NICS at Studholme Medical Centre

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

Overall summary

This service is rated as Requires Improvement overall.

The key questions are rated as:

Are services safe? – Requires Improvement

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 at North West Surrey Integrated Care Services NICS Ltd as part of our inspection programme. This was the first inspection of this improved access service. Our inspection included visits to offices where some of the service administrative staff were based and the five locations where the service operated. This report relates to our findings of the service as a whole and the specific findings relating to the Studholme Medical Centre location.

Our key findings were:

- Patients were supported and treated with dignity and respect. Services were offered weekday evenings and Saturday mornings from five hub locations across the area covered by the 38 practices of the federation, ensuring the service was accessible to all patients.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- Care and treatment was delivered according to evidence-based guidelines.
- Patients found the appointment system easy to use and reported they were able to access care when they needed it.
- The federation had reviewed the needs of their local population and ensured that additional services were offered. For example, cervical cytology screening, wound care and phlebotomy services.

However, we also found that:

- The service had not ensured care and treatment was always provided in a safe way to patients.
- The service was unable to assure themselves that people received effective care and treatment.
- The leadership and governance of the service did not ensure the delivery of high-quality care.
- The service could not evidence that all the checks required to employ staff appropriately were in place.
- We found that policies and procedures were not always written and shared with staff to govern activity and ensure staff were adhering to the same processes.
- The service did not have systems and processes to give assurance that staff would raise, share and record all significant events. There was a lack evidence to demonstrate that any identified learning was shared with the whole service team.
- The service did not always have sufficient oversight of the premises from where they delivered services. For example, the service had not reviewed premises management information sent from the host sites and had not followed up areas of non-compliance, so were unaware if the host sites had rectified problems found.

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

- 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.
- Ensure staff who are suitably qualified, competent, skilled and experienced persons, are deployed to meet the fundamental standards of care and treatment.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

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

The areas where the provider should make improvements:

- Review and improve the documentation of verbal complaints.

Dr Rosie Benneyworth BM BS BMedSci MRCGP Chief

Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included two GP specialist advisers and a nurse specialist adviser. The team also included two further CQC inspectors.

Background to NICS at Studholme Medical Centre

North West Surrey Integrated Care Services Ltd (NICS) is a formal alliance of 38 General Practices which delivers a range of services for the local population. Services include first contact physiotherapy assessments and a GP improved access service which includes face to face appointments with GPs on weekday evenings and Saturday mornings, Saturday morning cervical cytology, wound care and phlebotomy and an online e-consultation service with appointments seven days a week. Patients stay registered with their own GP practice but are able to access the improved access services online and through hubs in five locations. Appointments at the hub locations are booked through the patients' registered GP surgery. This is not a walk-in service.

This service is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC which relate to particular types of regulated activities and services and these are set out in and of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. NICS provides first contact physiotherapy assessments which, as a standalone treatment service run by physiotherapists, are not within CQC scope of registration. Therefore, we did not inspect or report on this service.

The 38 practices which form the federation are:

Chertsey Health Centre – KT16 8HZ

Crouch Oak Family Practice - KT15 2BH

The Ottershaw Surgery - KT16 0JX

Rowan Tree Practice - KT13 8DW

Church Street Practice - KT13 8DW

Hersham Surgery - KT12 4HT

Fort House Surgery - KT12 1UX

Ashley Medical Practice - KT12 2QY

Yellow Practice - KT12 3LB

Red Practice - KT12 3LB

White Practice - KT12 3LB

Parishes Bridge - KT14 6DH

Wey Family Practice - KT14 6DH

Madeira Medical - KT14 6DH

Upper Halliford - TW17 8SY

Sunbury Health Centre - TW16 6RH

Studholme Medical Practice - TW15 2TU

Shepperton Medical Practice - TW17 8EJ

Fordbridge Medical Practice - TW15 2S

Knowle Green Medical - TW18 1XD

Orchard Surgery - TW15 1HE

Grove Medical Centre - TW20 9QN

Packers Surgery - GU25 4RL

St Davids Family Practice - TW19 7HE

Hythe Medical Centre - TW18 3HX

Staines Health Group - TW18 1XD

Stanwell Road Surgery - TW15 3EA

The Family Practice - GU21 8TD

Chobham & West End Medical Practice - GU24 8NA

Pirbright Surgery - GU24 0JE

College Road Surgery - GU22 8BT

Hillview Medical Centre - GU22 7QP

Maybury Surgery - GU22 8HF

Southview Medical Practice - GU22 7RR

Sunny Meed Surgery - GU22 7EY

Heathcot Medical Practice - GU22 7XL

Goldsworth Medical Practice - GU22 7XL

Sheerwater Health Centre - GU21 5QJ

During this inspection we visited all five of the locations where patients can attend appointments:

