Essex Lodge Surgery

Quality 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.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Essex Lodge Surgery on 19 October 2017. Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- The service had systems to minimise risks to patient safety but policies were not always immediately accessible to staff and the recruitment procedure did not ensure clinical staff were appropriately insured.

Summary of findings

- Staff were generally aware of current evidence based guidance but the service did not carry out clinical quality improvement activity to improve patient outcomes.
- Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Feedback from patients we spoke to, CQC patient comment cards and service survey results showed patients were satisfied with their care and treated with compassion, dignity and respect.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with said they did not have to wait too long to access the service and there was continuity of care; however systems for patient prescriptions entailed delays.
- The service had good facilities and was equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The service proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the service complied with these requirements.

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.

The areas where the provider should make improvements are:

- Monitor and review cover arrangements for the absence of a clinician.
- Ensure completion of planned improvements for patients requiring prescribed medicines and storing patient paper records electronically.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

- We found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the service. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The service generally had clearly defined and embedded systems, processes and services to minimise risks to patient safety but recruitment procedures did not address the need to ensure clinicians had appropriate medical indemnity insurance relevant to their role.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding vulnerable adults relevant to their role but staff access to the safeguarding vulnerable adults and chaperoning policies needed improving.
- The service had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

- There was no evidence of clinical quality improvement activity.
- Staff had the skills and knowledge to deliver effective care and treatment with the exception of a best practice guideline referred to that was out of date.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet specific patients' needs.

Are services caring?

- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Summary of findings

Are services responsive to people's needs?

- The service understood referred patient's clinical needs and had used this understanding to meet the needs of its patients.
- Patients we spoke with said they found the service convenient to access as an alternative to hospital care and there was continuity of care.
- The service had facilities and was equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from examples reviewed showed the service responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

- The service had a clear vision and strategy to deliver care. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The service had policies and procedures to govern activity, most but not all were readily available to staff.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor identify risk, with the exception of ensuring clinicians medical indemnity insurance.
- There was insufficient clinical quality improvement activity and we noted a reference to a fundamentally applicable NICE best practice guideline was out of date.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour. In the examples we reviewed we saw evidence the service complied with these requirements.
- The partners encouraged a culture of openness and honesty. The service had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The service proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. However, arrangements for patients requiring prescribed medicines had not been evaluated and entailed delay, and potential inconvenience or longer periods experiencing pain.
- GPs and clinicians were skilled in specialist areas and used their expertise to offer additional services to patients such as anaesthesia and spinal injections where necessary.

Summary of findings

What people who use the service say

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received eight comment cards, six were entirely positive about the standard of care received, one contained mixed feedback and one negative feedback. There were no themes in the negative feedback and patients said they felt well treated and cared for.

We spoke with two patients during the inspection. Both patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

The service own survey results from July 2017 showed patients were satisfied and felt the benefits from treatment offered at the service clinics.

Areas for improvement

Action the service MUST take to improve

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Action the service SHOULD take to improve

- Monitor and review cover arrangements for the absence of a clinician.
- Ensure completion of planned improvements for patients requiring prescribed medicines and storing patient paper records electronically.

Essex Lodge Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Essex Lodge Surgery

Essex Lodge Surgery operates under the provider Essex Lodge I-health Ltd that was formed in 2009 to facilitate clinical care delivery from a community based setting. Essex Lodge Surgery is part of a consortium of providers (Barts Health, Homerton Hospital, BMI, Essex Lodge I-health Ltd, the East London Foundation Trust, and Patient First Ltd) to deliver specialist musculoskeletal care and chronic pain management to patients in NHS Newham Clinical Commissioning Group (CCG). The services are provided under an NHS contract and include physiotherapy with acupuncture as appropriate for some patients, steroid injections, spinal injections that are administered off site in a hospital setting, and chronic pain management including associated counselling and psychotherapy such as cognitive behaviour therapy (CBT). The service provides a variable amount of appointments ranging from 100 to 200 per month depending factors such as the time of year and amount of referrals from GPs within the local CCG area.

