Circle Clinical Services Limited

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Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 20 September 2018 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this service was providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this service was providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this service was providing responsive care in accordance with the relevant regulations.

Are services well-led?

We found that this service was providing well-led care in accordance with the relevant regulations.

Our key findings were:

- There were systems in place to keep patients safe and safeguarded from abuse.
- Risks well managed at the main Hub site we visited. The service recognised more assurances were required to ensure safety at other sites where care was also being delivered.
- Incidents were acted on and used to support learning.
- We visited only one of the 12 patient hubs which was located in a purpose-built health centre and appeared visibly clean and well maintained.
- There were systems in place to support infection, prevention and control and for managing the safety of equipment.
- The service did not dispence medicines but arrangements to manage emergencies and emergency medicines were in place.
- Appropriate processes were in place for the recruitment of staff. Staff were supported with their learning and development needs and had access to training and regular appraisals

Summary of findings

- There was evidence of audits undertaken to ensure the quality of service.
- Patient information was shared as appropriate with relevant health and care professionals involved in the patients care and treatment and patients were informed.
- Feedback from people about the service they received was positive. People who had used the service felt involved in decisions and said that they were treated with dignity and respect.
- There was a complaints process in place and available on the provider website.
- There were established governance arrangements and strong leadership to support the running of the service. Meetings were held at various levels to review service quality.
- There was a strong focus on continuous learning, improvement and innovation at all levels of the organisation.
- The service had a fixed term five-year contract with the CCGs and had been able to demonstrate increased activity whilst demonstrating savings for the CCGs. This was achieved through various means such as service re-design (innovative patient pathways) involving a multidisciplinary team, increased community provision and innovative technology.

There were areas where the provider could make improvements and should:

- Review processes to gain assurance that all hub sites can deliver safe care.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Circle Clinical Services Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Circle Clinical Services Limited have contracts with Bedfordshire and Greenwich CCGs to deliver a fully integrated system of care for patients with musculoskeletal issues. This includes bone, muscle, and tissue conditions; and associated pain; physiotherapy, podiatry, community triage, orthopaedic surgery, rheumatology and chronic pain under the NHS Prime Service Provider.

Patients are referred by their GPs to the service which then reviews them and directs them for treatment through appropriate care pathways. The service acts as a single triage point and a single patient hub, subcontracting with all the other providers, and offering patients choice over which provider they go to. Patients are directed to one of 21 secondary care locations of their choice or to one of 19 community therapy locations. The service also delivers care at one if its 12 community hub locations where appropriate. During this inspection we were only able to visit the main hub located in the Enhanced Services Centre, Kimbolton Road, Bedford. The service is located on the first and second floor of a purpose-built premises with lifts available for those patients that used a wheel chair.

The service serves a population of 440,000 in Bedfordshire CCG and 276,000 in Greenwich CCG. The clinical team consisted of a multidisciplinary team of physiotherapists, extended scope physiotherapists, GPs with special interests, sport and exercise medicine consultants, pain consultants, orthopaedic consultants, rheumatology consultants, spinal consultants, pain nurses, clinical psychologist and healthcare assistants. Some of the consultants worked on 'practicing privileges' where permission is granted through legislation to work in an independent hospital clinic. The clinical team is supported by a team of administration staff including patient choice advisors, quality and contracts management, GP liaison as well as the governance and service transformation team.

The service is registered to provide the regulated activities of diagnostic and screening procedures, surgical procedures and treatment of disease, disorder or injury.

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The director of operations 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

When we visited the service on the 20 September 2018 the inspection team consisted of a lead CQC inspector, a GP Specialist advisor and a nurse specialist advisor to CQC.