The Bedser Hub

Woking Community Hospital, Heathside Road, Woking, GU22 7HS

Monday to Friday evenings 6pm to 9pm

Saturday 8.30am to 12.30pm

Studholme Medical Centre

50 Church Road, Ashford, TW15 2TU

Monday and Wednesday evenings 6pm to 9pm

Saturday 9am to 12pm

Sunbury Health Centre

Green Street, Sunbury-on-Thames, TW16 6RH

Tuesday and Thursday evenings 6pm to 9pm

Saturday morning 9am to 12pm

Chertsey Health Centre

Stepgates, Chertsey, KT16 8HZ

Tuesday and Thursday evenings 6pm to 9pm

Saturday morning 9am to 12pm

Red Practice

Walton Health Centre, Rodney Road, Walton-on-Thames, KT12 3LB

Monday and Wednesday evenings 6pm to 9pm

Saturday morning 9am to 12pm

This service is registered with the Care Quality Commission (CQC) under the Health and Social Care Act 2008 and provides the following regulated activities:

- Diagnostic and screening
- Family planning services
- Treatment of disease, disorder or injury

The provider has a Board of Directors which includes a Chief Executive Officer, Medical Director and six non-Executive Directors. The provider has centralised governance for its services which are co-ordinated by the Chief Executive Officer, Medical Director, Chief Operating Officer and three administrative staff.

The Chief Executive Officer 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 practice is run.

As part of our inspection we asked for CQC comment cards to be completed by clients prior to our inspection visit. In total, across the five locations we visited, we received 97 comment cards which were mainly positive about the service and nature of staff. Five comment cards contained negative comments and four comment cards contained both positive and negative comments. We received 31 comment cards for Studhome Medical Centre of which 28 were positive and three were negative. Other forms of feedback, including patient surveys carried out by the provider, were positive.

Requires improvement

Are services safe?

We rated the service as requires improvement for providing safe services.

Safety systems and processes

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

- There were safety policies in place. However, some did not contain sufficient information to govern activity.
- Staff were given an induction to the premises before they commenced their first shift of work.
- The service employed some of the reception staff, administrative staff and one advanced nurse practitioner. GPs and one advanced nurse practitioner were employed through an online software platform designed to allow healthcare organisations to connect with bank staff. Most of the GPs also worked at one of the 38 GP surgeries within the federation and felt this was additional reassurance that they only used fit and proper persons to carry out the regulated activity. However, some of the recruitment files we reviewed did not contain the required information. For example, information to assess if they were of good character, full employment history, up to date Disclosure and Barring Service (DBS) checks and any required training. The service could not always evidence that recruitment information had been reviewed or recorded. Other reception staff and all the nurses, health care assistants and phlebotomists were employed by GP practices who were part of the federation. The federation requested evidence that recruitment checks and required training had been completed from the practices employing staff who carried out work for the federation.
- The memorandum of understanding between the provider and the host locations listed training required by staff working in the service. This could be done either at their own practice and evidence of the completed training sent to the head office or through the services' own on line training. The service was unable to evidence that all staff had completed up-to-date safeguarding and safety training appropriate to their role. We reviewed training records during the inspection and further training information that was provided after the inspection, which showed some staff did not have evidence of appropriate training. For example, the provider could not provide evidence that one nurse had completed safeguarding training for children or vulnerable adults. Additionally, out of 58 receptionists, the provider could not provide evidence that 21 had completed safeguarding training for adults or that 23 had completed safeguarding training for children. The overview of training showed only one receptionist (out of ten) employed by Studholme Medical Centre working for this service had completed safeguarding training for children.
- The service told us that reception staff could act as chaperones. We reviewed the training records which showed that 15 reception staff had not received chaperone training (ten of whom were employed by Studholme Medical Centre) and 15 reception staff did not have DBS checks (ten of whom were employed by Studholme Medical Centre). The provider did not have a risk assessment in place to determine whether a DBS check was required for this role. The overview of training showed that neither chaperone training or DBS checks were completed for reception staff working at the Studholme Medical Centre. Leaders in the service told us that Studholme Medical Centre had completed a risk assessment for the role of receptionist working within their GP practice and had determined that no DBS checks were required for the role. However, the memorandum of understanding between the provider and the host locations stated a DBS check was mandatory for staff working in the service.
- The service did not demonstrate that staff vaccinations were maintained in line with current Public Health England (PHE) guidance and leaders in the service told us no risk assessment had been carried out regarding staff vaccination. The service was only recording evidence of hepatitis B immunity status.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an induction system which involved an introduction to the premises where the staff member would be working. However, these held only operational details regarding the service and did not include any health and safety information, for example where the fire exits were. We were told by leaders in the service