The service is situated in a three storey premises which it shares with a GP surgery called Essex Lodge. It is registered with the Care Quality Commission to carry on the regulated activities of maternity and midwifery services, treatment of disease, disorder or injury, surgical procedures and diagnostic and screening procedures. However, during our inspection the provider explained its intention to deregister for Maternity and Midwifery Services as they were not being undertaken at the time of our inspection.

The Essex Lodge GP practice was granted planning permission to extend the premises. This work was underway at the time of this inspection. All treatment and consultations provided by Essex Lodge under the provider Essex Lodge I-health Ltd were undertaken in consultation and treatment rooms on the ground floor.

The staff team includes a range of clinical and non-clinical staff employed by either one of Barts Health NHS Trust, Essex Lodge I-Health Ltd or East London Foundation Trust. The clinical team are four GPs (three male and one female) including the lead specialist GP who is the Director of Essex Lodge I-health Ltd. GPs had a range of special interests in areas applicable to musculoskeletal care and chronic pain in areas including rheumatology, orthopaedics, and chronic pain management. Further clinical staff are two consultant anaesthetists, a Cognitive Behaviour Therapist (working with some patients with chronic pain), and four physiotherapists including some providing acupuncture and a team leader. Non clinical staff and a full time operations manager and four administrators working a range of part time hours. Essex Lodge Surgery patients were received by Essex Lodge GP practice reception staff as part services contracted by Essex Lodge I-health Ltd.

The services' opening hours are Monday to Friday from 9am to 5pm.

Clinics run and vary at approximately between two and seven sessions provided per week, according to patient need such as the number of patient referrals. On an average week there are likely to be a combination of five sessions from:

- Monday 2pm to 5pm or 6pm - Consultant anaesthetists' appointments of approximately 15- 20 minutes.
- Thursday 2pm to 4pm - Chronic pain clinic with a specialist GP, appointments are for 15 minutes.
- Thursday 9am to 12pm - Physiotherapy appointments that are for 20 minutes.
- Friday - Cognitive behaviour therapy for chronic pain 10am to 1.30pm and 3pm to 6pm.First and more complex appointments are for an hour, otherwise 30 minutes.

- Alternate Fridays 2pm to 5pm - Specialist GP Orthopaedic appointments alternating with Specialist GP Chronic pain relief and musculoskeletal clinics. Appointments are for 15 minutes.

- Saturday 9am to 12pm - Physiotherapy appointments that are for 20 minutes.
- Saturday 9.30am to 12.30pm - Specialist GP Rheumatology appointments every first and third Saturday morning of the month that are for 15 minutes.

Data from public health England showed there were around 65,000 to 70,000 people with a musculoskeletal problem known to GPs in Newham, as at May 2017.

The Index of Multiple Deprivation (IMD) score is the official measure of relative deprivation for small areas (or neighbourhoods) in England. The deprivation scores in England have been ranked from 1 (most deprived) to 209 (least deprived). The latest data release (2015) showed the Newham area was ranked the 22nd most deprived area out of 205 in England.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew. We carried out an announced visit on 19 October 2017.

During our visit we:

- Spoke with a range of staff (The Lead specialist GP and Director of Essex Lodge I-health Ltd, Operations Manager, and reception and administrative staff) and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with family members.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Visited the service location.
- Looked at information the service used to deliver care and treatment plans.

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?

Please note that when referring to information throughout this report, for example any reference to the data from Public Health England, this relates to the most recent information available to the CQC via the service at that time.

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the service manager of any incidents and there was a recording form available on the service's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From the sample of five documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The service carried out a thorough analysis of the significant events. There had not been clinical error significant events but we reviewed five significant events that were identified and managed appropriately and improvements made as a result. For example, after a patient received an appointment letter that was for earlier time than recorded on the electronic appointment system. The service treated this issue as a significant event, apologised to the patient and ensured they received treatment the same day. Staff discussed the issue and contacted the partner organisation responsible for the appointment scheduling system and introduced a double checking process locally to prevent recurrence.
- We saw evidence that lessons were shared and action was taken to improve safety in the service. For example, the operations manager received and cascaded relevant safety alerts and ensured they were acted upon as needed.

Overview of safety systems and processes

The service had systems and processes and services in place to minimise risks to patient safety.

