# Curo Health Limited

## Inspection report

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

## Ratings

| Overall rating for this location | Inadequate |
|---|---|
| Are services safe? | **Inadequate** |
| Are services effective? | **Inadequate** |
| Are services well-led? | **Inadequate** |

# Overall summary

We carried out an announced focused inspection at Curo Health Limited on 25 May 2021. Overall, the provider is rated as inadequate.

Safe - inadequate

Effective – inadequate

Caring - not inspected or rated

Responsive - not inspected or rated

Well-led - inadequate

Following our previous inspection on 14 November 2019, the provider was rated requires improvement overall and for the key questions safe, effective and well-led, and good for caring and responsive. We issued a Requirement Notice for a breach of Regulation 17 – Good governance. The full report for the previous inspection on 14 November 2019 can be found by selecting the 'all reports' link for Curo Health Limited on our website at www.cqc.org.uk

**Why we carried out this inspection**

This focused inspection was carried out to follow-up on concerns and issues identified at our previous inspection on 14 November 2019. We inspected the key questions safe, effective and well-led. The ratings in relation to caring and responsive are carried forward from the inspection undertaken in 2019 and remain good.

**How we carried out the inspection**

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

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

This included:

- Conducting staff interviews using video conferencing
- Requesting evidence from the provider
- A site visit

As part of this inspection we interviewed by video conferencing the Chief Executive Officer (CEO), the Managing Director, the Finance Director, two GPs, one advanced nurse practitioner, three practice nurses, two healthcare assistants and four receptionists. On the day of the inspection we interviewed the Medical Director, the GP Clinical Lead, a GP working in the extended access service and both practitioners for the microsuction service.

**Our findings**

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

# Overall summary

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

**We have rated this provider as inadequate overall and inadequate for the key questions safe, effective and well-led.**

We found that:

- The provider was open and transparent about the challenges of the past year. The service had stepped-up during the pandemic to provide temporary primary care COVID-19 assessment sites to provide core GP services for COVID-19 diagnosed or suspected patients. In addition, the provider had collaborated to support Primary Care Networks (PCNs) and GP practices vaccinate registered patients and health and care staff.
- Patient feedback had been positive about the service in relation to access and care provided.
- The provider had not addressed the findings from our previous inspections, and we continue to have concerns in relation to leadership, governance, the management of risk and performance, and continuous improvement and learning to drive patient safety. In particular, there were gaps in systems and processes in relation to safeguarding, recruitment, premises and equipment oversight, incidents, patient safety alerts, staff induction, training and appraisals.
- There was limited evidence of quality improvement, including clinical audit.
- The provider had undertaken a staff survey, which showed positive feedback from all grades of staff in relation to working for the service and the support provided.
- Staff involved and treated people with compassion, kindness, dignity and respect.

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

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Establish clear systems and processes to keep patients safe and safeguarded from abuse.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out their duties.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.

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

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

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

**Dr Rosie Benneyworth** BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

## Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser.

## Background to Curo Health Limited

Curo Health Limited, established in January 2014, is a GP Federation serving the needs of the population of North Kirklees. The Federation is made up of all 27 general practices spanning four Primary Care Networks (PCNs) in the Kirklees Clinical Commissioning Group.

Curo Health Limited is responsible for delivering extended access services to patients from all participating GP practices; approximately 195,000 patients. The provider also operates a microsuction service to patients referred into the service from the 27 general practices. Microsuction is a wax-removal technique which uses a binocular operating microscope to look straight into the ear canal, wax is then removed from the ear canal using a suction device at low pressure.

The focus of this inspection was the extended access service, which has been operational since August 2018 and the microsuction service, which has been operational since November 2020.

Curo Health Limited's administrative centre operates from Woodkirk House, Dewsbury and District Hospital, Halifax Road, Dewsbury WF13 4HS and is led by a Medical Director and Managing Director (Co-Chair), Finance Director, six board members of whom four represent the PCNs and a Chief Executive Officer.

Patient care for the extended hours service is delivered at three locations in the district, which we visited during our inspection:

- Dewsbury Health Centre, Wellington Road, Dewsbury WF13 1HN
- Liversedge Health Centre, Valley Road, Liversedge WF15 6DF
- Broughton House Surgery, 20 New Way, Batley WF17 5QT

The extended access service is open between 6.30pm and 9.30pm Monday to Friday, between 9am and 4pm on Saturdays, between 9am and 1pm on Sundays and 10am to 2pm on Bank Holidays.

