Farnham Integrated Care Services

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

Overall summary

This service is rated as Good overall.

The key questions are rated as:

Are services safe? – Requires Improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Outstanding

Are services well-led? – Good

We carried out an announced comprehensive inspection at Farnham Integrated Care Services on 3 July 2019 as part of our inspection programme. This was the first inspection of this service.

Farnham Integrated Care Services is a federation of five NHS GP services. They provide support and additional services to the patients registered with these practices.

One of the GPs is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our key findings were:

- The service had systems in place to manage risk, so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes.
- Some processes required a review, such as oversight of checks of the cold chain for medicines and escalation processes, and tracking and monitoring of blank prescription stationery.
- The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- The provider had reviewed the needs of the local population and offered integrated services to promote patient care and welfare. This had had a positive impact on the local health system. Their interventions had reduced GP call outs, ambulance call outs, attendance at the Emergency department and admission to hospital.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

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

- Ensure care and treatment is provided in a safe way to patients.

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

- Review the intercollegiate guidance for child safeguarding (January 2019) and ensure this is considered in the service policy for safeguarding.
- Consider how gaps in employment are identified and managed during the recruitment process.
- Review the process for receiving and disseminating information to all clinicians relating to patient safety and medicines alerts. Consider how any actions (including awareness of the alerts) are recorded.
- Consider how consent can be monitored.

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 inspector. The team included a GP Specialist Advisor and a Practice manager Specialist Advisor.

Background to Farnham Integrated Care Services

Farnham Integrated Care Services (FICS) is a federation of five NHS GP services from the Farnham area of Surrey. FICS is part of North East Hampshire and Farnham Clinical Commissioning Group.

FICS provides a same day appointment service (for GPs and Advanced Nurse Practitioner appointments) to patients from three of the GP practices from 8am to 6.30pm Monday to Friday. In addition, they offer an improved access service (extended hours for routine appointments) for all five GP practices from 6.30pm to 8pm Monday to Friday and 9am to 12pm on Saturdays. The provider also offers a pro-active care management service, a paramedic home visiting service, and integrated care service and a referral management service.

The provider registered with the Care Quality Commission in June 2017 to provide the following regulated activities; Treatment of disease, disorder or injury, Surgical procedures, Diagnostic and screening procedures and Maternity and midwifery services.

Services and regulated activities are provided by Farnham Integrated Care Services Ltd from: Farnham Centre for Health (also known as Farnham Hospital), Hale Road, Farnham, Surrey, GU9 9QS.

The service has a representative from each of the five GP practices within the federation who are directors for the service. There is a service manager who is currently being mentored by one of the practice managers from the federation. The provider has a proactive care lead, two paramedic practitioners, two healthcare assistants and three receptionists. Other staff who provide the same day and extended hours services are sourced from the five GP practices on a rota basis. This includes GPs and nurses.

Requires improvement

Are services safe?

We rated safe as requires improvement because:

There were system and processes in place to ensure safety, although these were not applied consistently. We found the provider was not following guidance for cold chain processes or monitoring of blank prescription stationery. We also found some governance and documentation concerns with staff training for safeguarding, staff recruitment files, dissemination of medicine and patient safety alerts.

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- The provider conducted safety risk assessments. It had appropriate safety policies, which were regularly reviewed and communicated to staff including locums. They outlined clearly who to go to for further guidance. Staff received safety information from the service as part of their induction and refresher training. The service had systems to safeguard children and vulnerable adults from abuse.
- The service had systems in place to assure that an adult accompanying a child had parental authority.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. We looked at four staff recruitment files and found they all contained relevant background checks and recruitment documentation. We noted there was no process in place to review employment history (from application form or CV) to check for any gaps in employment, and three of the four files had not been identified as showing information requiring further explanation. For example, one file demonstrated a gap in employment of five months with no documented reason, another had listed the previous employers but did not include dates of employment and the third contained previous employers and only the years of employment. Legislation on recruitment for the health and social care sector, states all employers should obtain a full employment history, together with a satisfactory written explanation of any gaps in employment. These checks reduce the risk of unsuitable personnel gaining employment and working with vulnerable groups.
- Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Staff who acted as chaperones were trained for the role and had received a DBS check.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. The service safeguarding policy stated non-clinical staff should be trained to level one for child safeguarding. The policy had been reviewed in June 2019. The provider had not included the new intercollegiate guidance for child safeguarding which had been published in January 2019, which recommended non-clinical staff, with a role that puts them in contact with children and/or the parents or carers of children, should be trained to level two. We noted one member of non-clinical staff had not been trained to level two for child safeguarding.
- There was an effective system to manage infection prevention and control. The service had liaised with the hospital facilities team to ensure environmental risks to patients, such as legionella checks, had been undertaken. (Legionella is a bacterium found in water supplies. Water sampling identifies if the bacterium has been identified or is safe).
- The provider ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.
- The provider carried out appropriate environmental risk assessments, which took into account the profile of people using the service and those who may be accompanying them.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed. The provider was

