Integrated Pathology Partnerships Limited

Building Three

Inspection report

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

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services responsive to people's needs?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

We do not rate this service. We found:

- The service had enough staff to provide the right level of service. Staff had training in key skills and managed safety well. The service controlled infection risk well. Staff assessed risks, acted on them and kept good records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and had access to good information. Limited key services were available seven days a week. Services were available to support timely care.
- The service was planned to meet the needs of local people.
- Leaders had the skills and abilities to run the service using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients. Staff were clear about their roles and accountabilities. The service engaged well to plan and manage services and all staff were committed to continually improving services.

However;

- There was a failure to inform CQC of incidents which is a legal requirement of the regulations. The registered address of the head office and website address were incorrect. The statement of purpose was incorrect and had not been updated.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical laboratories	Inspected but not rated	We did not rate this service. See the summary above for what we found.

Summary of findings

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Summary of this inspection

Background to Building Three

Building Three is one of three locations in Somerset run by the provider, Integrated Pathology Partnerships. Building Three is a purpose designed fully equipped laboratory. It provides routine pathology services excluding blood transfusion, to primary and secondary care providers across Somerset and a private contract for sexual health testing in London. It is part of an NHS Joint Venture with Integrated Pathology Partnerships, Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust.

The centre is located within an industrial estate and the building comprises a set of self-contained laboratories providing analysis in the disciplines of clinical chemistry, haematology, microbiology, histology and cytology. The provider operates a 'hub and spoke' design for services. The hub is an offsite state of the art laboratory (Building Three) to process 'non-acute' work. The spokes are termed 'Essential Service Laboratories' (ESLs) providing acute services designed to meet the clinical needs of Taunton and Yeovil hospitals.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? We did not inspect the caring domain at this inspection as the laboratory does not have any direct contact with patients.

The provider is registered to provide the following regulated activity

- Diagnostic and screening procedures

The location has a registered manager in post since 2020. Registered managers have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated regulations about how the service is run.

The provider employed 202 members of staff across the three sites. Technical and managerial staff are employed by Integrated Pathology Partnerships while clinical staff are employed by partners in the joint venture with Somerset NHS Foundation Trust and Yeovil District Hospital Foundation Trust.

The previous inspection of this service was March 2013 when the provider had met the standards but was not rated.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced inspection on 15 February 2022.

How we carried out this inspection

The team that inspected this location comprised of a CQC inspection manager and one CQC inspector with access to a specialist advisor with expertise in laboratory services. During the inspection, we spoke with 10 staff. We reviewed documents and records kept by the provider and inspected the premises.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Summary of this inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

- The provider should ensure all statutory notifications are made to CQC.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical laboratories	Inspected but not rated	Inspected but not rated	Not inspected	Inspected but not rated	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Inspected but not rated	Not inspected	Inspected but not rated	Inspected but not rated	Inspected but not rated

Inspected but not rated

Medical laboratories

Safe	Inspected but not rated
Effective	Inspected but not rated
Responsive	Inspected but not rated
Well-led	Inspected but not rated

Are Medical laboratories safe?

Inspected but not rated

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it (across the three locations).

Staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of staff. This included risks associated with handling processing specimens, including COVID-19. Different grades of staff had extra specific mandatory training courses as part of competence assessments added to their training plan, for example, good manufacturing practices. Compliance for mandatory training at February 2022 was 91.3% against the target of 95% but was on track to achieve this by the end of the year.

Managers monitored mandatory training and had oversight when staff needed updating. Staff were alerted when they needed to update their training. Compliance levels for mandatory training were monitored at the operation group meetings.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect themselves and others from infection and prevent cross contamination of specimens. They kept equipment and the premises visibly clean.

Laboratory areas appeared clean, had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. Staff followed infection control principles including the use of personal protective equipment (PPE). There were working protocols to make sure the risk of cross-infection and contamination was prevented or minimised. This included prevention of the spread of micro-organisms and contamination between specimens.

The provider had a category three laboratory which dealt with pathogens (micro-organisms that can cause severe human disease and present a serious hazard for directly exposed persons). The sealed laboratory provided a barrier in preventing the accidental release of the biological agent. It was also proofed against the entry or exit of insects and/or animals and was monitored with close circuit television cameras.

Inspected but not rated

Medical laboratories

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment ensured it kept people safe. Access was restricted to all parts of the building. Staff identification cards gave access to staff using an electronic locking system.