The extended access service at the three locations is provided by 13 GPs, five advanced nurse practitioners, three practice nurses, three healthcare assistants and 16 receptionists. Some staff work at multiple sites and some at one site. We saw that two receptionists were located at each of the three patient facing sites during operational hours.

At the time of our inspection there was no day-to-day Operations Manager in post and management and oversight was being shared by the Medical Director, Managing Director, Finance Director and CEO. The Lead Nurse position was vacant and a locum advanced nurse practitioner (ANP) is providing interim cover.

Patient care for the microsuction service is delivered at two locations in the district:

- Dewsbury Health Centre, Wellington Road, Dewsbury WF13 1HN
- Mirfield Health Centre, Doctor Lane, Mirfield WF14 8DU

We did not visit Mirfield Health Centre during this inspection but reviewed documentation as part of our review of premises.

The microsuction service is delivered by a trained healthcare assistant, supported by a qualified audiologist. At the time of our inspection the provider told us there was a vacancy for an Ear, Nose and Throat (ENT) clinical lead to oversee the microsuction service. Interim clinical oversight is provided by GPs on site at the locations where the service is delivered and the service's GP Clinical Lead.

Curo Health Limited is registered with the Care Quality Commission to the regulated activities diagnostic and screening procedures and treatment of disease, disorder or injury.

Inadequate

# Are services safe?

**At our inspection on 14 November 2019, we rated the service as requires improvement for providing safe care as the provider could not demonstrate that processes in relation to safeguarding, recruitment, and oversight of premises in relation to health and safety were sufficiently embedded and effective.**

**At this inspection, we found that the provider had not fully acted upon the findings of our previous inspection and we found ongoing concerns with safeguarding, recruitment and premises and equipment oversight. In addition, we found concerns in relation to medicines management, incidents, patient safety alerts and information to deliver safe care and treatment, for example the management of blood results and cervical screening samples.**

**We rated the provider as inadequate for providing a safe service.**

**Safety systems and processes**

Systems and processes in place to minimise risks to patient safety were not clearly defined and embedded.

- At our inspection in November 2019, we found that safeguarding policies did not provide guidance for staff in relation to key contacts within the organisation and wider locality. At this inspection, we found safeguarding policies did not clearly cite the safeguarding lead or include local safeguarding contact details. We interviewed 16 staff and found 10 did not know who the safeguarding children and safeguarding adult lead was.
- At our inspection in November 2019, we found systems for maintaining oversight of staff safeguarding training were not sufficiently thorough. At this inspection, we found there were gaps in the recording of safeguarding training for clinical and non-clinical staff in line with guidance. We reviewed 12 staff files and found five did not have a record of safeguarding children training and four did not have a record of safeguarding adult training.
- We found there was variation in how staff told us they would report a safeguarding concern, which suggested roles and associated responsibilities in relation to policies, procedures and guidance to prevent abuse were not sufficiently embedded.
- There had been no safeguarding meetings, including any partnership meetings with other relevant bodies to contribute to individual risk assessments or reviewing outcomes for people using the service in the past 12 months. There had been no safeguarding children or adult referrals in the past 12 months.
- At our inspection in November 2019, not all staff providing chaperone duties had received formal training or a Disclosure and Barring Service (DBS) check. 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. At this inspection, the provider was still unable to demonstrate that all staff acting as a chaperone had completed formal training or had a DBS check. We reviewed the training records for all 16 reception staff and found the provider could only demonstrate that five staff had undertaken chaperone training. However, staff we spoke with were able to describe their role and responsibility when chaperoning. Staff identified as chaperones wore a badge to that effect. We saw that notices were displayed at the three host sites to advise patients that a chaperone service was available, if required.
- At our inspection in November 2019, we found gaps in recruitment records. At this inspection, the provider could not demonstrate that appropriate recruitment procedures were in place. We reviewed 12 staff recruitment files and we found gaps in the recording of proof of identity, DBS checks, application form or curriculum vitae to demonstrate full employment history, interview summaries and appropriate medical indemnity.
- There was no system in place to record the immunisation status of staff in direct patient contact, in line with guidance. We reviewed 12 staff recruitment files and found no recorded immunisation status for 10 staff and partial status for one staff member.

