Hampton Wick Surgery

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

Overall summary

This service is rated as Inadequate overall.

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Inadequate

We carried out an announced comprehensive inspection of Richmond General Practice Alliance at their offices based on the top floor of Hampton Wick Surgery as part of our inspection programme. This was the first CQC inspection of these locations under the current CQC inspection methodology, since the service registered with CQC in 2016.

Richmond General Practice Alliance (RGPA) is a federation made up of 25 member practices across Kew, Sheen, Barnes, Richmond, Twickenham, Hampton and Teddington. The federation provides extended access for patients at Hampton Wick Surgery and Essex House. At Sheen Lane Health Centre the federation provides microsuction services. Microsuction is a specialist service for patients who require treatment for their ears.

RGPA provides regulated activities from:

Hampton Wick Surgery

Essex House Surgery

Sheen Lane Health Centre

The GP practices at these locations provide consultation rooms, equipment, patient reception and waiting areas and reception staff, under a contract with Richmond General Practice Alliance (RGPA). Under CQC regulations, RGPA is responsible for ensuring the quality of care of extended access delivered by its service at these sites. We visited each of these sites to check that the premises were safe and that safety risks were being well-managed. We only reviewed the clinical work of the extended access and microsuction services. We did not inspect the care delivered by the NHS GP provider at these locations.

RGPA has added the three host sites as individual locations on the CQC register. Care across all three sites is managed by each host site which then reports to RGPA based at Hampton Wick Surgery. This report therefore covers the care provided by the whole service – taking into account the evidence from the whole inspection, including the host GP surgeries.

We are mindful of the impact of COVID-19 pandemic on our regulatory function. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

Overall summary

One board member of the federation 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 way the service was led and managed did not promote the delivery of high-quality care. Governance policies had been established without considering the way that care was delivered, and where policies specified processes these had not been implemented.
- The service did not have good systems to manage risks to patient and staff safety.
- There was insufficient oversight and assurance of this service which meant that care was not consistently safe and effective.
- The service did not have effective systems to ensure that all staff involved in delivering the service were suitable and appropriately qualified for their roles or to ensure that all staff received an appropriate induction and ongoing training.
- Staff dealt with patients with kindness and respect and involved them in decisions about their care.
- The service organised and delivered services to allow patients to access care and treatment in a timely way.
- The service did not have good systems to ensure that all patients received effective care and treatment.

We found two breaches of regulations. The provider **must**:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

After the inspection, RGPA sent us a plan to improve oversight of risks associated with the premises from which care is delivered, to improve management of recruitment and training, and for clinical audits. We will follow up to ensure that the provider improves the service. This report is based on the evidence found during the inspection and that was sent to us immediately afterwards.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

Dr Rosie Benneyworth BM BS BMedSci MRCGP
Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector with a second inspector on site**.** The team included a specialist GP adviser who carried out work remotely.

Background to Hampton Wick Surgery

Richmond General Practice Alliance (RGPA) is an independent service provider which is a federation of 25 member practices and six PCNs. This service is registered to carry out diagnostic and screening procedures along with treatment of disease, disorder and injury.

The head office of RGPA is based on the top floor of Hampton Wick Surgery. RGPA provides care from three sites: Hampton Wick Surgery, Essex House Surgery and Sheen Lane Medical Centre. The GP practices at these locations provide consultation rooms, equipment, patient reception and waiting areas and reception staff, under a contract with Richmond General Practice Alliance (RGPA), who are responsible for the care delivered. At Hampton Wick Surgery and Essex House the RGPA provides extended access hubs. At Sheen Lane Medical Centre the RGPA provides microsuction services. RGPA is led by three GP board members. **How we inspected this service**

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.

Inadequate

Are services safe?

We rated safe as Inadequate because:

- The provider did not have safe infection control or health and safety processes or checks in place;
- Not all staff had completed mandatory training or recruitment checks;
- Medicines were not safely managed;
- There was little evidence of internal learning or improvements from incidents or events.