Before visiting, we reviewed information we gathered from the provider through the provider information return and other information we hold about the service. During the inspection we spoke with clinical staff including:

- Lead GP with special interest and chairman
- Head of Clinical Services

Detailed findings

- Musculoskeletal Physicians
- Physiotherapists
- Governance and quality lead and operations lead as well as other administration staff

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 27 completed comment cards where people who used the service shared their views and experiences of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

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. 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. Policies were regularly reviewed and were accessible to all staff, including locums. They outlined clearly who to go to for further guidance. We saw evidence that a safeguarding referral was made in February 2017; although this was not substantiated following review, it demonstrated that the service acted appropriately following concerns.
- 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. 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 files we looked at showed all staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check. The service also had some consultants working through 'practicing privileges' (permission granted through legislation to work in an independent hospital clinic). Records we looked at demonstrated that appropriate recruitment checks had been in place including qualifications and DBS checks.
- There was an effective system to manage infection prevention and control. The provider had contracts with Bedford and Greenwich CCGs to provide musculoskeletal services. There were two main hubs, one based in Bedford and another in Greenwich. The hubs were located in large healthcare centres managed by NHS Property Services. Many of the staff were based in the hub building including management staff. Patients were seen at the main hub buildings as well as 10 other hub locations which were generally rented spaces in existing GP practices. The service was able to demonstrate that legionella testing had been carried out at the main hub sites. The service sought assurances from other sites on several matrices (health and safety, infection control and fire risk assessments etc.) to ensure these sites were suitable and safe. For example, we were told that all sites had been inspected by the CQC and had been rated 'good' and used this as an indicator of having appropriate safe systems in place. However, the service did not specifically seek assurances regarding legionella testing. The management staff told us this would be included going forward during the inspection.

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 within the hub building. The service provided a musculoskeletal service and generated body fluids (joint aspirates) which was disposed of appropriately. Waste generated at the other sites were managed appropriately through existing waste management processes.

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 service had systems in place to review demand for each site daily and could realign resource to sites where there was more demand.
- There was an effective induction system for agency staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. The service had carried out a mock incident, testing out the emergency response procedures and learning was shared with staff; a report was also sent out to senior managers and the management board.

Are services safe?

- They service knew how to identify and manage patients with severe infections, for example sepsis. We saw evidence of sepsis training for staff.
- The service held emergency medicines in the hubs and we saw that most medicines were held. The service did not stock a sugar gel for the for the treatment of hypoglycaemia, a medicine used to relieve chest pain and another medicine for treatment of myocardial infarction. The service told us that they had followed guidance on this and according to their interpretation they did not need to stock these medicines. Following the inspection, the service informed us that they sought further guidance from the Resuscitation Council UK and had decided to stock sugar gel but not the other medicines. Evidence submitted to us demonstrated that the service had considered the risks of not stocking these medicines.
- The service held emergency equipment including a defibrillator and oxygen. Records seen showed these were checked weekly to ensure they were in working order.
- 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

Relevant staff files we looked at demonstrated that professional indemnity for clinical staff were in place and records of staff immunisations were maintained.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. The electronic patient record used by the service was the same as the ones used by the patients GPs in the CCG areas. Therefore, the service had access to patients NHS medical records and could also contribute to this following any test or treatment.
- The service had a system in place to retain medical records in line with DHSC guidance
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance. Information provided by the service showed that 87% of its referral were through the eReferral (electronic) process. Data provided by the service showed that all referrals were triaged within 24 hours to ensure patients received timely and appropriate care within the last 12 months.

Safe and appropriate use of medicines

The service had reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, including emergency medicines and equipment minimised risks. The service did not dispence any medicines; where The medicines were prescribed to patient for their musculoskeletal condition their GPs were advised through the record system.
- The service had a contract with Bedford and Greenwich CCG to deliver the musculoskeletal service and these were through referral from the patients GP. All were NHS patients and the service had access to the same patient record system to verify patient's identity.

Track record on safety

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues. However, this was for the two main hub premises. The service delivered care and treatment in 10 other locations which were rented rooms from NHS GP services. The managers told us that they had sought assurances from these practices through several matrices. The explained that all the services had been rated by the CQC as Good or above.
- 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.

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. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.

Are services safe?