Inadequate

# Are services safe?

- The extended access service operated from three host GP practices and the microsuction operated from two host GP practices. On the day of the inspection we visited three sites and observed the premises to be clean and tidy. We saw that the provider had undertaken an Infection Prevention and Control (IPC) audit at one site in December 2020 and at two sites in May 2021, by the Interim IPC Lead. Not all staff we spoke with knew who the IPC lead was. We reviewed training records and found the provider could not demonstrate that all staff had completed IPC training in line with guidance. Staff we spoke with knew how to access bodily fluid spill kits and described processes to clean rooms between patients. All staff had access to appropriate Personal Protective Equipment (PPE).
- The arrangements for managing waste and clinical specimens at the host sites kept people safe.
- At our inspection in November 2019, there was no formal systems and processes to oversee documentation relating to the premises and equipment safety at the host sites. After the inspection the provider told us they would implement a formal system to review health and safety, including IPC and fire safety at the host sites on a quarterly basis and report outcomes at Board meetings. At this inspection the provider told us these processes had not been implemented.
- We reviewed health and safety documentation for the host sites which included maintenance records and risk assessments and found gaps in relation to follow-up of some risk assessment findings. We saw the cleaning company had undertaken a Control of Substance Hazardous to Health (COSHH) risk assessment for cleaning products. However, the provider had not undertaken a COSHH risk assessment of any hazardous substances used or created by the service's activities.
- We saw that the provider had undertaken a premises check at two sites in April and May 2021 and had actioned some findings, for example, to commence a monthly check of emergency equipment. We reviewed equipment and consumables on the day of the inspection and found some consumables to be out of date. The medical equipment we reviewed on the day had been maintained according to manufacturer's instructions. The provider told us that some clinical staff used their own medical equipment but there was no mechanism in place to check this equipment was maintained in line with guidance.
- The provider could not demonstrate that all staff had undertaken fire awareness training. Staff we spoke with knew the location of the fire evacuation assembly point but there had been no formal evacuation training.
- We saw that the provider had acted on a recommendation from our previous inspection with regards to additional outside lighting to ensure staff and patient safety.

**Risks to patients**

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

- There were arrangements for planning and monitoring the number and mix of staff required for the service. Arrangements were in place for ensuring that this requirement was fulfilled and took account of holidays, sickness and busy periods. We saw evidence that rotas were planned ahead.
- The number and times of consultations were fixed, in line with the provider's contract. There were no walk-in or non-pre-booked appointments. Consequently, there was no requirement for any system for dealing with surges in demand.
- At our inspection in November 2019, we found staff induction processes were not sufficiently thorough and not all staff had received an induction relevant to the site at which they were based. At this inspection, we found the provider had a formal induction policy in place but had failed to follow their own procedures. We reviewed 12 staff recruitment files and found no documented formal induction for seven clinical staff and two non-clinical staff. This included the inclusion of the Care Certificate Standards for healthcare assistants.
- The service was equipped to deal with medical emergencies (including suspected sepsis) at all host sties. There was oxygen and a defibrillator at each location. At one site we found only adult oxygen masks available and no warning signage on the door where oxygen was stored. We saw that the provider had recently initiated a system to ensure emergency equipment was checked and fit for use.

Inadequate

# Are services safe?

- The provider could not demonstrate that all staff were suitably trained in emergency procedures, including basic life support, in line with guidance.
- Clinicians we spoke with knew how to identify and manage patients with severe infections including sepsis. Receptionists we spoke with told us they would speak with the duty GP if they encountered a deteriorating or acutely unwell patient. However, there was no sepsis protocol in place and there was no record of sepsis awareness training for staff.
- The service had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. We saw emergency contact details were available for staff at the host locations.
- The provider held a risk register for both their extended access and microsuction services. We saw that all identified risks had been assessed to define the level of risk by considering the category of probability against the category of impact on the service. All risks had been allocated a RAG (red, amber, green) rating based on this assessment. The provider told us the risk registers were in place to identify and highlight where changes and improvements were needed, to ensure mitigating actions were in place and undertook at corporate and operational level. It was unclear how often the risk registers were reviewed and how effective they were, as we identified gaps in some procedural activities which had been identified on the risk registers. For example, a weekly task to check medicines and prescription stationery had been on the risk register since November 2020 as a high priority. However, we found some medicines to be out of date and the process to log and record prescription stationery had not commenced at one location.

**Information to deliver safe care and treatment**

There were gaps in some systems and processes to ensure staff had the information they needed to deliver safe care and treatment to patients.