already planning for winter pressures and ensuring there were enough suitably skilled healthcare professionals and GPs to provide care during the winter months.
- There was an effective induction system for agency staff tailored to their role. The service used GP and nurse locums, who were known to them and were familiar with the service, to fill gaps in cover. We also saw an arrangement with the five GP practices to offer any locums they had already used and offered induction training to.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. Some staff told us they were unaware of the location of an emergency alarm or panic button to call for help and would physically shout for help if it was required. We were shown an example of an emergency scenario undertaken, where the emergency system and protocols were reviewed. The outcome of the scenario identified that opening the door and shouting for help was adequate for the service, whereas using the computer system emergency button had not alerted all staff to the emergency.
- Emergency medicines and equipment had been reviewed to ensure many emergency scenarios had been considered. A folder with up to date emergency guidance and protocols was available with the emergency trolley.
- Staff knew how to identify and manage patients with severe infections, for example sepsis, although we noted there was no formal training on sepsis (or other high priority illnesses) on the staff training recording tool.
- The paramedic practitioners used a Sepsis recognition tool to identify patients at risk of sepsis from known illnesses. For example, patients who had been discharged from hospital with a diagnosis of chest infection. We saw examples of early intervention reducing the risk of developing sepsis in patients who had been reviewed at their place of residence (home or residential home) for all their health and social needs.
- Healthcare staff used an observation recording tool to help identify patients at risk of severe illness. The tool was accessible in all clinical rooms and a copy was contained with the emergency medicines and equipment.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place to cover all potential liabilities

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 provider had an arrangement to access the records of patients that were on their patient list for each day. This enabled the service to view past medical history and enter details onto the patient record for individual patients, but restricted access to other records for the five GP practices within the federation.
- The service had systems for sharing and receiving information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Appropriate and safe use of medicines

The service had systems for appropriate and safe handling of medicines. However, we found some concerns with medicines storage and blank prescription security.

- The provider did not hold any medicines, other than emergency medicines, within their premises. The emergency medicines and equipment were securely stored, and all staff knew of their location.
- The provider had purchased a large vaccination fridge and had kept a log of daily temperatures recorded, with a view to using this in the future for storing vaccinations to be used by the service, such as flu vaccines. We found the highest and lowest temperatures recorded since February 2019 were all the same and were outside of the recommended range of between 2 degrees Celsius and 8 degrees Celsius. The out of range fridge temperatures had not been escalated according to policy and guidance, and the provider had not identified this as a risk. However, on the day of the inspection, there were no medicines stored in the fridge and the provider showed us a significant event record, after the

inspection, which determined no medicines had been stored in the fridge since February 2019 and the continued high/low recorded measurements were as a result of incorrect resetting processes. They also told us they had made a decision to de-activate the fridge until it was deemed appropriate to re-initiate it's use. The staff responsible for fridge temperature checking and escalation had also been scheduled update training.
- Blank prescription stationery was not logged or tracked, to identify misuse or theft, and we found printers in open clinical rooms with blank prescriptions in them. The provider told us the clinical and treatment rooms were open at the time of our checks as the cleaning team were on the premises and required access, on all other occasions the rooms were locked between use. The provider was unaware of how to track blank prescriptions as they had not identified how the prescription numbers could be tracked in numerical order. After the inspection, the provider told us they would review this and commence tracking and monitoring of blank prescriptions. We noted an entry onto the service risk log had been made around prescription safety which had identified the boxes of prescriptions were logged when they were received into the service and stored securely.
- The five GP practices (that made up the federation) carried out regular medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing. The provider had oversight of these and utilised information from the local clinical commissioning group to ensure the service prescribing was evidence-based.
- One of the GPs routinely reviewed the prescribing of non-medical prescribers to review safety and evidence-based care. (Non-medical prescribers include nurses who have undertaken additional training to prescribe and require regular review and oversight of their prescribing practice).
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The service had oversight of local antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.