- There was an electronic system for reporting, reviewing and investigating significant events when things went wrong. The service learned and shared lessons; identified themes and acted to improve safety in the service. The service produced regular newsletters for staff and learning was communicated through this. For example, the service recorded 40 incidents at the Greenwich site and 49 at the Bedford site. The overriding themes of the reported incidents across the service was communicated and included access, appointments, admissions well as transfer and discharge. The service transformation team were supporting and reviewing processes to drive improvement. We saw evidence where posters were used to communicate learning of incidents and complaints to staff members monthly.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents
- The service gave affected people reasonable support, truthful information and a verbal and written apology
- They kept written records of verbal interactions as well as written correspondence.
- The service acted on and learned from external safety events as well as patient and medicine safety alerts. There was evidence that learning from incidents were reviewed and shared with staff monthly.
- The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.

Are services effective?

(for example, treatment is effective)

Our findings

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 relevant to their service. The service assessed needs and delivered care in line with relevant and current evidence based guidance and standards such as the National Institute for Health and Care Excellence (NICE) best practice guidelines. The service had carried out a number of audits and we saw examples where these had referenced NICE guidance. The service followed local guidance from the Bedfordshire and Hertfordshire Clinical Priorities Forum and South East London Treatment Access Policy. There was an internal clinical steering group to oversee the clinical direction of the service with membership consisting of all clinical leads. These were held monthly and the group reviewed care pathways to ensure it was evidence based.

- Patients were referred to the service by their GP if they had any musculoskeletal issues. The service ensured a comprehensive assessment was undertaken which included an up to date medical history to deliver appropriate care. The service set up pathways through their clinical advisory forum which was included consultants who had been asked to provide advice on a sessional basis. Patients and other stakeholders were also involved such as Healthwatch. Following the inspection, we were told that a patient self-management application was also under development.
- Clinicians had enough information to make or confirm a diagnosis
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients. Patients were referred to the service by their GPs. If there were repeat referrals the lead clinicians engaged with the GPs and visited them to discuss referral criteria and patient pathways. The service had set up a clinical enquiries email for GPs to enable timely access to musculoskeletal advice and guidance. We were told that the service received up to four queries from GPs a week and there were plans to develop a dedicated advice telephone line.
- The service had self-management advice and videos with condition specific advice on its website.
- The service had created an electronic application to help patients understand their journey when undergoing secondary care procedures.
- A self-management application was planned for September 2018.

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 service used a tool to determine the quality of life years associated with a health state. This was a standardised questionnaire and the service had collected approximately 62,000 forms for the physiotherapy pathway. Analysis showed that 82% of patients had improved health status. This was an improvement from 76% before the service started.
- The service had a contract with Bedfordshire and Greenwich CCGs to manage all patients with musculoskeletal issues and were referred to the service by their GPs. The service assessed these patients and ensured they followed appropriate treatment pathways. If patients required surgical intervention they were referred to an appropriate provider.
- Following knee and hip surgery national Patient Reported Outcome Measures (PROMS) demonstrate that 94% of hip patients and 84% of knee patients improved (Bedfordshire CCG) compared to national average of 89% for hip patients and 81% for knee patients.
- The service made improvements through the use of completed audits. There was an annual audit plan in place and we saw a number of audits which showed a positive impact on quality of care and outcomes for patients. These included diagnostics audits, referral triaged to secondary care, clinical notes audit amongst others.
- There was clear evidence of action to resolve concerns and improve quality. Staff, patients and other stakeholders were involved in improving service.
- The provider delivered care directly from 12 hub locations. We saw evidence where performance of each

Are services effective?

(for example, treatment is effective)

location and team were reviewed on a daily, weekly and monthly basis based on several operational matrices. Where poor performance was identified people were held accountable and resources were made available to improve patient outcomes.

- The service carried out peer review of consultation and referrals to ensure appropriate information was recorded and referrals contained relevant information. We looked at an example of a referral which contained relevant information. As part of the peer review process, staff consultation was observed and learning discussed.

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. Staff were provided with a handbook with relevant information and advice.
- Relevant professionals (medical, physiotherapy and nursing) were registered with their appropriate bodies and were up to date with revalidation where relevant.
- 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. Staff were encouraged and given opportunities to develop. The service had its own learning academy and we saw evidence that the service supported staff through master's modules. Mentors were allocated to these staff while completing the master's modules.
- The service had a training matrix with dedicated staff responsible for ensuring it was kept updated. The service had identified mandatory training based on the role of the staff. We looked at the most up to date staff training matrix which showed that 97% of the staff were compliant with their mandatory training. The service held monthly clinical governance risk management committee (CGRMC) meetings where training status of staff were reviewed.

