and all host community service sites, to control the risk from Legionella.
- Staff had been immunised according to the requirements of the 'Green Book'.
- The provider ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. For example, we saw evidence of checks to ensure spirometry equipment is cleaned and maintained according to the manufacturer's guidance.
- There were systems for safely managing healthcare waste.
- 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

There were 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. They knew how to identify and manage patients with severe infections, for example sepsis.
- The emergency medicines and equipment kept on site at Downham Health & Leisure and at the host community services were appropriate for the type of treatments offered to patients. We saw these were stored appropriately and checked regularly. If items recommended in national guidance were not kept, there was an appropriate risk

assessment to inform this decision. However, at the time of this inspection, there was no evidence of regular and effective checks (by the service provider) to ensure that emergency medicines and equipment held at the host community service sites would be available and effective if needed. We raised this concern with the provider and following our inspection, the provider told us they had reflected on our feedback and taken action to change their processes to improve oversight of risks in relation to management of emergency medicines, held at host service sites. This included implementing a health and safety risk matrix to review the host service's risk assessments for managing emergencies.

- Although the dermatology service did not see acutely unwell patients, staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. Staff had completed a range of training to manage medical emergencies.
- There were indemnity arrangements in place, but these were not always effective. For example, we looked at records of Medical Indemnity for staff and saw that cover for one locum GP who worked at the dermatology service, had expired on 11 June 2022. There was no record of medical indemnity for one spirometry technician employed by the provider at Marvels Lane respiratory hub. (The provider told us the technician is covered through Crown indemnity but no copy was seen). Following our inspection, managers sent us evidence of medical indemnity insurance cover for these members of staff.

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 provider's own systems for handling medicines worked well. There were systems for appropriate and safe handling of medicines at the SAS satellite clinic sites. However, oversight of risks in some areas of emergency medicines management, at the Marvels Lane host community services, needed strengthening.

- The systems and arrangements for managing medicines, including vaccines, controlled drugs, emergency medicines and equipment, minimised risks. The service kept prescription stationery securely and monitored its use.
- The SAS service prescribed Schedule 2 and 3 controlled drugs (medicines that have the highest level of control due to their risk of misuse and dependence). They did not prescribe schedule 4 or 5 controlled drugs. The SAS service did not keep controlled drugs on the premises.
- The service carried out regular medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing. For example, we discussed prescribing of controlled drugs (CD's) with the GP lead for the SAS service. The GP lead carried out monthly audits of prescribing of Schedule 2 and 3 controlled drugs, to ensure all SAS patients at risk of prescribing harm were identified early and received the required monitoring.

Requires Improvement

Are services safe?

- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. Processes were in place for checking medicines and staff kept accurate records of medicines. Where there was a different approach taken from national guidance there was a clear rationale for this that protected patient safety.
- There were effective protocols for verifying the identity of patients including children.
- We found that there were suitable medicines and equipment at the provider's site and at the dermatology clinics and respiratory hub at the Marvels Lane site, managed by the host community services. We spoke with DH&LC staff about the arrangements for providing suitable emergency medicines and equipment at the SAS satellite sites. Staff told us that the clinical team employed by One Health Lewisham were supplied with an emergency bag to take with them to SAS satellite sites. However, at the time of our visit to the Tessa Jowell Health Centre, there was no SAS clinic taking place, so we were not able to check the contents of the emergency bag. However, at the time there was insufficient oversight of available emergency medicines at the host community service at Marvels Lane. Leaders told us that as the SAS satellite sites were health centres or GP practices, defibrillators, oxygen and nebulisers were available for the SAS clinical team to use, should the need arise. At the Tessa Jowell Health Centre, we checked the defibrillator, oxygen cylinder and nebuliser and found these were accessible, stored appropriately and checked regularly. We saw evidence of calibration certificates obtained from the Tessa Jowell Health Centre building management team, to provide assurance that equipment was safe in the event of an emergency.

Track record on safety and incidents

The provider was aware of areas of weaknesses and worked to improve them.