Safety systems and processes

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

- The provider, Richmond General Practice Alliance (RGPA) assumed but did not ensure that appropriate safeguarding arrangements were in place at the places from which care was delivered. It was unclear whether staff received up-to-date safeguarding training appropriate to their role, because the provider's records were incomplete, and not all staff we spoke with knew how to identify and report concerns. No safeguarding concerns had been identified.
- There were safety policies, but the governance processes did not take into account the policies also in place at the host practices, or ensure that staff were aware of relevant RGPA policies. Not all staff we spoke with knew about the RGPA policies and were unclear as to when they should follow them, rather than the local policy.
- Safety risk assessments and mitigation measures were not being completed consistently, even when these were specified in RGPA policies, and the provider had no mechanism to verify that they had been completed or that the quality was sufficient. We saw no health and safety risk assessments at one location.
- The provider did not consistently carry out staff checks at the time of recruitment or on an ongoing basis where this would be appropriate. We reviewed eight recruitment files and found that all of them were disorganised and three did not have items such as proof of identity or sufficient professional references. Disclosure and Barring Service (DBS) checks were undertaken where required.
- There was not an effective system to manage infection prevention and control. The provider did not carry out the processes documented in their policy (including annual audit, annual statements and evidenced monitoring of cleanliness) and assumed, but did not ensure, that appropriate arrangements were in place at the practices. Records of staff training on how to prevent and control infections were incomplete.
- We looked at management of infection prevention and control at the host practices. Sheen Lane Medical Centre and Essex House both had suitable audits and systems in place. However at Hampton Wick Surgery, the last annual infection prevention and control audit available on the day of the inspection dated from 2015, and the action plan available to address the issues identified was incomplete. We asked RGPA to send us any further evidence, and were sent audit documents for this site dated 2016 – 2020 (meaning the last annual infection prevention and control audit was completed 22 months previously, during which the service operated during the Covid-19 pandemic, when extra care was required). The quality of these audits was poor, and the action plans to address the issues recorded were incomplete. At this site we noted some infection prevention and control risks that had not been addressed in areas used by RGPA, for example, an undated sharps bin, damage to the walls of a clinical room, and some dust left after recent light replacement.
- There was not an effective system to manage safety risks related to the facilities and staff provided under contract by the host practices. The provider did not carry out appropriate environmental risk assessments or ensure that they had been completed and were sufficient. At one site we found that the fire risk assessment was incomplete (as there was no assessment of the provision of fire systems and equipment (such as fire doors, extinguishers and emergency lighting) and the risks of the presence of oxygen cylinders had not been assessed. At the same site, there was a local policy for weekly fire alarm checks and quarterly evacuation drills. We reviewed the records and noted that these had not been completed consistently.

Inadequate

Are services safe?

- The provider did not complete processes to mitigate other risks related to facilities provided by the host practices, or ensure that they had been completed, and action taken where necessary. We saw evidence of checks of electrical safety and calibration checks to ensure clinical equipment remained accurate. However, at one site we checked three sets of scales in clinical rooms and found no evidence that they had been assessed as accurate. Review of the log from the host site showed that four sets of scales had failed their calibration check. We asked RGPA to send any further evidence, and were sent evidence that one set of scales had been purchased a month before the calibration check took place, and note (dated after the inspection) that some scales had been ordered.

Risks to patients

There were insufficient systems to assess, monitor and manage risks to patient safety.

- There was not an effective system to ensure that staff received a sufficient induction to the service, including to details of processes in place at host sites and relevant service-wide RGPA policies and processes. Some, but not all staff files had evidence of induction.
- There was not an effective system to ensure that appropriate emergency medicines and equipment would be available if required. The provider had not carried out a risk assessment to ascertain what emergency medicines and equipment should be available, how it should be stored, or reviewed those of the host practices. At one site we noted that storage and range of medicines and equipment available did not meet national guidance, including that from the Resuscitation Council on management of anaphylaxis. The provider assumed but did not ensure that medicines and equipment were checked regularly. At the same site we found that checks were infrequent and ineffective as we found multiple expired items, including devices for taking blood, gloves and oxygen masks.