Requires improvement

Are services safe?

that staff were given a walk through induction from a member of staff from Studholme Medical Centre which included health and safety but this was informal and not documented.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention.
- The service did not always have oversight of safety risk assessments that had been undertaken in the host sites. For example, the service was unable to provide evidence of required information on risk assessments completed, infection control monitoring and the portable appliance testing (PAT) of equipment. The service told us that this information had been requested.
- The service requested infection control audits from each of the host sites. However, when we reviewed a sample of these, we found that some of the audits had indicated areas for improvement. The service had not followed these up with host sites and were therefore unaware if these improvements had been completed or not.
- The host site had cleaning checklists for each of the clinical rooms that they utilised.
- There were appropriate indemnity arrangements in place to cover all potential liabilities.
- The service expected clinicians to provide their own equipment but there was no contractual requirement for or oversight of the cleaning, calibration or PAT testing of clinician's own equipment.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Where patients required referrals, the clinicians made the referral and a message was sent to the patients' own practice.

Safe and appropriate use of medicines

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

- The service required that each of the host sites supplied emergency medicines. However there was no standard list of emergency medicines or risk assessment in place to determine which emergency medicines should be available on site whilst the service was operating.
- The service did not administer vaccinations or prescribe high-risk medicines (for example, warfarin, methotrexate and lithium). Patients requiring these medicines were seen at their usual GP practice.
- Staff prescribed and gave advice on medicines in line with current national guidance. The service had reviewed its antimicrobial prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- The service supplied prescription stationery and at Studholme Medical Centre it was securely stored and monitored.

Track record on safety

The service did not have a good safety record.

- The service did not have robust systems in place to ensure that host sites were providing the required risk assessments or for monitoring the information received. Risk assessments were not always completed adequately to demonstrate compliance. In addition, some host sites had not provided all the required information.
- The service could not evidence that risks were monitored or reviewed to enable them to have a clear and accurate picture of the service which led to safety improvements. For example, unannounced checks at the host sites carried out by NICS were not fully completed.
- There was a system for disseminating patient safety alerts, however there was no overview of the alerts that were sent or a record of actions taken. We saw evidence that recent alerts had been shared with clinicians working in the service and GPs we spoke with confirmed they had received patient safety alerts from NICS.

Lessons learned, and improvements made

The service did not evidence that they learnt and made improvements when things went wrong.

Requires improvement

Are services safe?

- The service was reviewing and investigating when things went wrong but were unable to demonstrate that there was a comprehensive system in place.
- The service had a system for recording and acting on significant events. However, some staff members we spoke with were unaware how they would raise a significant event. They told us that they would e-mail any events to head office staff, who would then complete the necessary forms. The service told us they carried out a thorough analysis of significant events and had appropriate systems to manage them but we did not always see written evidence of this. The service was not able to evidence that lessons learnt and improvements made were shared amongst the whole team. For example, meeting minutes did not reflect that all significant events were discussed.
- Staff we spoke with told us that they had raised concerns regarding inappropriate appointment bookings, they gave us several different examples of this occurring. However, we did not see any evidence these had been recorded, investigated or reviewed. When asked, senior staff in the organisation told us that the appointments were booked by the patient's own GP practice and was not something that NICs would consider an event that required investigation or reviewing.
- The provider encouraged a culture of openness and honesty. Staff we spoke with understood their duty to raise concerns and report incidents and near misses however some were unaware of how to raise a significant event. Most told us they had not needed to report any incidents.