Track record on safety

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- Safety alerts were received by the operations manager who printed them and kept them in a file for staff to view. We noted the file contained several alerts that did not relate to primary care and did not need reviewing. The operations manager told us they would review how they identified suitable alerts along with support from the clinical leads, after the inspection. We also discussed the staff dissemination lists for the alerts to be sent by email and found not all members of the clinical team (including sessional and agency staff) were on the list to receive these alerts. There was no process in place to confirm when action had been taken or if the alerts had been read by all pertinent personnel.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service. For example, a template was updated to include a specific question relating to the pregnancy status of patients to ensure safer prescribing of antibiotics.
- The service learned from external safety events and shared learning from events with other GP services and the clinical commissioning group.

Good

Are services effective?

We rated effective as good because:

The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.

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' 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. Clinical staff had access to patient records for the same day and improved access services, which ensured previous medical history (including medications) were seen.
- Although the same day service was to see and treat patients with an urgent problem, if a clinician saw a patient alert regarding their care, they did their best to review this at the same consultation. For example, identifying that a patient required a review of care in line with the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions such as diabetes and implementing preventative measures. The results are published annually).
- The pro-active care lead used a predictive modelling tool to identify patients who were living with frailty or enhanced/complex care needs. This included older patients who were recently discharged, or soon to be discharged, from hospital. Those identified received a full assessment of their physical, mental and social needs. The assessments were carried out by the proactive care lead (a healthcare professional) who liaised with various stakeholders to offer support and input into their care. We were shown examples where this intervention had considerably reduced GP home visit call outs, calls to the ambulance service, admission to hospital and attendance in the local Emergency Department.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. Follow-up on the outcome of health assessments and checks were the responsibility of the patient's NHS GP. For example, if any abnormalities of risk factors were identified.
- The service assessed the physical and social needs of patients with a mental illness and liaised with external stakeholders to co-ordinate care needs. We were shown an example where this intervention had improved the patient understanding of NHS services and who to contact when requiring help and support. This had also reduced their use of services inappropriately.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service was actively involved in quality improvement activity.

The service used information about care and treatment to make improvements. The pro-active care service used information from hospital discharge and inpatient data to identify and monitor vulnerable patients who required additional support. Between May 2018 and February 2019, they had identified approximately 400 patients, of which only 2% (eight patients) did not require further intervention or input from the integrated care team. By identifying these patients at the point of discharge and assessing the risk of them returning home with or without care and support, the service had prevented further hospital attendance and admission. They had also reduced the workload on GPs through offering home visits and assessments with paramedic practitioners.

We were shown case reviews for patients which demonstrated positive patient outcomes. For example, the intervention for a patient and their spouse when they were identified as being at risk. When one of them had deteriorating health and had contacted the GP for a home visit, the home visiting service attended and identified both the patient and their spouse required additional support

and help. This was arranged and liaised by the pro-active care lead and integrated care team. Regular reviews and multi-disciplinary team meetings resulted in the patient making improvements and they did not require hospital admission. Within a month, there was an improvement in the health of the patient and overall improved wellbeing for the couple. All the interventions put into place had avoided an acute hospital admission, additional use of primary care services and prevented the social situation reaching a crisis point. The couple remained independent and were supported throughout.