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 practices to enable them to deliver safe care and treatment. As this service did not treat long-term conditions, it had a detailed process to ensure that any patient's actual GP was informed of any follow up work or treatment needed for patients.
- All records were stored on a system shared by all other practices within the federation which enabled easy access and cross working, although staff told us that there had been several recent instances of this system being unavailable, meaning GPs and nurses did not have access to patient records.

Safe and appropriate use of medicines

The service did not have consistent and reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, including vaccines, controlled drugs, emergency medicines and equipment were not effective in minimising the risks at all sites from which the service operated. The service did not carry out regular medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing.
- There were not effective arrangements in place to ensure that prescription stationary was managed safely. At one site we found that prescription forms were not stored securely, and there was no system in place to ensure forms could be tracked. There was not an effective system to ensure that medicines were always administered legally. Patient Group

Inadequate

Are services safe?

Directions (PGDs) are needed to allow nurses to administer vaccinations legally, without the patient first seeing a doctor or nurse prescriber. PGDs are signed by the nurse, to confirm that they believe they have the required qualifications, experience, knowledge and skills and then by an authorising prescriber, who is confirming this is the case. A PGD can be used to authorise more than one nurse, but as the prescriber is signing to confirm the competency of each individual, if names need to be added after the PGD has been signed by the prescriber, the PGD needs to be re-authorised. At one site we reviewed a sample of 10 PGDs and found that four PGDs had names added after the authorising prescriber signature.

- We saw records of checks of the temperature of vaccine fridges. We noted that all recent records at one site were all in the same handwriting and in same ink, despite some being noted as completed by different staff members. A nurse explained that the records had been re-written.

Track record on safety and incidents

The service did not have effective systems to monitor safety and act on issues identified.

- The provider did not carry out or have oversight of sufficient risk assessments to understand the risks in the service.
- During the inspection we found risks that had not been addressed. We asked the provider to send us any further risk management policies/assessments. We were sent a risk management policy and a risk register marked as updated on 18/03/2022. The risk assessment only considered risks related to the newly-established microsuction service and the mitigation noted was based on assumptions that the provider had not checked were correct, e.g. that sufficient and appropriate emergency medicines and equipment would be available at the site where care was delivered.

Lessons learned and improvements made

The service did not have an effective system to learn and make improvements when things went wrong.

- There was a system for recording and acting on significant events, but it was not effectively implemented. Staff understood their duty to raise concerns and report incidents and near misses and said that they would be supported if they did so, but not all staff were clear (if they also worked for a host practice) how the RGPA process interacted with that of the host practice or how they would hear about any learning that resulted from significant events.
- One significant event had been recorded which was fairly recent. We heard about some learning from this, but the matter was still being investigated and was not yet resolved.

When there were unexpected or unintended safety incidents.

- The service gave affected people reasonable support, truthful information and a verbal and written apology. We saw examples of clear responses to complaints which considered matters objectively and fairly.
- They kept written records of verbal interactions as well as written correspondence.
- It was unclear whether the service acted on and learned from external safety events as well as patient and medicine safety alerts. The service could not demonstrate that it had an effective mechanism in place to disseminate alerts to relevant stakeholders.

Requires Improvement

Are services effective?

We rated effective as Requires improvement because:

- There was no audit cycle to ensure effective clinical care;
- There were no competency checks or appraisals for staff;

Effective needs assessment, care and treatment

Monitoring care and treatment

The service was not actively involved in quality improvement activity.