- We reviewed some individual care records and found they were written and managed securely and in line with current guidance and relevant legislation.
- The provider had Information Commissioner's Office (ICO) registration in place.
- The same clinical system was used for all practices within the federation, so clinicians had access to patient information to enable them to deliver safe care and treatment.
- Referral letters contained specific information to allow appropriate and timely referrals.
- There was no formal documented approach to ensure the management of blood test results in a timely manner, particularly when requesting clinicians were absent.
- There was no failsafe system or processes for safety-netting cervical screening undertaken at the service. The provider did not monitor that a result was received for each cervical screening sample undertaken by their sample takers and sent for pathology.
- There were no clear referral guidelines into the microsuction service in line with the provider's clinical protocol to ensure the referring GP had assessed the patient prior to referral for microsuction and screened for contraindications.

**Appropriate and safe use of medicines**

There were gaps in systems to ensure appropriate and safe handling of medicines.

- Clinical staff we spoke with prescribed medicines to patients and gave advice on medicines in line with current national guidance.
- The provider had not undertaken any formal audits of the service's prescribing, for example, hypnotics, controlled drugs and high-risk medicines, including prescribing by the non-medical prescribers.

Inadequate

# Are services safe?

- The service had undertaken a review of antibiotic prescribing between February and June 2020 and July and December 2020 for a random sample of clinicians' as part of a wider clinical notes review. However, the provider had not undertaken a formal audit of all antibiotic prescribing by the GPs and non-medical prescribers.
- The service held appropriate emergency medicines at each site and had recently initiated a system to monitor stock levels and expiry dates. However, during a site visit, we found one medicine to be out of date.
- The service did not hold or administer any medicines which required refrigeration. At the time of our inspection the service did not undertake immunisations in the extended access service.
- The service did not dispense any medicines and did not hold any controlled drugs.
- At our inspection in November 2019, we saw that systems for storing and logging prescription stationery was not consistently applied across all sites. At this inspection, we found prescription stationery was securely stored at all sites. A system to log prescription stationery at the host sites had recently been implemented but at one site the logging system had not commenced.

**Track record on safety**

The provider could not demonstrate fully developed safety systems were in place

- We were not assured that the service monitored and reviewed information from a variety of sources to demonstrate a comprehensive approach to learning and quality improvement.
- The provider had failed to act on the findings from our previous inspection in relation to good governance and we continued to have concerns that safeguarding, recruitment, and oversight of premises in relation to health and safety were not sufficiently embedded and effective.
- There were gaps in systems and processes to report and respond to incidents and critical incidents/near misses to allow reflection and learning and so improve patient care.
- There was no system in place for receiving and acting on patient safety alerts.
- There was limited evidence of quality improvement, including clinical audit.

**Lessons learned and improvements made**

- The provider could not demonstrate an effective system to report, share, investigate, record and respond to incidents and critical incidents/near misses. There was an incident policy in place but there was a variation in staff's understanding of the process to report an incident. From our conversations with staff and review of documentation submitted as part of the inspection process, we found some examples of events which could have been used to allow reflection and learning and so improve care. The provider discussed incidents at monthly operational meetings for senior staff, but there was no formal and consistent system in place to share outcomes with all staff.
- The leadership team demonstrated their awareness of notifiable incidents under the duty of candour (a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The service had only recorded one significant event in the past 12 months, so it was not possible to assess if the provider complied with the duty of candour.
- There was a duty of candour policy in place but not all staff we spoke with understood the term duty of candour. The provider had identified duty of candour training as recommended for all staff but could only demonstrate that one member of the management team had completed this training.
- The provider could not demonstrate an established system and process to receive, review and act on Patient Safety Alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS) relevant to the service.

Inadequate

# Are services effective?

**At our inspection on 14 November 2019, we rated the service as requires improvement for providing effective services as the provider could not demonstrate that processes in relation to clinical audit, staff training, induction and appraisals were sufficiently embedded and effective.**

**At this inspection, we found the provider had not acted upon the findings of our previous inspection and we continue to have concerns in relation to quality improvement, including clinical audit, induction, staff training and appraisals.**

**We have rated the provider as inadequate for providing an effective service.**

**Effective needs assessment, care and treatment**

- We spoke with clinicians and reviewed some clinical records and found from those reviewed that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance.
- We saw no evidence of discrimination when making care and treatment decisions.
- The provider could not demonstrate an effective system and process to keep clinicians up to date with current evidence-based practice. There were no clinical meetings or bulletins in place as a way to cascade information.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- Reception staff knew to contact the duty GP for any patients presenting with high-risk symptoms, such as chest pain or difficulty in breathing.