- There were comprehensive risk assessments in relation to safety issues. The provider's own risk assessments gave a good overview of safety issues, and any issues the risk assessments identified were addressed.
- 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 provider was aware of the additional risks posed by delivering care from premises run by other providers, including the risk that the host community service's risk assessments may not be of sufficient quality. At the time of our inspection, the provider had not set out information on what was expected of host services to carry out safety risk assessments to manage risks in areas used by Downham Health & Leisure Centre patients. We asked what written agreements were in place to give managers oversight of safety at the host services sites? The provider, Downham Health & Leisure Centre (DH&LC), sent us an example of a service level agreement (SLA) for the Tessa Jowell Centre where the provider rented a clinic room to treat SEL SAS patients. The service level agreement documented the standards for the provision of a clinical room and medical equipment rented from the Tessa Jowell Centre. The provider DH&LC told us that the host service sites used for treating NELSAS patients were provided through commissioners. The provider, DH&LC, book and pay for a room as and when required and the host service do not provide any SLAs as they are not in contract with the provider. Staff told us that they request and book the same clinic room, which had been risk assessed.

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.

Requires Improvement

Are services safe?

- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service. For example, the provider showed us the documented process to manage significant events. There was a mechanism to ensure that DH&LC is aware of any relevant significant events investigated by host services. Learning from incidents was shared with service staff in a number of ways. Staff told us that learning was shared over emails and at team meetings.
- 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.
- The service acted on and learned from external safety events as well as patient and medicine safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.

Good

Are services effective?

We rated effective as Good because:

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 had effective 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 relevant current legislation, standards and guidance. These included the National Institute for Health and Care Excellence (NICE) and British Association of Dermatologists (BAD) best practice guidelines.
- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- Clinicians had enough information to make or confirm a diagnosis
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service was actively involved in quality improvement activity.

- The service used information about care and treatment to make improvements. 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. We saw examples of audits to improve care for patients; Staff at the respiratory hub at Marvels Lane told us about how they were improving care for patients, for example, staff carried out a three-monthly audit of the spirometry team's consultation notes to check the quality of the spirometry testing undertaken for the diagnosis of asthma. In July 2022, staff at the SAS service at Rushey Green Group Surgery had completed a first audit on antibiotic stewardship to improve antibiotic prescribing across SELSAS and NELSAS. The first audit outcome showed staff were prescribing antibiotics in line with local or national guidelines. Staff were due to repeat the antibiotic stewardship audit in July 2023.

Effective staffing

In the main, staff employed by the service had the skills, knowledge and experience to carry out their roles. There was a system to ensure that staff employed by host services that patients interacted with had the appropriate skills, knowledge and experience, but no mechanism to check it was effective.

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC)/ Nursing and Midwifery Council and were up to date with revalidation.
- The provider understood the learning needs of staff and provided protected time and training to meet them. In the main, up to date records of skills, qualifications and training were maintained. However, at the time of our inspection, the provider was not able to demonstrate that all staff who performed spirometry tests or interpreted results were competent to do so. There was no record that training qualification had been verified and registration was current for

one spirometry technician employed by OHL. (Spirometry should only be performed by people who have been appropriately assessed as competent, demonstrating that they have achieved the standards established by the ARTP for the performance and interpretation of spirometry measurements). Following our inspection, the provider sent us a copy of the ARTP Foundation spirometry qualification for this member of staff.
- Staff were encouraged and given opportunities to develop.

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.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history.
- Referrals to the community services came from NHS GPs and the provider shared details of consultations and any medicines prescribed with the referring GP.
- The provider had risk assessed the treatments they offered. They had identified medicines that were not suitable for prescribing if the patient did not give their consent to share information with their GP, or if they were not registered with a GP. For example, medicines liable to abuse or misuse, and those for the treatment of long-term conditions such as asthma. Where patients agreed to share their information, we saw evidence of letters sent to their registered GP in line with GMC guidance.
- Care and treatment for patients in vulnerable circumstances was coordinated with other services. The SAS service had a vulnerability and Carer's policy. There was a process for searching on notes at registration/first assessment of new patients to look for record markers for vulnerability and caring responsibility.
- 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.

Supporting patients to live healthier lives

Staff supported patients 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 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.

- 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 caring?

We rated caring as Good because:

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The provider had a set of documented values which described how the service used openness, transparency and fairness in their approach to patient care.
- The service sought feedback on the quality of clinical care patients received.
- Feedback from patients was positive about the way staff treat people.
- 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.

