Todmorden Health Centre

Inspection report

Lower George Street
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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 well-led?	Good

Overall summary

This service remains rated as Good overall and now good for providing well-led services. (Previous inspection June 2021 Good).

We carried out an announced focused inspection at Pennine GP Alliance to follow up on breaches of regulation identified at our previous inspection.

At the last comprehensive inspection on 23 June 2021, we rated the practice as Good overall and for four of the five key questions. We rated the practice Requires Improvement for providing well-led services. This was because:

- There were gaps in recruitment documentation.
- There were gaps in core training and frequency of training updates.
- There were gaps in the business disruption and continuity plan and the process had not been practised.
- Health and safety risk assessments of the providers service within the host GP practices, including fire evacuation, had not been undertaken.
- There was insufficient oversight of premises and equipment facilities management undertaken by host GP practices.
- Policies and procedures contained insufficient information and did not always reflect the provider's procedures.

In addition, we told the provider they should make improvements in the following areas:

- Implement a system to track and monitor prescription stationery used by the service.
- Review the system to identify and record incidents and significant events to ensure all potential learning opportunities are captured to drive quality improvement.
- Develop a system to monitor the process for seeking consent to ensure consent and decision-making is in line with legislation and guidance.
- Improve and develop staff awareness of duty of candour and ensure all staff are aware of their responsibilities in relation to this.

We asked the provider to make improvements regarding the issues identified and submit an action. We checked these areas as part of this focused inspection and found these had been resolved.

How we carried out the inspection

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

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

This included:

- Requesting evidence from the provider
- A short site visit
- Staff questionnaires sent to staff ahead of the inspection

Our findings

We based our judgement of the quality of care at this service on a combination of:

Overall summary

- what we found when we inspected
- information from our ongoing monitoring of data about services and
- information from the provider, patients, the public and other organisations.

We have rated this practice as Good for providing well-led services and for the service overall.

We found that the provider had:

- Recruited a new chief executive officer and expanded the Board and management team since our last inspection, to improve management and governance oversight across the organisation.
- A clear vision and strategy was in place, and was accessible to staff and patients.
- Implemented an electronic management system which enabled them to record and monitor information including recruitment documentation, staff training, premises and policy documentation.
- Reviewed and updated the business continuity plan.
- Established records of premises and facilities documentation for each of the host locations.
- Developed a comprehensive record of significant events and incidents which clearly outlined learning outcomes and action taken by the provider.

Whilst we found no breaches of regulations, the provider **should**:

- Recruit an external Freedom to Speak Up Guardian and ensure all staff are aware of their contact details.
- Conduct a fire evacuation during operational hours at each location.
- Continue with plans to increase frequency of staff meetings and consider improving visibility of leadership and management team to improve staff engagement.
- Improve communication mechanisms to ensure feedback from staff is responded to.

Our inspection team

Our inspection team was led by a CQC lead inspector who was supported by a second CQC inspector**.**

Background to Todmorden Health Centre

Pennine GP Alliance is a GP Federation serving the needs of the population of Calderdale. The Federation is made up of all 21 general practices in Calderdale, serving a patient population of 227,000 and spanning five Primary Care Networks (PCNs) in the Calderdale Commissioning Group (CCG).

The provider's head office is located at The Elsie Whiteley Innovation Centre, Floor 2, Office 2 and 3, Hopwood Lane, Halifax, HX1 5ER. We visited this location as part of our inspection.

The focus of this inspection was the delivery of the GP extended access service, which had been operational since August 2017. Extended access services are provided for three practices within the Upper Calder Valley PCN and five practices within the North Halifax PCN. This is a patient population of approximately 80,000.

The extended access service operates from two locations:

- Todmorden Health Centre, Lower George Street, Todmorden, OL14 5RN
- Keighley Road Surgery, Keighley Road, Halifax, HX2 9LL

The extended access service is provided between the hours of 6.30pm – 8.00pm, Monday to Friday.

Pennine GP Alliance is overseen by a board of directors which includes the chief executive, five clinical directors (representing each of the five PCNs) and a non-executive practice manager. Working alongside the board was a management team, led by the chief executive, which included a senior operations manager, project manager and human resources manager.

The extended hours service is staffed by five general practitioners, twelve advanced clinical practitioners and three receptionists.

Pennine GP Alliance is registered with the Care Quality Commission (CQC) to provide the following regulated activities:

- Diagnostic and screening procedures
- Family planning
- Maternity and midwifery services
- Surgical procedures
- Treatment of disease, disorder or injury

Good

Are services well-led?

We rated well-led as Good because:

We rated the provider as Good for providing a well-led service because the provider had a clear vision to deliver high quality patient care and promote good outcomes for patients. We saw that there was a governance framework in place to support this.

There was a strong focus on continuous learning and improvement. This was demonstrated by the improvements made as a result of our previous inspection in June 2021.

Leadership capacity and capability;

At our last inspection in June 2021 we found that not all staff were aware of who the current designated leads were for specific areas. For example; infection prevention control and the Freedom to Speak Up Guardian. At this inspection we found that there was a clearly documented structure in place and communication had been circulated to staff via a newsletter.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. For example; following the last CQC inspection in June 2021, the provider had recruited a new chief executive officer and created additional roles to expand and strengthen the management team.
- The provider had effective processes to develop leadership capacity and skills within the service, including planning for the future leadership of the service.
- There was a clear operational structure which outlined dedicated leads for specific areas. For example we saw that the chief executive was the freedom to speak up guardian and the practice and patient engagement lead was the non-executive director. This information had been communicated to staff via a staff newsletter which we reviewed as part of our inspection.
- We reviewed minutes from a clinical meeting which had been held prior to our inspection. The provider told us they were looking to hold regular meetings on a quarterly basis going forward.
- Some of the staff feedback we received indicated that although support was available within the practice they were operating from, they had little or no input from the Pennine GP Alliance management and leadership team.