- The service was not pro-active in auditing its clinical decisions or records to make improvements. There were two clinical audits from 2021 which had considered consultation notes and referrals. The service could not demonstrate how it had made improvements through the use of these audits. There was no clear evidence of action to resolve concerns and improve quality. There was no clear evidence that the findings of these audits had been disseminated.

Effective staffing

There was not an effective system to ensure that staff had the skills, knowledge and experience to carry out their roles.

- Staff records were disorganised and incomplete, meaning it was not possible to confirm that staff were appropriately trained, checked or qualified at the time of recruitment.
- Records of induction were incomplete, and the induction process did not ensure that all staff had the information required, on both RGPA policies and processes and local processes in place at the host sites.
- All relevant professionals (medical and nursing) were registered with the General Medical Council (GMC)/ Nursing and Midwifery Council (NMC) and were up to date with revalidation. However, there was no system or process to monitor revalidation or professional registration.
- The provider did not understand the learning requirements of staff or how to assure compliance. Up to date records of skills, qualifications and training were not maintained or audited.
- Appraisals were not being completed for staff. We found that there was only one internal appraisal record for one member of staff dated 2020.

The provider did not have effective systems to keep clinicians up to date with current evidence based practice. The records we reviewed showed that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance (relevant to their service)

- The provider told us how they shared guidance with clinical staff who delivered care, but said that some meetings were not minuted and there was no log or index of information that had been cascaded by email (allow clinicians to be confident they were up-to-date or refer to updates).
- 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.
- Staff assessed and managed patients' pain where appropriate.

Coordinating patient care and information sharing

Requires Improvement

Are services effective?

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. This was managed by the fact that all member practices had access to the same patient management system and there was a process in place to ensure safe follow-up with other GPs.
- Doctors at the service were normally able to access the patient's medical record to ensure they had adequate knowledge of the patient's health, any relevant test results and their medicines history before providing treatment.
- 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.
- The provider policy stated that all patients must be asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service, but the provider could not demonstrate that it monitored the process for seeking consent appropriately.

Supporting patients to live healthier lives

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

- Where appropriate, staff gave people advice so they could self-care.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their usual 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

There was not an effective system to ensure that consent to care and treatment was obtained in line with legislation and guidance.

- The provider did not have an effective system to ensure that staff understood the requirements of legislation and guidance when considering consent and decision making.

Good

Are services caring?

We rated caring as Good because:

Kindness, respect and compassion

Staff treated treat patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received.
- Feedback from patients was positive about the way staff treat people.
- 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.

Privacy and Dignity

The service respected patients' privacy and dignity.

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

Good

Are services responsive to people's needs?

We rated responsive as Good because:

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. As an extended access service, patients had the ability to have appointments via telephone or face to face when their own GP wasn't available. This was essential during the pandemic and lockdown periods of 2020 and 2021.
- The facilities and premises were appropriate for the services delivered.

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, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.

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 a complaints 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 reviewed one complaint where a patient had raised a concern about a clinician's use of personal protective equipment (PPE). The provider had investigated the complaint and acted appropriately to ensure safe compliance with policies regarding PPE.

Inadequate

Are services well-led?

We rated well-led as Inadequate because:

- Leaders had failed to follow their own policies, contracts and procedures to ensure good governance;
- There was minimal assurance of processes and systems carried out internally. Some areas of essential safety assurance had been neglected for prolonged periods of time;
- The provider lacked clarity and cohesion throughout its organisation in terms of its policies and communication of information.
- The leaders did not understand how to ensure appropriate risk management;
- There was minimal evidence of information being used to drive consistent improvements or developments.

Leadership capacity and capability

Leaders did not have the capacity and skills to deliver high-quality, sustainable care.