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. We saw notices in the reception areas, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them. Information leaflets were available in easy read formats, to help patients be involved in decisions about their care.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.

Privacy and Dignity

The service respected respect 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:

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, a welcome pack was sent to new patients registered with the Special Allocation Service with information about how to contact the service. Patients new to the SAS service receive an early appointment offer and 30-minute appointment times are provided to ensure that consultations are not rushed.
- Following feedback from patients, the provider developed a gender specific care policy for patients who expressed preferences over the gender of their clinician. However, at the time of our inspection, One Health Lewisham management was not able to tell us about activities or plans to appoint dedicated staff members to implement gender-sensitive practice.
- The facilities and premises were appropriate for the services delivered.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others.

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. People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment were reducing since the pandemic and the service was supporting other NHS PMS services with their wait lists.
- 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 system was easy to use.
- Referrals and transfers to other services were undertaken in a timely way.

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. The service learned lessons from individual concerns, complaints and from analysis of trends. It acted as a result to improve the quality of care. We saw examples of actions taken to improve patient experience. The lead GP of the SAS service told us they had approached NHS England to change national SNOMED CT codes for patients who had complained about being coded in their records as

Good

Are services responsive to people's needs?

“Registered with Violent Patient Scheme” and “Removed from Violent Patient Scheme”. (SNOMED CT are structured clinical terms for electronic health and social care records). These codes were changed nationally, to “Registered with Special Allocation Service” and “Removed from Special Allocation Service”, respectively to reflect that most patients in the SAS scheme had no history of violence.

Requires Improvement

Are services well-led?

We rated well-led as Requires improvement because:

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.

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).
- 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.

Culture

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

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they could 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. Most staff had received regular annual appraisals in the last year. However, one member of non-clinical staff who worked at the respiratory hub told us they had not had an appraisal in the last twelve months. Staff were supported to meet the requirements of professional revalidation where necessary. Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff. The community service provision had expanded in size in recent years, and the provider had developed additional ways to communicate with staff and promote their well-being. For example, there were health and wellbeing resources available for staff online.
- 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.

Requires Improvement

Are services well-led?

- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management, although some systems were not consistently effective.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The service began taking action immediately after the inspection on the areas we identified for improvement.
- The provider held monthly clinical governance meetings where staff reviewed any safeguarding, clinical audits, complaints, alerts and incidents. The provider recorded decisions and monitored actions using an action log which staff could access.
- 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
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- The provider had a gender specific care policy but at the time of this inspection there was no evidence of staff undertaking training and professional development activities to ensure best practice gender-sensitive care, was incorporated into routine practice.

Managing risks, issues and performance

There were clear processes for managing risks, issues and performance. There were regular opportunities for staff to meet, discuss and learn from the performance of the service.

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. The provider's own risk management processes were clearly documented and well embedded.
- The provider was aware of the additional risks posed by delivering care from premises run by other providers, including the risk that the host community service's risk assessments may not be of sufficient quality. The provider kept copies of the host services' health and safety policies and risk assessments. For example, during our inspection, we saw copies of the fire safety risk assessment carried out by an external assessor, on behalf of the tenant organisation, responsible for safety at the Tessa Jowell GP Surgery SAS site. At the time of our inspection, the provider had not set out information on what was expected of host services to carry out safety risk assessments to manage risks in areas used by Downham Health & Leisure Centre patients. The provider began taking action immediately after the inspection on the areas around risk management, we identified for improvement. For example, the provider changed its processes to review actions from risk assessments carried out by the host community services, to improve safety at all the host sites used by Downham Health & Leisure Centre patients.
- 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. Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact. They were committed to learning from when things go well and when they go wrong.
- 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.
- The provider had plans in place and had trained staff for major incidents.

Requires Improvement

Are services well-led?

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 sufficient access to information.
- There was a demonstrated commitment to using data and information proactively to monitor and improve performance 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.
- 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. The service invited all patients to complete the friends and family test and carried out regular patient satisfaction surveys to get more detailed feedback.
- Staff could describe to us the systems in place to give feedback. We saw evidence of feedback opportunities for staff and how the findings were fed back to staff. We also saw staff engagement in responding to these findings.
- The service was transparent, collaborative and open with stakeholders about performance.

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.
- 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.