**Monitoring care and treatment**

The provider did not have a comprehensive programme of quality improvement activity, including clinical audit to monitor outcomes of care and treatment.

- The service served a patient population of approximately 195,000 registered at 27 GP practices. The service was commissioned to provide an extended access service from three locations on Monday to Friday 6.30pm to 9.30pm, on Saturday from 9am to 4pm, on Sunday from 9am to 1pm and Bank Holidays from 10am to 2pm. All sessions were led by a GP or advanced nurse practitioner (ANP). Some extended access sessions were supported with practice nurse appointments providing cervical screening, simple wound care and long-term condition review. Healthcare assistant appointments provided access to phlebotomy services.
- There was limited evidence of quality improvement to monitor and improve the quality and safety of the service. There was no systematic programme of clinical audit, including prescribing audits. There was limited evidence of audits in the past two years.
- The GP Clinical Lead had undertaken a clinical consultation review between February and June 2020 and July and December 2020 for a random sample of clinicians, which included antibiotic prescribing. Feedback was shared with the individual GPs but not used as part of wider learning with clinical staff. We saw some findings could have been recorded as an incident to further drive learning, quality improvement and patient care.

**Effective staffing**

The provider could not demonstrate effective systems and processes to ensure that staff had the skills, knowledge and experience to carry out their roles.

Inadequate

# Are services effective?

- At our inspection in November 2019, the provider could not demonstrate that staff had received an induction. At this inspection, we found there was no consistent formal induction programme for new staff, including locum staff, which prepared them for their role. This included the inclusion of the Care Certificate Standards for healthcare assistants. We reviewed 12 staff recruitment files and found no documented formal induction for seven clinical staff and two non-clinical staff.
- At our inspection in November 2019, the provider could not demonstrate that all staff had completed core training. At this inspection, the provider could not demonstrate an effective system to record training of individual staff members at the start of their employment and there were no processes in place to ensure that training was up to date in line with guidance. The provider had identified a schedule of mandatory training which included safeguarding children and adults, chaperoning, Mental Capacity Act (MCA), infection prevention and control (IPC), basic life support (BLS), data security awareness, fire awareness, health and safety and equality and diversity. However, the provider was unable to demonstrate that the majority of its staff had undertaken this training. Staff we spoke with told us that they had undertaken some training in their daytime employment within GP practices. However, the provider did not have an effective system in place to capture this.
- The provider could not demonstrate how they ensured role-specific training was in place and up-to-date in line with guidance, for example cervical screening competency training and updates for the practice nurses.
- The provider could not demonstrate that clinical protocols were in place aligned to all the roles of responsibilities of its nursing staff. The provider showed us a clinical protocol for cytology and phlebotomy, but staff told us they also undertook wound care and some long-term condition reviews. Staff we spoke with told us they would seek support from the GP on site, if required.
- At our inspection in November 2019, the provider told us they had plans to initiate appraisals for staff employed within the service. At this inspection, we found the provider could not demonstrate an effective system of regular appraisal of staff performance including how training, learning and development needs were identified, planned for and supported. We reviewed 12 staff recruitment files, of which six staff had been employed for more than a year, and none had a documented formal appraisal.

**Coordinating care and treatment**

Staff mostly worked together and with other health and social care professionals to deliver effective care and treatment.

- Staff working at the service had access to each patients' full clinical record. All practices whose patients accessed the service shared a common clinical system. Staff were able to view correspondence within the record, order further tests or make referrals when appropriate.
- Information was relayed to patients' own GP via the clinical system.
- Patients with vulnerability factors were identified via a 'flagging' system on the patient record and could be viewed by staff.
- We saw that details were entered into the patients' electronic record at the time of the consultation.
- There were arrangements in place for booking appointments. All appointments were pre-booked by the patient's own GP practice and NHS 111. There were no walk-in patients.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs. Staff also referred patients back to their own GP to ensure continuity of care, where necessary.
- There was a system in place to monitor urgent two-week wait referrals and this was demonstrated at our inspection.
- There was no failsafe system for safety-netting cervical screening samples sent for pathology.

**Helping patients to live healthier lives**

As an extended access service, the provider was not able to provide continuity of care to support patients to live healthier lives in the way that a GP practice would. However, we saw the service demonstrate their commitment to patient education and promotion of health and well-being advice.