Requires improvement

Are services effective?

We rated the service as requires improvement for providing effective services.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence-based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance, supported by clear clinical pathways and protocols.

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed.
- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs. This included back to their own GP or to the local Accident & Emergency Department.
- Clinicians had enough information to make or confirm a diagnosis and we saw that care and treatment was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- We saw no evidence of discrimination when making care and treatment decisions.
- There was a system in place to identify patients with particular needs, for example patients who were vulnerable and care plans were in place to provide the appropriate support.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service collected a range of performance information for the local Clinical Commissioning Group (CCG). This information included the number of appointments offered, numbers of patients who did not attend their appointments, appointment utilisation statistics and patient feedback.

During the inspection, the provider shared examples of the performance data submitted to the CCG for the period April 2019 to December 2019:

- The federation offered more than the contracted minutes of appointment time (quarter one 103%, quarter two 98% and quarter three 108%).
- The percentage of appointments booked was above the target of 95% in all three quarters.
- More than 25% of patients completed feedback surveys each quarter.
- The percentage of completed patient surveys which rated the service as good or excellent was 95% or higher in each quarter.

The service was completing some audits that had a positive impact on the quality of care and outcomes for patients.

Audits of the GPs' consultations had been undertaken using a scoring matrix to determine the range of outcomes, including history, accurate summarisation, medical examination, prescribing decisions and onward plan, including referrals and appropriate contact with the patients' own GP practice. We were informed that this was an ongoing audit and that not all GPs had been reviewed at the time of inspection.

The service had also carried out an audit of approximately 1% of the online consultations which had been completed by the federations e-consultation service between October 2018 and June 2019. These consultations all related to patients registered at a single GP practice within the federation. The results were discussed with the provider of the online e-consultation service but the audit had not been extended or repeated.

We noted there was a lack of clinical audits to support improvement. However, we saw evidence that the service had audited the urgent cancer "two-week rule" referrals from both face to face and online consultations. The results showed that referrals were within the expected levels. We also saw evidence that in early 2020 a single cycle audit of a specific antibiotic prescribed for urinary tract infections had been completed, which included face to face and online consultations. The service told us that learning from this audit was shared with prescribing clinicians within the service and also with the provider of the online e-consultation service.

Effective staffing

Some staff did not have recorded that they had the skills, knowledge and experience to carry out their roles.

Requires improvement

Are services effective?

- The service asked that staff complete a list of training they required. This could be done at their main practice of work and evidence sent to the provider or completed through the service's online training system. The service monitored training through spreadsheets. We viewed the training overview spreadsheets provided by the service and saw that there were gaps in training. For example, 94% of the GPs and 79% of the nurses, phlebotomists and advanced nurse practitioners had completed training in basic life support in the last twelve months. For non-clinical staff training, 37% had completed fire safety, 57% had completed information governance and 34% had completed sepsis training. We also noted that one member of staff whose training record and recruitment checks were provided during the inspection was not included on the overview spreadsheets.
- The service had an induction programme for all newly appointed staff. A staff member from the host site or the administration team would meet the staff member at one of the host sites and walk them through the location. The site inductions were normally carried out by non-clinical staff. There was a manual for each host site that staff could refer to. This included where emergency medicines were stored, key policies and details of people to contact if required.
- Staff worked within scope of their practice and had access to clinical support.
- The service had started to audit the competency of their staff by auditing their clinical decision making through reviewing the patient record and each clinician was provided with individual written feedback. At the time of our inspection clinical records audits had been completed for 72% of the GPs and all the advanced nurse practitioners' working in the service. The clinicians we spoke with told us they valued this feedback.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. Staff communicated promptly with patients' own GPs so that the GP was aware of the need for further action. Staff also referred patients back to their own GP to ensure continuity of care, where necessary. Before providing treatment, clinical staff at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history.
- Referrals were made by the service, including two-week rule referrals where cancer was suspected. The service had a protocol to ensure that all referrals were sent correctly, and the administration team routinely checked referrals had been completed.
- The provider ensured that details of any treatment provided to patients was received by the patient's own GP practice and then recorded electronically in the patient's own medical record to ensure continuity of care.