The service made improvements through the use of completed audits. The audits we were shown had been carried out by one of the individual GP practices and had been shared and utilised by the service to make improvements for commonly utilised areas of practice. For example, an audit of antibiotic prescribing for urinary tract infections had identified 95% of patients had appropriate prescribing for their condition and 77% had prescribed the appropriate duration of course of antibiotics in accordance with guidance. The learning for the service included reviewing the guidance for type and duration of course of antibiotic prescribing.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC)/ Nursing and Midwifery Council and were up to date with revalidation.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. However, we noted child safeguarding training for one member of non-clinical staff was not in line with the latest guidance. Staff were encouraged and given opportunities to develop.
- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required.
- The provider provided staff with ongoing support. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The provider could demonstrate how it ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

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. The integrated care service held regular meetings with multidisciplinary teams, such as district nurses, community nursing teams, social care teams and mental health teams to discuss care and ongoing support for patients.
- Care and treatment for patients in vulnerable circumstances was coordinated with other services. The service had developed care plans in association with the GP practices and uploaded these onto external stakeholder databases, such as the ambulance and GP out of hours services, so they could follow the care plans if patients contacted them.
- 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 arrangements for following up on people who had been referred to other services, was the responsibility of the GP practice with which the patient was registered. If a referral for treatment was made, the clinician sent a message to the GP practice to inform them.
- Staff communicated promptly with patient's registered GP's 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.

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.

Good

Are services effective?

- Where appropriate, staff gave people advice so they could self-care. They also recommended other sources of care or support when patients had used services that may not have been suitable for their needs. For example, seeking the advice of a pharmacist.
- The service identified patients who may be in need of extra support. The pro-active care service had identified patients from the five GP practices, in need of support following discharge from hospital or an attendance at the Emergency Department. They arranged a home visit (or sometimes a pre-discharge visit at the hospital) to check on the care and social needs of individual patients, and co-ordinated with the services required.
- The home visiting service undertook patient assessments and reported back to the patients GP practice of the outcome. The template for assessment included requesting information about smoking status and alcohol intake. This assisted GP services to monitor and support patients with lifestyle information and fulfill the requirements of the quality outcomes framework (QOF). (Some of the QOF indicators relate to obtaining smoking status and alcohol intake).
- The provider instigated, co-ordinated and facilitated twice yearly health and wellbeing events for patients to attend and learn about healthy living. Topics included avoiding sports injuries, supporting people with dementia or mental health problems and preventing falls. They also invited services and groups to attend, such as carers organisations and Heartstart (an external organisation who provide information and training for patients with heart conditions). The events received interest and promotion from the local newspaper.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The provider had not monitored the process for seeking consent appropriately. We were told they would review this after the inspection. We did see an audit of joint injections which required written consent.

Good

Are services caring?

We rated the service as good for caring because:

Patient feedback was positive about the care received and our observations of the service demonstrated a caring approach to all patients.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- All of the 21 patient Care Quality Commission comment cards we received were positive about the services experienced. This was is in line with the results of other feedback received by the service. We saw patient feedback data for May and June 2019 which demonstrated over 90% satisfaction.
- Verbal 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. Information leaflets were available in easy read formats, 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.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Staff respected confidentiality at all times.
- 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.

Outstanding ☆

Are services responsive to people's needs?

We rated responsive as Outstanding because:

The provider had reviewed its local population and had identified their needs. The provider had a system to identify vulnerable patients at risk and pro-actively intervened to prevent escalation of crisis situations. There was clear and demonstrable impact of positive patient outcomes and reduced demand on services (including external stakeholders).

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.

- The importance of flexibility, informed choice and continuity of care was reflected in the services provided.
- The facilities and premises were appropriate for the services delivered.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. There was level access to the main building and all the services were delivered on the ground floor.
- The service considered the needs of their patients with learning disabilities and offered them information in an easy to understand format. For example, patients were contacted by telephone to identify a suitable time and date for their visit and explain what the service could offer them. We were shown examples where early intervention had prevented deteriorating health in a patient with a long term condition and avoided an escalating crisis after a patient had experienced a difficult situation.
- The service had links to external mental health stakeholders and organisations and signposted patients to them in a sensitive way. For example, young patients were referred to a safe haven café for patients experiencing mental health problems. We saw an example where this had been suggested for a young patient experiencing difficulties.

The service had been commissioned to provide integration between primary care and acute care, initially as part of a vanguard project. (Vanguards were established in 2014/15 as part of NHS England five year forward view. The vanguards introduced new care models and established different ways of working within the care system to support and improve patient care. In particular, between acute and primary care settings and community services, establishing integrated care to patients between hospital and home).