Coordinating patient care and information sharing

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

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with other services when appropriate. All patients were referred by their GPs and the service used the same patient record system which ensured a co-ordinated approach to care delivery.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history. We saw examples of patients being signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment. The service managed all patients with musculoskeletal health issues through referral from their GPs. Patients once referred, were reviewed and placed on the appropriate care pathways. The service provided choice of pathways and patients could choose based on the location, waiting times and clinician (if referred to e.g. secondary care). If there were no obvious care pathway, further diagnostic testing was carried out so that appropriate care could be delivered.
- 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. There were clear and effective arrangements for following up on people who have been referred to other services. The service had operational links with main providers to ensure for example, referrals were received.

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.

- The service followed making every contact count (MECC), an approach to behaviour change encouraging those who have contact with the public to talk about their health and wellbeing. Information supplied by the service showed that almost 20,000 patients were screened using the MECC questionnaire to empower healthier lifestyle choices such as smoking and alcohol advice between May 2017 and April 2018 (Bedfordshire CCG patients). Since the start of the service over 36,000 patients had MECC as part of their consultation.

Consent to care and treatment

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

Are services effective?

(for example, treatment is effective)

- During our discussion staff were able to demonstrate that they understood the requirements of legislation and guidance when considering consent and decision making. Training records we looked at showed that training in consent had been completed. The service carried out joint injections through appropriate Patient Group Directions (PGDs) and consent was sought and documented.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Are services caring?

Our findings

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treated 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.
- As part of the inspection we asked for CQC comment cards to be completed by people who used the service prior to our inspection. We received 27 completed comment cards, all feedback received was positive. People were very complimentary about the service they had received and the way they were treated by staff. Patients said staff were friendly and professional and that they were treated with respect.
- The service regularly sought feedback in a number of ways. Patients were asked to rate their consultation with clinicians on several matrices and the service reviewed these regularly. The service also carried out compassion in care audits regularly and reviewed these.
- Training records we looked at showed that staff had completed equality and diversity training.

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. Telephone translation service was also available. Patients were also told about multi-lingual staff who might be able to support them. The service in the process of translating letters in different languages. The service was also in the process of enabling their website to be translated in other languages. Following the inspection, we were informed that the website had been updated to be able to be translated into other languages.
- 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. The service prided itself in developing care pathways with a multidisciplinary team approach. The service had access to specialist GPs, physiotherapists, nurses as well as specialist consultants.

Privacy and Dignity

The service respected patients' privacy and dignity.

- The service delivered care at 12 different locations (hubs); we visited one of the two main hubs in Bedford as part of this inspection. From our observations and discussion with staff at the site we saw evidence that staff recognised the importance of patients' dignity and respect.
- We were told that if people appeared distressed or wished to speak in private at reception the service could offer a private room they could offer away from the main waiting area (this relates to the main hub visited on the day).
- Feedback received from the people who used the service through the completed CQC comment cards confirmed patients felt they were treated with dignity and respect.
- Privacy curtains were available in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consulting room and treatment room doors were closed during consultations and conversations taking place in them could not be overheard.
- The practice complied with the Data Protection Act 1998. Staff training records we looked at on the day showed that relevant training had been completed.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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 service had been contracted by local CCGs to provide care for patients with musculoskeletal needs. The service was contracted to bring the musculoskeletal service to a single triage point and a single patient hub, subcontracting with all the other providers, and offering patients choice over which provider they went to. This service was able to demonstrate that this ensured a much smoother and quicker patient pathway.
- The service engaged with patients, staff, other clinicians and stakeholders to understand patient care needs and develop and improve care pathways.
- We visited the hub building located in Bedford. This building was located on the first and second floor of a purpose-built health centre. The premises were appropriate for the services delivered. For example, there were lifts available for patients to access care if they used a wheel chair.
- The service enabled the re-design of community pain and rheumatology services to increase provision and reduce the number of patients requiring onward referral to secondary care.
- The service had dedicated patient choice advisors in the hub centres in Bedford and Greenwich. These advisors contacted patients to have a conversation with them about where they would like to be referred for secondary care. During 2017/18, 100% of patients were offered choice of referral, 94% of patients were referred through discussion with patient care advisors (the remaining 6% of patients who could not be contacted by phone received a letter).
- The service ensured patients were provided with information about the range of options available to them. For example, the consultant available (if they required surgery), the waiting times and if parking was available.
- The service understood the needs of their patients and improved services in response to those needs. It engaged with patients and stakeholders to re-design pathways where relevant. Patients had the choice for every part of their journey and were involved in their care.