Helping patients to live healthier lives

- As a GP improved access service, the provider was not required to deliver continuity of care to support patients to live healthier lives in the same way a GP practice would. However, we saw the provider demonstrated their commitment to patient education and the promotion of health and well-being advice. Staff we spoke with demonstrated a good knowledge of local and wider health needs of patient groups who may attend the service. Patients typically attended the service with non-life-threatening health conditions, injuries and illnesses. Healthcare promotion advice was available in the waiting rooms of the various host sites and staff told us that patients could be referred to appropriate specialists, for example for smoking cessation guidance and treatment.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support.
- Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs. GPs and nurses told us they offered patients general health advice within the consultation and if required they referred patients to their own GP for further information.

Consent to care and treatment

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

Requires improvement

Are services effective?

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. All patients were required to consent to the GP viewing their clinical record and this was recorded.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The provider monitored the process for seeking consent appropriately.

Good

Are services caring?

We rated the service as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- Feedback from patients was positive about the way staff treated people.
- The provider gave patients timely support and information.
- We received 31 patient Care Quality Commission comment cards about Studholme Medical Centre, 28 of which were positive and three were negative about the service experienced. This was in line with feedback received by the service. Patients reported the service provided was excellent and staff were friendly and helpful. The negative comments related to difficulties booking appointments and a lack of continuity of care.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given).

- Interpretation services were available for patients who did not have English as a first language. Information leaflets were available to help patients be involved in decisions about their care.
- Patients told us through comment cards, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- Staff communicated with people in a way that they could understand.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff respected confidentiality.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Good

Are services responsive to people's needs?

We rated the service as good for providing responsive services.

Responding to and meeting people's needs

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

- The provider understood the needs of its population and improved services in response to those needs. The provider engaged with commissioners to secure improvements to services where these were identified. For example, the provider was also delivering phlebotomy, cervical screening and wound care.
- The provider had developed an A5 quick reference guide for staff in the federation GP practices to use when they booked patients into NICS federation appointments.
- The provider had systems in place that alerted staff to any specific safety or clinical needs of a person using the service. For example, alerts were in place on the clinical system to identify patients at risk or on any safeguarding registers.
- The facilities and premises were appropriate for the services delivered. The provider made reasonable adjustments when patients found it hard to access services. Patients had access to translation services and online consultations were available in five languages (the most commonly spoken languages in the federation area).
- The service was advertised and available to patients registered in all of the 38 GP practices within the federation.
- The provider carried out cervical screening on Saturday mornings to help improve access for patients and increase the uptake of screening in the CCG area.
- The provider had a monitoring system that enabled them to determine which practices were booking in patients to be seen at the services. This allowed the provider to ensure that there was a fair distribution of appointments.
- The facilities and premises were appropriate for the services delivered. We found that waiting areas were large enough to accommodate patients with wheelchairs and prams, and allowed for access to consultation rooms. There was enough seating for the number of patients who attended on the day of inspection. Toilets were available for patients attending the service including accessible facilities. Baby changing, and breast-feeding facilities were available.

Timely access to care and treatment

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

- Patients had timely access to initial assessment, diagnosis and treatment.
- Waiting times and delays were minimal and managed appropriately.
- Patients were able to access improved access services three days a week from Studholme Medical Centre (Monday and Wednesday 6pm – 9pm and Saturday 9am – 12pm). Patients could access improved access appointments at other locations throughout the federation Monday to Friday evenings and Saturday mornings.
- The provider had a partnership with an online consultation service that patients could access. Access to the online consultations was through an app that allowed patients to book an online video consultation appointment with a GMC-registered GP who could give medical advice and prescriptions for a wide range of symptoms. If the symptoms required a physical examination, the GP would refer the patient to other medical services or specialists, for example back to the patient's own GP. This was available to all patients from the 38 practices six days a week from 7am- 10pm Monday to Friday and 8am to 4pm during the weekend.
- Patients could only access the service through their own GP practice. Information about how patients could access help out-of-hours was available on all of the practices' websites.
- The service did not see walk-in patients. However, we did not see a policy or protocol for staff that clearly outlined what approach should be taken if a patient arrived without having first made an appointment.
- Where a patient's needs could not be met by the provider, staff redirected them to the appropriate service for their needs.