Staff carried out daily safety checks of specialist equipment. There was an electronic quality management system which comprised of an inventory of equipment including name of manufacturer, serial number, date of purchase or acquisition, current location and a record of equipment breakdown and contracted maintenance. Specialist equipment such as the sample analyser was registered and tested by an external quality assurance provider to ensure it was accurate for the tests it was used for

The service had enough suitable equipment to help them safely complete tests for patients. The provider also has a contingency plan for each piece of equipment in the event of a system failure and arrangements for frequent and secure back-up of data. There was a protocol for manual processing of urgent specimens if there was a system failure for analysers.

There was a safe system for storage and disposal of specimens and other clinical waste. An external contractor collected clinical waste three times a week.

There was a contract with Somerset NHS Foundation Trust for the provision and maintenance of IT equipment.

Assessing and responding to patient risk

Staff prioritised results where patients needed urgent medical attention and made sure they informed the person who requested the test as soon as possible.

Staff knew about and dealt with any specific risk issues and shared key information to keep patients safe. Staff described the process to make sure unexpected or abnormal results requiring immediate or urgent medical intervention were communicated in a timely way to the person or team who initiated the test. Staff were able to seek support from senior staff in these situations.

Laboratory staffing

The service had enough laboratory staff with the right qualifications, skills, training and experience to provide the right level of service. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough laboratory staff to keep patients safe. Staffing levels and skill mix was planned and reviewed through electronic rostering, so staff did not work excessive hours. Staff rotated between the three locations. The provider had arrangements to support the out of hours service and shift system with enough staff to support the requirements of the service.

Inspected but not rated

Medical laboratories

The service had high vacancy rates for laboratory staff of 16.27% at January 2022. This represented an almost 10% increase on January 2021. This was because new posts had been created and approved in this years' budget.

The provider supported apprenticeships and currently had three apprentices, one in information technology and two as trainee biomedical scientists.

Managers could access locums when they needed additional laboratory staff. All locums were expected to have in date mandatory training and received a full induction to the service before they started work. Locum staff were engaged for a period of time rather than adhoc shifts to promote continuity and consistency.

Senior clinical staffing

The service had enough medically qualified consultants and consultant-level scientists with the right qualifications, skills, training and experience to provide clinical advice. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service always had a consultant on call during evenings and weekends. The on-call consultant pathologist could be contacted at all times through the Trust switchboards for advice about the interpretation of results, appropriate further investigations, and the management of clinical pathological problems.

Every shift was covered by a team manager. Senior staffing levels and skill mix was planned and reviewed through electronic rostering, so staff did not work excessive hours. Cover was provided for staff absence.

Records

Staff kept detailed records of patients' specimens. Records were clear, up-to-date, stored securely and easily available to all staff.

Records were stored securely electronically. The provider had a laboratory record information system that operated across the three locations so staff could access it from whichever site they were working at. This meant samples transferred between sites for analysis could be tracked and progress monitored. To ensure the correct amount of information required was on the specimen request, the provider had a sample acceptance policy containing acceptance criterion. More than 90% of requests were electronic and were barcoded to match the barcode on the specimen. This helped to prevent patient samples getting mixed up. Manual requests were processed one at a time to prevent errors.

The provider had a procedure for deleting, amending or relinking a chemistry or haematology request which staff were able to explain. This meant the patient would not be required to provide another blood sample.

Medicines

The service stored and used medical reagents and gases safely.

Staff followed systems and processes when recording and storing reagents. Refrigerator temperatures were controlled electronically and had an alarm system. Medical gases were stored correctly in a locked compound with restricted access.

Inspected but not rated

Medical laboratories

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. They raised concerns and reported incidents and near misses in line with the provider's policy. For example, staff told us the process if a sample was compromised or contaminated, an incident was raised.

Reports from investigations showed managers investigated incidents thoroughly. Changes had been made as a result of identified learning and staff received feedback from investigation of incidents. Managers shared learning about serious incidents with their staff and across the organisation. The provider ensured investigations and learning from adverse incidents were discussed and shared with other providers when appropriate.

Managers investigated incidents thoroughly and managers debriefed and supported staff after any serious incident. Staff confirmed they received feedback after reporting an incident and an action plan was shared. Learning was shared using a variety of methods. Firstly, there was an immediate response and any local action taken to help prevent a reoccurrence and formal feedback by email to help spread any learnings from incidents. General emails were circulated about health and safety and general data protection regulation issues.

Are Medical laboratories effective?

Inspected but not rated

Evidence-based care and treatment

The service followed national guidance when presenting results. Managers made sure staff followed quality control procedures.

Staff followed up-to-date policies to plan and deliver high quality testing according to evidence-based practice and national guidance. The laboratory quality assured the standard of presentation and interpretation of results through their comprehensive quality management system.

The provider subscribed to National and International External Quality Assessment Schemes. The organisation had hundreds of national and international external quality assessments for all the disciplines across the three locations. For example, immunocytochemistry cytology, general urine chemistry, tumour markers and blood gases on all sites.