There were several services offered to improve local patient care:

- The same day service provided urgent care access to patients from three of the GP practices within the federation. Patients could access this service by contacting their own GP practice. The practice would then assess them to determine if they were suitable and safe to attend the same day service. If so, they would be told to attend the same day service on a sit and wait basis. Feedback to the provider about the same day service was positive and patients reported they could access urgent care quickly. We spoke with two patients who had used this service and they felt it was useful and convenient. They told us they thought the staff were caring and helpful.
- We were shown data from the Vanguard who had tracked Emergency department activity monthly. The Farnham Integrated Care Service had a 2% reduction in Emergency department attendances by patients using the same day service. They were 3% below the clinical commissioning group target.
- The service provided an improved access (extended hours GP service) for the five GP practice sites. The service offered appointments from 6.30pm to 8pm Monday to Friday and on Saturday mornings. Patients could access this service through contacting their own GP practice and requesting an appointment. Patients could access a variety of healthcare professionals including GPs, nurses and healthcare assistants. We spoke with two patients who had attended to use the improved access service. They told us the staff had been helpful in assisting them to access care at a time that was convenient and suitable for them.
- The service had initiated and continued to offer a community paramedic home visiting service for all five practices. If a patient requested a home visit, they were assessed by one of their own GPs and if they met the criteria, a paramedic practitioner would attend. They had remote access to patient notes and could undertake a full assessment of their immediate and ongoing care needs. If there were concerns regarding their health or care, the paramedic would discuss with the patients GP. Any social or environmental concerns

were referred to the proactive care lead and the integrated care team, who would follow up with the patient to ensure additional care or social needs were identified and actioned.

- We were shown data from the provider, which demonstrated the home visiting service interventions had prevented 25 hospital admissions, 66 Emergency department visits and 1430 GP callouts in the six months from January 2019 to July 2019 for patients feeling unwell with symptoms of a urinary tract infection. The majority of these were older patients (over 70 years of age). The service had enabled many patients to be treated in their own home and reduced the need for going to hospital or calling the GP to attend.
- Proactive case management service for patients from all five practices. The proactive care lead undertook searches of patients who had attended, or were still an in-patient, at a local hospital and undertook a risk assessment for each patient identified. Four identified patients per week were discussed at an anticipatory intervention meeting (AIM) which was attended by staff from the service (including a GP and the proactive care lead) and external services, such as dementia link practitioner and a mental health practitioner. The patients were then contacted by the proactive care lead to offer a home (or hospital) visit for an initial assessment. Any care or social needs identified from the assessment visit were escalated and co-ordinated by the integrated care team in liaison with the proactive care lead. We were shown case studies where the proactive care management service had demonstrated positive patient outcomes and had impacted on other services, such as a reduction in ambulance call outs, reduced Emergency Department admission/attendance and reduced GP appointments/call outs.
- The integrated care service offered patients a co-ordinated response to identified care needs. The provider had developed pathways of care with external stakeholders and could access rapid and joined up responses to developing crises or escalating need. Weekly meetings were held between the provider and external stakeholders such as social care, community health, community rehabilitation services, mental health teams and local voluntary organisation. The meetings enabled the provider to promote patient centred care by developing individual proactive anticipatory care plans. These plans were then shared with the GP service and external organisations such as the ambulance service and out of hours GPs.
- The intervention of the integrated care service had reduced hospital admissions and attendance. We were shown current unverified data which demonstrated the service was 13% below the national attendance rate for Emergency Department attendance and had a 9% reduction in the number of bed days. (Bed days is the term used to demonstrate bed availability and occupancy within hospital settings. It is a quarterly collection of the total number of available bed days and the total number of occupied bed days by consultant main specialty. A reduction in bed days demonstrates less demand on the hospital, which enables them to offer bed space to patients with more urgent needs).
- The provider was also pro-active in identifying patients who utilised services inappropriately and offered them solutions and options available for them, such as seeking the opinion of a pharmacist, dentist or self-care.
- The referral management service offered a peer review approach to all non-urgent and routine referrals from the five practices. The referral reviews enabled patients to be seen at the right place and at the right time for their needs. We were shown data by the provider that demonstrated 49% had been redirected (a referral made to another stakeholder from the original GP decision) and 8% had been upgraded to urgent or under the two week wait referral system. Overall there had been a reduction in referrals from GPs to secondary care by 17% and the Farnham services had a lower referral rate per weighted population compared to other areas within the clinical commissioning group.