Listening and learning from concerns and complaints

- The provider took complaints and concerns seriously and told us that they responded to them appropriately to improve the quality of care.

Good

Are services responsive to people's needs?

- The service had received eight written complaints in the last 12 months and we found these were dealt with in an appropriate and timely manner.
- Information about how to make a complaint or raise concerns was available to staff.
- We saw evidence that following a complaint about a referral being sent to the incorrect hospital, the provider had reviewed their referral process and made changes to reduce the chance of error. A reminder email was sent to all clinicians regarding the referral process.
- The provider's complaints procedure stated that verbal complaints would be recorded for the purpose of monitoring trends but the provider could not evidence that verbal complaints were recorded. Staff we spoke with were not all aware that verbal complaints should be recorded or how they should be reported.

Inadequate

Are services well-led?

We rated the service as inadequate for providing well-led services.

Leadership capacity and capability

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

- Leaders demonstrated they had knowledge about issues and priorities relating to the quality and future of services. They understood the challenges. However, the capacity to address these issues was challenging.
- The service informed us that there was uncertainty around the future of the improved access contract and this in itself created problems in being able to plan for the future for the service, including forming a permanent base and employing staff for roles to help with the capacity to deliver services.
- Staff told us leaders were visible and approachable.
- Senior management was accessible throughout the operational period, with an effective on-call system that staff were able to use. However, this included a limited number of the provider's senior team who were also working throughout the day to manage the service.
- The provider did not have effective processes to develop leadership capacity and skills, including holding contracted staff accountable for their performance.

Vision and strategy

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

- There was a clear vision and set of values. The service had developed its vision, values and strategy jointly with staff and external partners.
- The strategy was in line with health and social priorities across the region. The provider planned the service to meet the needs of the local population.
- The provider monitored progress against delivery of the strategy.

Culture

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

- Staff we spoke with felt respected, supported and valued. They were proud to work for the service.
- Staff told us they felt that the service focused on the needs of the patients.
- When they identified behaviour and performance that was inconsistent with the vision and values of the service, leaders and managers acted on it, for example, where GPs who were performing below standard in the medical records audit were supported to improve and re-audited. However, there were not always effective processes in place to identify behaviour and performance which was inconsistent with the values and expected behaviours across the service.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they could raise concerns. However, they were not always confident their concerns would be acted upon. Staff we spoke with gave us examples of incidents that they had raised but did not think any review or investigation of these had occurred.
- The provider did not have processes for providing all staff groups with the development they needed. Most staff were either locums or classed by the provider as bank or contract staff and so the provider felt that formal appraisals would not be appropriate. However, the provider was in the process of auditing clinical performance and was giving feedback to the clinical staff in relation to their work. We saw that where clinical performance was below the level expected by the provider; action was taken to support the clinician and their performance reviewed again.
- The provider failed to demonstrate there was a strong emphasis on the safety and well-being of all staff. The provider had not completed their own records or checks to assure themselves that host sites were meeting their commitments as per the memorandum of understanding signed between the provider and the host sites.
- Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

Responsibilities, roles and systems of accountability to support good governance and management were inadequate.

Inadequate

Are services well-led?

- Structures, processes and systems to support good governance and management were not 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 not always established proper policies, procedures and activities to ensure safety and had not assured themselves that they were operating as intended. Prior to and during the inspection we were provided with policies which were not available to staff either through the staff website or the hard copy folders available at the host sites. There were multiple versions of some policies on both the staff website and in the hard copy folders. There were key policies or procedures that we expected to see that were not available for staff or that did not include sufficient information. For example, the infection control policy did not contain any information regarding the cleaning of clinicians' own equipment that they used whilst working in this service.

Managing risks, issues and performance

The process to identify, understand, monitor and address current and future risks including

risks to patient safety was not always adequate.