There were effective procedures for internal quality control of all examinations which verified the intended quality was achieved. The provider had a programme of external quality assurance which was used for all tests offered by the laboratory.

Patient outcomes

Inspected but not rated

Medical laboratories

Staff monitored the effectiveness of their service. They used the findings to make improvements and achieved good outcomes. The service used national and international quality assurance schemes to monitor and check their results. The service had ISO151819 accreditation.

The service participated in relevant national and local clinical audits. The provider had a comprehensive audit programme across all three locations. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. All staff participated in auditing. Outcomes were usually positive, consistent and met expectations, such as national standards. Managers shared and made sure staff understood information from the audits. Non-conformance was identified and actions taken and monitored. These were discussed at weekly operations meetings with representatives from management, procurement, IT and transformation.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. Managers supported staff to develop through yearly, constructive appraisals of their work.

Managers supported laboratory staff to develop through regular, constructive clinical supervision of their work. . Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. The provider had an education budget so staff could apply for funding of further education. The provider has workplace training and competence assessments for different grades of staff to achieve. These were repeated at intervals and audited to ensure the procedure was performed to the appropriate standard and to check the operator's knowledge remained current. Managers made sure staff received any specialist training for their role. Managers identified poor staff performance promptly and supported staff to improve.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Multidisciplinary working

Staff worked with other providers' teams to benefit patients. They supported each other to provide a good service.

Staff held regular multidisciplinary meetings with the two other locations to discuss patients results to improve their care. The provider also participated in local, trust and national meetings. For example, Local Medical Committee meetings.

Seven-day services

Services were available to support timely care.

A seven-day, 24-hour service was available for COVID-19 testing. Consultants were available for advice at weekends.

Inspected but not rated

Medical laboratories

Are Medical laboratories responsive?

Inspected but not rated

Service planning and delivery to meet the needs of the local people

Managers planned and provided services in a way to meet the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. Facilities and premises were appropriate for the services being delivered. The organisation provided information for health and social care providers for the service provided. Service specifications were contained within contracts and service level agreements made sure the service provision met the needs of patients. During the COVID-19 pandemic, services provided were prioritised to reflect and ensure the most essential needs of the population were served.

All key performance indicators (KPIs) were reviewed at the quality meeting, pathology meeting, board meetings, analytics and facilities meeting.

Access and flow

People could access the service when they needed it and received the right tests promptly.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

The provider had a policy for monitoring user's satisfaction of the service and complaints. For laboratory services this included satisfaction and complaints from providers. Managers worked closely with the acute trusts with whom they were linked. Managers understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Are Medical laboratories well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Inspected but not rated

Medical laboratories

Leaders had the skills, knowledge, experience and integrity to run the service and had a commitment to their staff and each other. Leaders understood the challenges to quality and sustainability and could identify the actions needed to address them. Staff told us leaders were visible and approachable. There were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and a leadership development programme (internal and external), which included succession planning.

Leaders had an established process to manage new and emerging guidance and ensured its effective implementation. This included the National Institute for Health and Care Excellence (NICE), professional bodies and COVID-19 guidance.

The leadership team were knowledgeable and passionate about the service. They were visible and approachable. They were proud of the efforts of staff and their commitment to the business during the extreme circumstances of the pandemic

All staff we met said they felt valued and part of the team and were proud to work in the team. They felt supported by the management team and their colleagues. We received positive feedback from staff who had a high regard and respect for their managers.

Managers encouraged learning and a culture of openness and transparency. Staff were supported to develop their skills and competencies within their roles.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a clear vision and a set of values including quality and sustainability. There was a realistic strategy to achieve the priorities and deliver good quality, sustainable care. The vision, values and strategy had been developed using a structured planning process in collaboration with staff and external partners. Staff knew and understood what the vision, values and strategy were, and their role in achieving them.

There was a strategy aligned to local plans in the wider health and social care economy, and services had been planned to meet the needs of the relevant population. Progress against delivery of the strategy and local plans was monitored and reviewed.

Key plans included the refresh of haematology, the replacement of the laboratory information management system (LIMS), extending histopathology working day to increase capacity to cope with increased demand. (Musgrove Park hospital were currently operating at full capacity with Yeovil District hospital around a third). There were plans to have a single site to serve both hospital sites in liaison with Somerset NHS FT.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff felt supported, respected, valued and were positive and proud to work in the organisation. They told us this had increased since the pandemic

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution. The culture encouraged openness and honesty at all levels within the organisation, including people who used services, in response to incidents.