Timely access to the service

Patients were able access care and treatment from the service within an appropriate timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment. The service had a number of
- Waiting times, delays and cancellations were minimal and managed appropriately. The same day appointment service was offered to patients from three of the five GP practices that made up the federation

between 8am and 6.30pm. All patients from the five practices could access improved access appointments between 6.30pm and 8pm Monday to Friday and on Saturday mornings.

- Patients with the most urgent needs had their care and treatment prioritised. Patients were assessed by their own surgery to ensure safety and appropriateness to be seen at the same day service. Patients with high priority needs were directed to their own GP practice or to emergency services.
- Patients reported that the access and appointment system was easy to use and they were seen within a reasonable timescale.

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 complaint policy and procedures in place. The service learned lessons from individual concerns, complaints and from analysis of trends. It acted as a result to improve the quality of care. For example, a review of referral processes and a meeting with an external stakeholder to discuss how referrals were received and actioned.

Good

Are services well-led?

We rated the service as good for leadership because:

There were clear governance structures and processes in place. We found some areas where these were inconsistently applied, and the provider told us they would review these after the inspection.

Leadership capacity and capability;

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Vision and strategy

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

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- The service developed its vision, values and strategy jointly with staff and external partners (where relevant).
- Staff were aware of and understood the vision, values and strategy and their role in achieving them
- The service monitored progress against delivery of the strategy.

Culture

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

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance that was not in line with the service vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. (Add examples as appropriate). The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management. However, governance arrangements for monitoring of some areas required a review.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective.
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and coordinated person-centered care.
- Staff were clear on their roles and accountabilities.
- Leaders had established proper policies, procedures and activities to ensure safety, although they had not assured themselves that they were operating as intended. For example, they had not ensured all clinicians (including locums) received patient safety and medicines alerts and recruitment documents were not reviewed effectively to identify any gaps in employment. In addition, cold chain daily checks had not been

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monitored and staff were not aware of appropriate escalation or fridge re-setting processes. The provider told us after the inspection refresher training had been undertaken by the appropriate staff.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance. However, we found these were inconsistently applied.

- There were processes in place to identify, understand, monitor and address current and future risks including risks to patient safety. However, the provider had not monitored or tracked blank prescription stationery through the service or monitored consent processes.
- The service had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change services to improve quality.
- The provider had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information which was reported and monitored, and management and staff were held to account
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- The service encouraged and heard views and concerns from the public, patients, staff and external partners and acted on them to shape services and culture. For example, patients from all five practices were consulted on the initiation of the service and asked for their views and opinions. They were invited to further discussion events, once the service was established, to consider the services offered and identify any additional needs for the population.
- The provider had a locality participation group, which comprised patients from some of the five practices. They worked with the provider to offer feedback about patient concerns and identify processes that required a review. They were also involved in publicity and patient communications, including newsletters.
- Staff could describe to us the systems in place to give feedback, such as feedback forms and verbal feedback, which was logged by the provider. We were shown how patient feedback had led to additional notices in the waiting room advising the same day service was undertaken on a “sit and wait” basis.
- We saw evidence of feedback opportunities for staff and how the findings were fed back to staff. We also saw staff engagement in responding to these findings. Staff newsletters were circulated monthly offering information about changes in process, updates on patient feedback and service delivery. The reverse of the newsletter included a staff feedback form where suggestions for improvements or observations of the service could be made and fed back to management. One example of feedback which had action taken, was the process for dealing with urine samples and testing.
- The provider held an annual away day for staff.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement.

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- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- There were systems to support improvement and innovation work. The provider encouraged ideas and suggestions from staff and patients to improve the service.
- There was a focus on continuous learning and improvement at all levels within the service. For example, feedback received on the home visiting service included a rating tool of how concerned the patient was by their overall health. If a negative score was reported, the patient was followed up by the pro-active care lead to identify any further areas of concern.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met…** Assessments of the risks to the health and safety of service users of receiving care or treatment were inconsistently carried out. In particular: • Blank prescription stationery was not tracked or monitored to prevent misuse. • Staff were unaware of escalation processes for fridge temperatures when they went out of range and there had been no oversight of the logs since February 2019.