Timely access to the service

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

- The service received over 46,000 referrals for the year 2017/18 from patients within Bedford CCG (27,000 for Greenwich CCG) and we were told that it had triaged 100% of the referrals within 24 hours.
- In 2017/18 46,542 referrals were managed (an average of 3879 per month).
- Patients with the most urgent needs had their care and treatment prioritised. Data supplied by the service showed that waiting times for a physiotherapy appointment before the service had a contract with Bedford CCG was nine to 12 weeks. Since the service had taken over the contract, appointments for physiotherapy had been reduced to one week for urgent cases and four weeks for routine appointments.
- Access to MRI diagnostic testing had been reduced from a six-eight week wait to an average of three weeks.
- Referrals and transfers to other services were undertaken in a timely way. For example, approximately 3000 patients (Bedford CCG) were on an incomplete care pathway before the service had taken over the contract. This had been reduced to approximately 1900 by March 2018 which was an increase from 1700 in March 2017.
- There were 370 patients who did not get secondary care treatment within the 18 weeks' time limit in March 2014 (before the service had taken over the contract). By March 2017 this had reduced to 198 patients.
- Patients reported that the appointment system was easy to use. However, we did notice that some patients reported that they had waited long for a physiotherapy appointment on NHS choices. The service did state that since March 2017 the number of patients waiting over 18 weeks had increased due to winter pressures but expected these numbers to fall.

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.

Are services responsive to people's needs?

(for example, to feedback?)

- 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 complaint policy and procedures in place. The service learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. We saw that the Bedford hub received seven complaints for August 2018. We saw that themes were identified and learning shared with the staff through posters and through the monthly staff newsletter.
- Following the inspection, we were told that patients were invited to face-to-face meetings in the hub to support complaint resolution. Actions agreed with service users were then shared with the appropriate teams.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Our findings

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. For example, leaders discussed the challenges of reducing waiting times and were working with all stakeholders to reduce them. The service had a priority to deliver quality care and this was informed by quality audits and patient outcome measurements.
- 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 provider had been contracted by the CCG for the last four years and the service was able to demonstrate savings along with improved patient outcomes such as quality-adjusted life year (QALYs), a generic measure of disease burden, including both the quality and the quantity of life lived. The provider had a plan to offer other services and to become a long-term part of the local health economy.
- The service engaged with local clinicians through the External Clinical Steering Group meetings held monthly. This group represented GPs, orthopaedic, rheumatology & pain consultants; physiotherapists (as well as extended scope physiotherapists) and GPs with special interest from the local health economy. The purpose of the group was to review and maintain the vison of the service through discussion current practice and areas where further improvement could be made.
- The service developed its vision, values and strategy jointly with staff and external partners (where relevant). For example, the service engaged with external clinicians as well as developing links with Healthwatch to obtain independent feedback on the system. The service had commissioned the local Healthwatch of Bedfordshire and Greenwich to undertake an independent review to inform development of the service. We looked at the review on the day and saw that where appropriate the service had taken action.
- 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. For example, the service aimed to improve quality of care delivered and provide better financial value. Evidence provided by the service demonstrated that they were monitoring this. The service was able to demonstrate improvement in service such as performance against the 18 weeks waiting times as well as other patient outcomes.