There were mechanisms for providing all staff at every level with the development they needed, including appraisals and career development conversations. There was a strong emphasis on the safety and well-being of staff. The provider had mental health first aiders (staff trained to listen, reassure, and respond), gave good support to staff returning from sick leave and had provided a well-being room for staff and links to well-being resources on the providers intranet. Equality and diversity were promoted within and beyond the organisation. Staff, including those with protected characteristics under the Equality Act, felt they were treated equitably. There were cooperative, supportive and appreciative relationships among staff.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective and efficient structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. These were regularly reviewed and improved. Most levels of governance and management functioned effectively and interacted with each other**.** There was a clear performance management reporting structure with regular governance meetings looking at operational performance. However, there was a failure to inform CQC of the change of the registered address of the head office and the website address were incorrect. Also, the statement of purpose was incorrect and had not been updated. When this was brought to the attention of the provider, it was rectified immediately.

Staff at all levels were clear about their roles and understood what they were accountable for, and to whom. Arrangements with partners and third-party providers were governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care.

These included a bi-monthly facilities board meeting to look at risk, performance, finances and strategy; a monthly analytics board meeting to consider operations and elective recovery; and a bi-monthly pathology committee with lead consultants, trust, directorate leads and the quality manager to look at evidence-based practice, NICE guidelines and outcomes.

The general manager participated in Somerset and Yeovil NHS foundation trusts' governance meetings.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The organisation had assurance systems and performance issues were escalated through clear structures and processes. There were processes to manage current and future performance which were reviewed and improved through a programme of clinical and internal audit.

Inspected but not rated

Medical laboratories

Leaders monitored quality, operational and financial processes and had systems to identify where action should be taken. Reports demonstrated action was taken when required and improvements monitored.

The provider has UKAS (UK Accreditation Service) accreditation ISO 15189 for each type of test carried out at each location.

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. There was alignment between recorded risks and what staff said was on their 'worry list'. The provider regularly reviewed and acted on the laboratory risk register.

The provider had taken measures to ensure it was in a position to continue to support clinical services over the COVID-19 period. There was a review of work in order to safeguard core services whilst moving to minimal staffing levels to promote resilience, social distancing and provide testing 24 hours a day, seven days a week. Also, facilities, equipment and reagents were available to cope with the pandemic and maximise COVID-19 testing capacity.

Potential risks were considered when planning services, for example, seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. Impact on quality and sustainability was assessed and monitored. There were no examples of where financial pressures had compromised care.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Information was used to measure improvement, not just assurance. Quality and sustainability both received coverage in relevant meetings at all levels. The provider had access to both the acute trusts computer system in the other two locations to ensure results could be checked quickly. The two acute trusts provided and maintained the computer system.

Staff had sufficient access to information and challenged it when necessary. There were clear service performance measures, which were reported and monitored with effective arrangements to ensure information used to monitor, manage and report on quality and performance was accurate. When issues were identified, information technology systems were used effectively to monitor and improve the service provided.

The provider compiled a quality manual that described the quality management system to meet the requirements of ISO15189 and appropriate national and international standards. It contained references to Blood Safety and Quality Regulations (BSQR) regulated by the Medicines and Healthcare products Regulatory Agency, The Human Tissue Act (HTA), Good Manufacturing Practice (GMP), Good Clinical Practice (GCP) ISO 15189:2012 Medical laboratories and procedures written fulfilled these requirements. This arrangement provided assurance data or notifications were submitted to external bodies as required. However, this did not include the CQC as two statutory notifications had not been submitted. The provider remedied this as soon as it was pointed out. There were also arrangements (including internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards.

The provider was inspected by UKAS in January 2022 but had not received the latest report. The last MHRA compliance report was 2013.

Inspected but not rated

Medical laboratories

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Views and experiences were gathered and acted on to shape and improve the services and culture. This included the providers who had contracts and service level agreements with this service and the annual staff survey. Staff were also actively engaged, including those with a protected characteristic, so their views were reflected in the planning and delivery of services and in shaping the culture. There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. There was transparency and openness with all stakeholders about performance.

Staff felt empowered to make suggestions for quality improvement. This could be through departmental meetings, suggestion boards, in one to one discussion with senior staff or to their departmental manager. These suggestions were reviewed monthly at the Operations Group and any action agreed and response returned. For example, staff suggested the organisation provided free fresh fruit for staff in rest rooms; this was agreed and was readily available for staff.

The provider had liaised with local universities and schools to provide support for students looking to progress their careers within Biomedical Sciences. Laboratory tours had been made available for visitors and students at different levels. This had been dependent on COVID-19 restrictions.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Leaders and staff aspired to continuous learning, improvement and innovation. This included participation in recognised accreditation schemes. The provider achieved the internationally recognised ISO 15189 accreditation for each test provided.