- The process to identify, understand, monitor and address current and future risks, including risks to patient safety was not always effective.
- The provider had some processes to manage current and future performance.
- The provider was in the process of reviewing the performance of clinical staff through auditing consultations, prescribing and referral decisions. At the time of our inspection not all clinicians had been reviewed.
- Leaders had oversight of safety alerts, incidents, and complaints but could not evidence that processes were always being followed and that learning was disseminated to all staff.
- Leaders had a good understanding of service performance against the local key performance indicators. The service's performance was discussed at senior management and board level meetings, as well as with the local CCG, as part of contract monitoring arrangements.
- The provider did not conduct a diverse range of clinical audits to ensure there was a positive impact on quality of care and outcomes for patients.
- Written minutes of the operations team meetings were not recorded and so the provider could not evidence that any actions resulting from these discussions had been completed.

Appropriate and accurate information

The service did not always have appropriate and accurate information.

- The provider requested certain information from host sites, for example infection control audits and fire safety audits. This was not always reviewed or monitored, and management, staff and host sites were not always held to account.
- Audits and checks carried out by this service were not always reviewed or monitored, and management and staff were not always held to account. For example, checklists designed and used by the provider when carrying out unannounced checks at the host sites were not fully completed. It was also difficult to determine when checks had been completed as they did not always contain the name of the host site or a date.
- The service did not have sufficient oversight of training to ensure that all staff working in the service had completed the training the provider determined was mandatory.
- The provider had not considered different ways to monitor performance to promote the delivery of quality care. For example, there was a limited number of audits being completed, including prescribing where only a single cycle audit for one specific antibiotic had been carried out.
- The provider submitted data or notifications to external organisations as required.
- There were arrangements for data security standards for the availability, integrity and confidentiality of patient identifiable data and records.

Engagement with patients, the public, staff and external partners

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

- A range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.

Inadequate

Are services well-led?

- Patients were encouraged to provide feedback about the service. The provider had a process of recording patient feedback. The data showed a high percentage of patients were satisfied with the services provided.
- Staff we spoke with told us that they were happy with the systems in place to give feedback. They told us that they would contact leaders in the service if required but some staff were not always confident that any comments or concerns would be responded to.
- We saw evidence that as a result of a staff questionnaire, administration support in the late afternoon was increased. We also saw evidence that some improvements to the service suggested by staff had been implemented, such as offering cervical cytology.
- The provider was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was a strong culture of innovation, evidenced by the number of pilot schemes the provider was involved in. For example, the provider had piloted a home visiting service from February 2019 to August 2019, had provided an online e-learning package and a software platform for booking locum clinicians for all of the 38 practices to use, and provided through a partnership with an online consultation service, an online e-consultation service for all patients to use seven days a week.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 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: There was insufficient monitoring of risk assessments and infection control audits including cleaning logs, from the host practices. There was additional evidence that safe care and treatment was not being provided. In particular: By not ensuring that GPs and other clinicians own equipment, that was used in the delivery of this service, had been calibrated and PAT tested. Staff vaccinations were not monitored in line with current Public Health England guidance and the service had not carried out a risk assessment to support this decision to deviate. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had systems or processes in place that 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:

This section is primarily information for the provider

Requirement notices

The registered person did not assure themselves that systems and processes were not operating as they expected.

There was a lack of systems and process in place to ensure good governance in accordance with the fundamental standards of care. For example,

- A lack of governance arrangements
- A lack of safety alerts overview
- The significant events process being ineffective including not acting on all incidents raised and sharing the actions taken
- Not fully completing the unannounced checks (carried out by NICS) at the host sites

The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person to evaluate and improve their practice in respect of the processing of the information obtained throughout the governance process. In particular:

- Insufficient information in the memorandums of understanding to hold people / host sites to account.
- There was a lack of monitoring of compliance with memorandums of understanding.

There was additional evidence of poor governance. In particular:

Policies and procedures were not always up to date and clearly documented. They were not always easily accessible to all staff.

There was a lack of clinical audits.

This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing
Family planning services	The service provider had failed to ensure that persons employed in the provision of a regulated activity
Treatment of disease, disorder or injury	

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Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person's recruitment procedures did not ensure that only persons of good character were employed. In particular: Recruitment procedures were not fully established and operating effectively. This was in breach of regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular:

The provider failed to evidence that staff were suitably qualified, competent, skilled and experienced persons were deployed to meet the fundamental standards of care and treatment.

This was in breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.