Inadequate

# Are services effective?

Staff we spoke with demonstrated a knowledge of local and wider health needs of patient groups who may attend the extended access services. Clinicians told us they offered patients general health advice within the consultation and if required they referred patients to their own GP for further information.

Where patients need could not be met by the service, staff redirected them to the appropriate service for their needs.

**Consent to care and treatment**

The service obtained consent to care and treatment in line with legislation and guidance but there were no systems in place to monitor this process.

- Clinicians we spoke with understood the requirements of legislation and guidance when considering consent and decision making.
- We saw that Mental Capacity Act (MCA) training was included as part of the mandatory training schedule. However, the provider could not demonstrate that all staff had undertaken the training.
- We reviewed a sample of microsuction consultations and saw that verbal consent was sought and recorded in the clinical system. The practitioners told us they discussed with patients any potential side effects or contraindications prior to the procedure and recorded this in the clinical notes. However, the service did not have a formal patient information leaflet, which included consent and aftercare, signed by the patient.
- The provider did not have any system in place to monitor the process for seeking consent appropriately.

Inadequate

# Are services well-led?

**At our inspection on 14 November 2019, we rated the provider as requires improvement for being well-led because systems to oversee health and safety issues at all sites and staff recruitment were not sufficiently embedded and policies and procedures were not effectively operating to support staff and patient safety.**

**At this inspection, we found the provider had not acted upon the findings of our previous inspection and we found ongoing concerns in relation to leadership, governance, the management of risk and performance and continuous improvement and learning to drive patient safety.**

**We have rated the provider as inadequate for providing a well-led service.**

**Leadership capacity and capability**

- The provider was open and honest about the challenges of the last year with staff changes and stepping-up to deliver patient care during the pandemic.
- At the time of our inspection (25 May 2021), there had been no operations manager in post since March 2021 and day-to-day operational management and oversight was being shared by the Medical Director, Managing Director, Finance Director and CEO. There was a locum Advanced Nurse Practitioner (ANP) providing interim nurse and infection prevention and control (IPC) lead cover.
- Not all staff we spoke with knew who all the current designated leads were.
- Although staff did not have access to managerial support in person during operational hours, they were able to access support by telephone, if needed. Staff had been provided with contact details.

**Vision and strategy**

The provider had a vision, values and a strategy to achieve its priorities. However, deficiencies in governance and oversight undermined the provider's ability to achieve their vision.

- The provider told us that their vision was, 'to be recognised as the leading GP provider network, run by clinicians for the benefit of our local population'. This was underpinned by their objectives: 'to be recognised as a centre of excellence for service delivery; to develop outstanding services with primary care at the heart of the integrated care delivery system; to be the organisation that staff strive to work for; to develop community pathways of care that meet the care and wellbeing needs of the local population; and to generate sustainable services that maintain and sustain general practice'.
- We found that there was a lack of oversight in key areas relating to monitoring and management of risk to patient safety and gaps in governance structures all of which had the ability to compromise the quality of care provided by the service and impact on its vision, values and strategy.
- Not all staff we spoke with were aware of the vision or strategy.

**Culture**

There were gaps in systems and processes which impacted on the ability for the provider to drive and effectively support a culture of high-quality sustainable care.

- The provider had implemented some measures to ensure the safety and well-being of all staff. For example, there were two non-clinical staff working at each location at all extended access sessions. Staff told us they felt safe and supported. The provider had also acted on some findings of our previous inspection and added additional lighting outside the premises for staff safety.

Inadequate

# Are services well-led?

- The provider had undertaken a staff survey in November 2020. We saw that 41 staff had responded to the survey, which included GPs, nurses and non-clinical staff. Feedback was very positive in relation to being happy working at the service, feeling supported and being informed about the service. Staff told us they had recently been asked directly about their wellbeing since the changes in the management team. The provider told us they planned to repeat the formal staff survey.
- For the most part, staff told us they enjoyed working for the service and felt supported by the team working in their location. For staff who only worked at only one location there was limited contact with other colleagues in the organisation and not all staff had met all the management team and leads.
- The management team were aware of the requirements of the duty of candour. There was a duty of candour policy in place but not all staff we spoke with understood the term duty of candour. The provider had identified duty of candour training as recommended for all staff but could only demonstrate that one member of the management team had completed this training.
- The provider had a whistleblowing policy in place which referenced a Freedom to Speak Up Guardian but did not name them. Not all staff we spoke with knew who the Freedom to Speak Up Guardian was.
- Staff told us that although they were not discouraged to raise concerns and incidents they were also not encouraged and there was variation in the way staff told us they would raise a concern. However, staff we spoke with told us they could and would raise concerns and felt they would be supported if they did so.
- There had been a lot of recent management changes at the organisation and not all staff we spoke with knew who all the current designated leads were. Staff told us they had been provided with contact details of who to contact during operational hours.
- The provider could not demonstrate that processes for providing all staff with the development they need, including induction and regular appraisal were not embedded.
- The provider had identified equality and diversity training as mandatory but could not demonstrate that all staff had completed this.