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. Patient outcomes were monitored to improve service. Patient feedback coupled with other stakeholders was used to improve the patient journey.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff 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. The service had developed a staff handbook, Circle Operating System (COS) with the vision, values and underlying culture. The handbook explained what was expected from staff and what staff could expect. The handbook detailed its adoption of 'stop the line', a process originally developed by Toyota for use in production lines of its car manufacturing plants. This was adapted to healthcare and staff were empowered to report this immediately and to 'stop the line' if anyone encountered a situation where a patient may be harmed. The process for raising this and the timeline

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

with an example was detailed in the handbook. The handbook also detailed the process for a 'swarm' meeting, the services approach to problem solving where all relevant personnel would be invited.

- There were processes for providing all staff with the development they needed. 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. Staff were supported to attend courses and mentored to help them progress.
- There was a strong emphasis on the safety and well-being of all staff. The provider had an 'employee assist' programme for staff. Staff had access to discounts and offers (perk box); we were told that the service provided free fruit and beverages for staff and they could also access massage and social events.
- 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.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The Clinical Governance and Risk Management Committee (CGMRC) had an overview of the performance and risks of the organisation and reported to the board. The CGMRC received feedback on other sub-committees such as medicines management, health and safety and infection prevention and control.
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. For example, the service had 12 locations (hubs) where service was being delivered and we saw evidence that performance of each hub were regularly reviewed on a number of management and patient's outcomes matrices. The service was able to demonstrate that it was able to review capacity and resource for each location so that it was able to re-direct resources where it was more required. For example, if waiting times for a location was higher than usual, resources could be re-directed from another location where there was less demand.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. Staff were empowered to raise any issues and could 'stop the line' if they felt that patients could be harmed.
- The service had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their consultations and referral decisions. Leaders had oversight of safety alerts, incidents, and complaints. We saw evidence of trend analysis from incidents and complaints which were shared with staff monthly.
- 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. The service reviewed performance of each of the 12 hubs regularly on a number of matrices to ensure resources were matched to demand. 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. Incidents and complaints were discussed at regular meetings which were attended by clinical staff. The service held monthly Clinical Governance and Risk Management (CGMRC) meetings to discuss

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

performance (including patient feedback, clinical outcomes as well as complaints), risks (including incidents, health and safety, medicines as well as safeguarding) and evidence based guidance.

- The service used performance information which was reported and monitored and management and staff were held to account. Performance for each hub site was reviewed at meetings.
- 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. For example, the service had contracts with CCGs and regularly provided feedback them in regard to risks and performance.
- 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 publics', patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example, the service had developed links with Healthwatch to obtain independent feedback on the system and had commissioned them to undertake independent reviews. We looked at the reports for both Bedford and Greenwich CCGs following review by Healthwatch and saw evidence that suggested recommendations to improve quality of service were being actioned. For example, the service had updated its website to provide more accurate information about the locations with maps and postcodes.
- The service had recruited a patient representative who attended relevant meetings to discuss performance, patient feedback and service improvements.
- The service was transparent, collaborative and open with stakeholders about performance. Performance was reviewed and discussed with internal and external stakeholders and where relevant feedback used to improve service. For example, the service engaged with local clinicians through the External Clinical Steering Group meetings held monthly. This group represented GPs with special interest, orthopaedic, rheumatology and pain consultants, physiotherapists (as well as extended scope physiotherapists) from the local health economy. This allowed the service to understand improvement areas for example, re-design of patient pathways or amendments to templates (for referral letters) through.
- Staff were able to describe to us the systems in place to give feedback. There was a speak up guardian in place and we were told that staff survey revealed that 80% of staff would recommend working for the provider.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements. The service produced newsletters and posters to communicate learning from incidents and complaints.
- 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 service engaged with the wider clinical team in the local health economy through the external clinical steering group to review service delivery and make improvements.
- The service provided physiotherapy practitioners to work free within local GP practices to support them with their workload for musculoskeletal issues. This involved one session per week to reduce the burden on GPs and acted as a link between the service and GP practices. This resulted in better management of patients as there was involvement of a multidisciplinary team.
- The service invested biomechanical devices to certain conditions to such as osteoarthritis help deliver effective care; we were told these devices were not yet available to NHS services.