- Leaders were not knowledgeable about issues and priorities relating to the quality of the service.
- The provider delivered services using premises, facilities and staff provided by other organisations. Leaders had not recognised the additional challenges this would present to meeting regulatory requirements, and had not put in place measures to address them.
- Leaders had established a governance system by using policies from a third-party organisation. These are designed for organisations that manage their own premises and therefore, for example carry out their own premises risk assessments. Leaders had not realised that this system still placed the responsibility on them to carry out oversight and assurance.
- Although the board of RGPA met quarterly, the provider could not show us how these meetings had resulted in improvements in the care provided.
- Where leaders carried out governance processes, these did not result in the intended assurance, for example, contract meetings with one of the host practices had failed to identify significant failings in the safety systems.

Vision and strategy

The service did not have a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a vision and values, but the provider could not demonstrate that it had a realistic strategy and supporting business plan to achieve priorities.
- There were four different types of meetings held internally at the provider between different levels of staff. Each meeting type had a different attendance register and none of the meetings consistently recorded minutes or could demonstrate consistency in regularity. The provider could not demonstrate that information, visions or strategies were well communicated or discussed with all stakeholders.
- The provider could not demonstrate that it monitored progress against delivery of a strategy. The organisation and management of the provider was convoluted and poorly arranged.

Culture

The service did not have a culture of high-quality sustainable care.

Inadequate

Are services well-led?

- It was difficult to identify a consistent culture or existence of an organisation that extended across the whole service, as there was limited evidence of whole-service communication or efforts to engage with non-clinical staff who delivered care at the host sites.
- There was not a culture of quality management as an active, documented, system to ensure good quality care. For example, for staff training the provider relied on verbal conversations, brief emails or minimal training certificates. There were no records of staff training ever being reviewed, checked or audited, and staff did not know how to use tools within their information system to check compliance.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints.
- Staff were positive about working for the service. They told us they could raise concerns and they had confidence that these would be addressed.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were not clear, understood by all staff or effective. Leaders had not established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. There were some governance activity in specific areas, but this was inconsistent, and there was no evidence of systemic, active and consistent governance of the service as a whole.
- There was a suite of RGPA policies, but these had been obtained from a third-party provider and minimally adapted (e.g. by adding names) to the provider, without consideration of how the processes described would be implemented within the service model. Policies on managing safety specified particular risk assessment and monitoring activities which were not occurring.
- The governance arrangements for the supply of facilities and staff by host practices were not fit-for-purpose and were poorly monitored. The contracts defined some aspects very clearly and specifically, but provided no details of the quality or safety of other key aspects of what was to be supplied, referring only, for example to “accordance with Good Practice and/or any applicable Care Quality Commission requirements (as appropriate)”.
- The provider had assumed, but not assured that sufficient safety and quality processes were in place at the host practices. The provider did not have a mechanism to allow them to identify whether these processes were being completed consistently or to a sufficient standard. Monitoring was described in the contracts as being through monthly exception reports and bi-monthly contract meetings. We did not see any evidence of exception reports at the inspection, and found only limited evidence of contract meetings. The monitoring that took place was ineffective as it had failed to ensure the provider identified the safety risks we found during the inspection.
- The contracts with host practices refer to services being delivered “in accordance with RGPA’s applicable policies” but do not specify what these are or where they can be found, and do not discuss how governance will be handled on areas where both RGPA and the host have their own (different) policies or where the host has responsibility for some aspects and RGPA for others.
- There were some audits of clinical care, but these were focused on the quality of notes, and had limited evidence of improvement. There was no overall audit programme, and no audits had been undertaken on other key areas of clinical care, such as antibiotic or other prescribing.
- The service used some performance information which was audited but there was no evidence that staff were held to account.

Managing risks, issues and performance

There were not clear and effective processes for managing risks, issues and performance.

Inadequate

Are services well-led?