**Governance arrangements**

Although there was an overarching organisational governance framework in place this was not implemented adequately to ensure the delivery of good quality care.

- At our inspection in November 2019, we found systems and processes to ensure effective governance were not sufficiently embedded. The provider submitted an assurance in the form of an action plan that all issues had been addressed. At this inspection, we found the provider had not acted upon the findings of our previous inspection and we remained concerned that systems and processes were failing to ensure effective care and to drive quality improvement. In particular, we found concerns around safeguarding, recruitment, incidents, patient safety alerts, staff inductions, training and appraisal, and an overall lack of clinical monitoring and audits.
- There had been some recent organisation and operational changes and oversight of day-to-day management of the service.
- There were policies and procedures in place but some of these were generic and did not include leads. We found the provider did not always follow their own procedures, for example recruitment and induction.
- We saw that policies were available at all host sites. The provider had invested in a Quality Compliance System (QCS) which held their policies and procedures and enabled the service to know that staff had accessed and read them. However, not all staff we spoke with were aware of this system.
- The service held fortnightly operational meetings and monthly board meetings. There was no formal staff meeting structure, including clinical meetings, or staff bulletins to effectively keep staff informed of safety and quality outcomes, for example, incidents, alerts, audits, clinical guidance updates and complaints. The provider told us they updated staff via email, but we found gaps in staff knowledge, for example, the current operational structure which suggested this was not effective.

Inadequate

# Are services well-led?

- Not all staff we spoke with were clear on some lead roles and responsibilities, for example, safeguarding, infection prevention and control and the Freedom to Speak Up Guardian.

**Managing risks, issues and performance**

We were not assured that there were effective structures, processes and systems in place which included appropriate accountability and oversight to support performance and identify, manage and mitigate current and future risk.

- There were gaps in systems and processes to manage current and future performance.
- There was no programme of quality improvement, including clinical audit to drive quality of care and outcomes for patients.

**Appropriate and accurate information**

- There were gaps in the provider's operational systems and processes which had impacted on the provider's ability to identify, manage and mitigate risk.
- The service submitted data or notifications to external organisations, including the Care Quality Commission, as necessary.
- Arrangements for data security, patient confidentiality and data management systems were appropriate.

**Engagement with patients, the public, staff and external partners**

- The provider continued to contribute to the local health agenda and work in partnership with local NHS trusts, council, voluntary sector and other commissioned providers to deliver patient care. The provider worked in alliance with other health care providers to delivery services in the community.
- The provider engaged with the local Clinical Commissioning Group (CCG), attended monthly contract meetings and provided a monthly delivery and performance report, which included utilisation of the service and quality assurance updates, for example, complaints, incidents and patient survey feedback.
- A staff survey had been carried out in November 2020 which showed positive feedback from all grades of staff in relation to working for the service and the support provided. The provider planned to undertake a further formal survey as there had been some recent staff and management changes.
- The service obtained feedback from patients for the extended access service and microsuction service in the form of a formal patient survey, complaints and direct feedback during clinical encounters.
- The service had commenced a patient survey for the microsuction service. We reviewed 10 surveys responses which described the service as efficient and excellent and staff as friendly. The provider told us the miscrosuction patient survey was ongoing
- We reviewed the outcome of a patient survey for the extended access service undertaken in September and October 2020 and found very positive patient feedback about access to the service and care provided at all sites. We found, based on 207 responses, that:
- 70% of respondents rated the care they received as excellent and 28% as good.
- 100% of respondents said they would recommend the service.
- 100% of respondents said they would use the service again in the future.
- 95% of respondents accessed their appointment through their GP and 5% through NHS 111.
- 51% of respondents said it was very easy to book an appointment and 33% said it was easy.
- 33% of respondents said they would have gone to accident and emergency (A&E) if they had not been able to access their appointment, 11% said they would have contacted a GP Out of Hours Service, 44% would have waited for an appointment at their normal GP practice, 3% would have gone to a pharmacy and 9% would have ignored their health problem.