Vision and strategy

- There was a clear vision to deliver high quality, sustainable care, this was supported by documented values.
- We saw the vision and values were available on the providers website and therefore accessible to both staff and patients.
- The service had a realistic strategy and supporting business plans to achieve their identified priorities.
- The service developed its vision, values external partners in line with health and social care priorities across the Calderdale area.
- The service monitored progress against delivery of the strategy.

Culture

- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.

Good

Are services well-led?

- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. We reviewed the incident register and saw that there had been 31 incidents identified and reported to date in 2022. We saw that these contained clear learning outcomes and the provider had used the incidents raised to influence audit activity and identify further learning.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. Following our previous inspection, the provider had implemented a new policy in place and information had been communicated to staff in a recent newsletter. The provider also had information available on the website which included a video explaining the duty of candour.
- Staff told us they could raise concerns and felt comfortable in doing so. However, we received feedback from some staff members that they had received no feedback in response to concerns they had raised so were unsure if the issues had been addressed.
- The provider had taken steps to support staff health and well-being and had signed up to an employee assistance programme which offered a range of services. These included services such as counselling and free advice services.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality and included equality and diversity training as part of the mandatory training programme.

Governance arrangements

At our last inspection in June 2021 we found that, although there were roles and systems of accountability to support good governance and management, we found gaps in its oversight. At this this inspection we found that the provider had implemented an electronical management system which provided detailed information and oversight in areas such as recruitment, training and overall governance. The provider had effectively addressed the issues identified in our previous report.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Leaders had established comprehensive policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. At the time of our inspection the provider was conducting a review and update of all policies in place.
- We reviewed a sample of staff files on the electronic management system and saw that these contained a full breakdown of recruitment documentation, training and immunisation status. The system clearly highlighted any areas for action such as outstanding training, and sent notifications to the management and leadership team in order for these to be addressed.
- The provider had worked with the host practices to ensure they had oversight of all premises and facilities management. We were able to review this documentation which included records of medical equipment calibration, risk assessments including hazardous waste, slips trips and falls, fire equipment checks and fire drills. However; the provider had not carried out an out of hours fire evacuation drill to ensure all members of staff were aware of their roles and responsibilities in the event of a fire during the opening times of the extended hours service. We discussed this with the provider during the inspection and received assurance that this would be actioned.
- We reviewed the provider's business continuity plan and saw that this contained key contact information. We spoke with members of the management team who told us that a tabletop exercise had been carried out to test the plan. They also confirmed that the plan was available for all staff, with additional copies kept off-site to ensure ease of access in the event of a service disruption.
- The provider had implemented a system to record prescription stationery serial numbers in order to monitor distribution and use. We reviewed these records as part of our inspection and found that they contained a record of stationery batch numbers and the dates and times they were issued to printers. The provider told us they used audits to monitor electronically generated prescriptions.

Good

Are services well-led?

- The service used performance information, which was reported and monitored, and management and staff were held to account
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service submitted data or notifications to external organisations as required.
- 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.

Managing risks, issues and performance

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. The provider had a dedicated risk group to monitor and address any issues arising.
- The service had processes to manage current and future performance. The provider advised us that clinical performance was monitored by reviews of clinical record keeping, history keeping and appropriate safety netting during of their consultations, prescribing and referral decisions. Leaders had oversight of safety alerts, incidents, and complaints.

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.

Engagement with patients, the public, staff and external partners

- The provider continued to contribute to the local health agenda and work in partnership with stakeholders to deliver patient care.
- The provider engaged with the local Clinical Commissioning Group (CCG) and Primary Care Networks (PCNs) to develop services to meet the needs of the local population.
- We saw evidence of staff engagement through staff surveys. We reviewed the results of the survey and saw the majority of staff who had responded were happy with their current role and how their skills were being used.
- The provider had produced an action plan to respond to staff feedback. This included more regular meetings with senior leads, practices and Primary Care Network managers. We saw that this work was ongoing.
- The service obtained feedback from patients for the extended access service through the Friends and Family Test (FFT) and complaints. We noted that patient feedback about the service had been positive.
- The service was transparent, collaborative and open with stakeholders about performance.

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. For example incidents identified which involved other services were discussed and shared in order to promote wider learning opportunities.
- There were systems to support improvement and innovation work. For example the provider carried out regular two-cycle audit activity to monitor and improve services. We saw that the provider had carried out an audit of urgent cancer referrals from the extended hours services, following an incident which had been identified.

The audit reviewed whether appropriate communication had taken place between the extended access hub and patients own practices, and whether the onward referral had been actioned. We saw that all referrals had been actioned appropriately. As a result of the incident, and subsequent audit, the provider carried out this audit on a weekly basis.

Good

Are services well-led?

In addition, the provider had taken steps to address all areas for improvement identified during our previous inspection. This included developing a consent policy to support all staff in discussions with patients regarding consent and how to document this appropriately. The provider advised us that this was an area they would be auditing in the near future.