- Leaders had not established processes that allowed effective identification and understanding of risk, and for risks recognised to be effectively addressed and monitored.
- The provider had a policy on the management of risk, which referred to a suite of other policies, but these were generic and did not take account of the model of service. The measures specified to assess risk (e.g. that the provider would undertake annual infection control audits and documented reviews of cleanliness) had not been undertaken, nor had the provider established a method to review assessments carried out by others. As a result leaders were unaware of poorly managed risk within their service.
- In response to a request for any additional evidence on risk management, we were sent a risk register (marked as updated after the inspection). This only assessed the newly developed, relatively low risk microsuction service. None of the risks we had found and shared with the provider about the extended access service were included. The risk assessment was of poor quality, as it was based on the provider's unverified assumption that risks within the host practices were well-managed, and that processes carried out by the provider (such as recruitment checks and monitoring of training) were effective.
- The service did not have consistent processes to manage current and future performance. There were audits of clinical consultations and referral decisions. However, none of these audits set out effective actions or learning points which could be demonstrated as having been resolved since the audits. For example, clinical audits from 2018 and 2021 found that clinicians were not always ensuring that safety netting was discussed with patients. The outcome in both audits was to discuss the findings with clinicians even though the same issue was found to still be present after three years. The service had sent the outcomes and results to all clinicians involved in the audit.

Appropriate and accurate information

The service did not act on appropriate and accurate information.

- Quality and operational information was not used to ensure and improve performance. Although the provider collected patient feedback, no conclusions or actions were created or recorded as a result of this feedback.
- Quality and sustainability were sometimes discussed in some meetings but there was no evidence to demonstrate that all staff had access to the findings or outcomes.

Engagement with patients, the public, staff and external partners

The service involved patients and the public but did not obtain staff or external partner feedback to support high-quality sustainable services.

- We saw some evidence of transparent, collaborative and open communication with stakeholders about some areas of performance, but it appeared to be inconsistent and there was no clear dissemination process. As the provider had insufficient governance and monitoring, it was unable to share with stakeholders a complete and accurate picture of the service.
- The provider relied on the host practices to share information, updates and learning from complaints/incidents with non-clinical staff, but had no mechanism to ensure this happened or identify where it had not.
- We did not see evidence of feedback opportunities for staff and how the findings were fed back to staff.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

Inadequate

Are services well-led?

- There were some examples of learning and improvement, for example in its wider role supporting GP practices in the primary care networks, the provider had set up new services, for mental health services, Covid clinics and a paramedic home visiting service. These pilots had ended in 2020 and 2021 and there was limited additional evidence of innovation and quality improvement activity by the provider.
- The service made use of internal reviews and complaints.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to: • Assess, monitor and improve the quality and safety of the services being provided. In particular: There was minimal assurance of processes and systems carried out internally. Some areas of essential safety assurance had been neglected for prolonged periods of time. There was minimal evidence of information being used to drive consistent improvements or developments. • Maintain securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity or activities. In particular: Staff records were disorganised and incomplete, meaning it was not possible to confirm that staff were appropriately trained, checked or qualified at the time of recruitment or that staff had maintained and updated their knowledge and skills while in post. There was additional evidence of poor governance. In particular: • The provider lacked clarity and cohesion throughout its organisation in terms of its policies and communication of information. • Leaders had failed to follow their own policies, contracts and procedures to ensure good governance.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Enforcement actions

The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:

- The provider did not consistently carry out staff checks at the time of recruitment or on an ongoing basis where this would be appropriate.
- There was not an effective system to manage infection prevention and control.
- There was not an effective system to manage safety risks related to the facilities and staff provided under contract by the host practices. The provider did not carry out appropriate risk assessments or safety checks or ensure that they had been completed by others and were sufficient.
- The service did not have an effective system to learn and make improvements when things went wrong.

There was not proper and safe management of medicines. In particular:

- The systems and arrangements for managing medicines, including vaccines, controlled drugs, emergency medicines and equipment were not effective in minimising the risks at all sites from which the service operated.
- The service did not carry out regular medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing.
- There were not effective arrangements in place to ensure that prescription stationary was managed safely.
- There was not an effective system to ensure that medicines were always administered legally.