**Continuous improvement and innovation**

Inadequate

# Are services well-led?

- The provider had stepped-up during a difficult year to provide temporary primary care COVID-19 assessment sites to provide core GP services for COVID-19 diagnosed or suspected patients. The provider had also collaborated to support Primary Care Networks (PCNs) and GP practices to vaccinate registered patients and health and care staff.
- The provider described their vision and strategy to achieve their priorities. However, deficiencies in governance and oversight undermined the provider's ability to achieve their vision.
- We found concerns with good governance to underpin quality and continuous improvement. The provider could not demonstrate a comprehensive approach to quality improvement and did not routinely review the effectiveness and appropriateness of care provided. There was no programme of continuous clinical audit and there was limited learning from incidents.

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 were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br>**The provider did not have clear systems and processes in place to keep patients safe and safeguarded from abuse.**<br>• The provider could not demonstrate that roles and associated responsibilities in relation to policies, procedures and guidance to prevent abuse were sufficiently embedded. We found not all staff knew who the safeguarding lead was, and safeguarding policies and procedures did not contain key contacts within the organisation and wider locality.<br>• The provider could not demonstrate that all staff had received safeguarding training in line with Intercollegiate Guidance.<br>• The provider could not demonstrate that safeguarding meetings, including any partnership meetings with other relevant bodies to contribute to individual risk assessments or reviewing outcomes for people using the service, had been carried out.<br>**This was in breach of Regulation 13(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>**The provider had not ensured that staff had received the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities.**<br>• The provider was unable to demonstrate that staff had received an induction which prepared them for their role, including the inclusion of the Care Certificate Standards for Healthcare Assistants. |

This section is primarily information for the provider

# Requirement notices

- The provider was unable to demonstrate that staff had undertaken core and role-specific training.
- The provider was unable to demonstrate clinical protocols were in place and aligned to all the roles of responsibilities of its nursing staff
- Staff had not received a regular appraisal of performance including how training, learning and development needs were identified, planned for and supported.

**This was in breach of Regulation 18(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br>• The provider was unable to demonstrate that appropriate recruitment checks had been undertaken to ensure staff were fit and of good character, with the necessary qualifications, skills and experience for their role.<br>**This was in breach of Regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** |

This section is primarily information for the provider

# Enforcement actions

## Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>**There was a lack of systems and processes established and operated effectively to ensure compliance with the requirements to demonstrate good governance.**<br><br>• The provider had failed to establish and operate systems and processes to effectively prevent abuse of service users.<br>• The provider had failed to establish and operate an effective recruitment process to ensure staff were fit and of good character, with the necessary qualifications, skills and experience for their role.<br>• The provider had failed to establish an effective system and process to record the immunisation status of staff in direct patient contact in line with guidance.<br>• The provider had failed to establish an effective induction programme for staff which prepared them for their role, including the inclusion of the Care Certificate Standards for healthcare assistants.<br>• The provider had failed to establish an effective system to record training of individual staff members at the start of their employment and have processes in place to ensure that training was up to date and in line with guidance<br>• The provider had failed to establish an effective system of regular appraisal of staff performance including how training, learning and development needs were identified, planned for and supported.<br>• The provider had failed to establish an effective system and process to report, share, investigate, record and respond to incidents and critical incidents/near misses.<br>• The provider had failed to establish a system and process to receive, review and act on Patient Safety Alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS) relevant to the service. |

This section is primarily information for the provider

# Enforcement actions

- The provider had failed to establish an effective system and process to ensure blood test results were reviewed in a timely manner, in particular when the requesting clinicians were absent.
- The provider had failed to establish a failsafe system and process for safety-netting cervical screening samples undertaken at the service.
- The provider had failed to establish an effective system and process to distribute and discuss updated clinical guidance with staff.
- The provider had failed to establish effective systems and processes to assess, monitor and improve the quality and safety of the service. There was no systematic programme of clinical audit, including prescribing audits. There were limited quality improvement activities in the past two years.
- The provider had failed to establish an effective system and process to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users at the host sites.
- The provider had failed to establish a structured and effective communication system to keep staff informed and to discuss safety and quality outcomes, for example, incidents, alerts, audits, clinical guidance updates and complaints. There was no formal meeting structure, including staff or clinical meetings.
- The provider had failed to establish clear referral guidelines into the microsuction service in line with their own clinical protocol.

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