- The service was contracted to provide services to people aged over 18 only. There were policies in place but the most up to date adults safeguarding policy was not immediately or intuitively accessible to staff because it had been renamed as the "Adults at risk" policy. We also found the chaperoning policy was not located in the shared desktop policy folder but was saved in a different folder. However, other policies were clearly and easily accessible on the shared drive; they were in date and located to be made accessible to all staff on the day of inspection. Management staff told us they would review systems to ensure staff clear and easy access to all policies. The adult safeguarding policy clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The lead specialist GP was the lead member of staff for safeguarding.
- Staff told us there were no patients subject to adult safeguarding provisions at the time of our inspection receiving services, but staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding vulnerable adults relevant to their role. GPs were trained to level two or three and non-clinical staff to level one.
- A notice in the waiting room advised patients that chaperones were available if required. Staff who acted as chaperones were trained for the role and had received 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).

The service maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The Essex Lodge GP practice nurse was the infection prevention and control (IPC) clinical lead for the whole premises but the operations manager for Essex Lodge Surgery also undertook IPC audits independently. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

Are services safe?

The arrangements for managing medicines, including emergency medicines in the service minimised risks to patient safety. (including obtaining, recording, handling, storing, security and disposal).

- Essex Lodge Surgery did not hold any blank prescriptions. Service prescribers did not issue prescriptions directly to patients but issued a documented prescription request for patients to take to their own GP practice, they also sent a message to the patient's own GP for this purpose. This method entailed delay and the task of patients arranging to deliver a paper copy of the prescription to their own GP, including patients that may have been experiencing pain. Staff told us improvements to the current electronic system were being made and it was anticipated this issue would be improved or resolved by December 2017.
- Refrigerated medicines such as steroid injections were safely stored and managed.

We reviewed personnel files and found appropriate recruitment checks had generally been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS. However, there was no evidence to show all clinicians had sufficient medical indemnity insurance cover to practice for or at Essex Lodge Surgery, for example where staff were employed by a consortium partner. All registered healthcare professionals are required to have adequate and appropriate insurance or indemnity to cover the different aspects of their practice to potentially compensate the patient, depending on the individual circumstances. This has been a legal requirement since July 2014 and the introduction of the Health Care and Associated Professions (Indemnity Arrangements) Order 2014. Staff told us clinicians would be covered but there was no process to ensure this would be the case. After our inspection the service sent us its recruitment protocols and evidence of appropriate medical indemnity cover in place for clinical staff. However, the service protocols did not cover clinical staff medical indemnity insurance.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The service had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the service and a fire evacuation plan.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The service had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were some arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs and clinics were adjusted to accommodate demand. There was a limited pool of clinical staff available to cover some roles and clinics had been cancelled if key staff were absent, although this did not happen often. Staff told us patient preference was to wait a bit longer and see the same clinician, rather than keeping their appointment time with a covering clinician. There were no induction arrangements for specialist clinicians to cover in the event of unexpected absence.

Arrangements to deal with emergencies and major incidents

The service had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The service had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the service and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The service had a business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Assessment and treatment

The service generally assessed needs and delivered care in line with relevant evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines, but was sometimes out of date and did not effectively undertake clinical quality improvement activity.

- Staff had access to guidelines from NICE and other best practice guidelines and used this information to deliver care and treatment that met peoples' needs.

Management, monitoring and improving outcomes for people

- There was no evidence of clinical quality improvement activity but the service had undertaken two completed audits regarding spinal and steroid injections in 2016 and 2017 to collect patient feedback from 2015 and 2016 respectively. It also undertook a single cycle audit in 2017 to establish possible patient abuse of a specific medicine. We noted both the spinal and steroid injection audits showed patient feedback on whether the injection helped, and complications such as weakness or numbness had improved between 2015 and 2016. However, the spinal injections were not undertaken by Essex Lodge Surgery because they referred patients to another service provider to receive these. None of the audits demonstrated clinical improvement activity. Staff told us the audits regarding spinal and steroid injections were completed audits intended for clinical quality improvement purposes but had not been documented accordingly.
- After our inspection the service sent us more comprehensively recorded versions of the audits:
- The audit of spinal injections undertaken by another provider showed the clinical improvement intervention at Essex Lodge Surgery was to give patients information leaflets on various spinal injections at the point of referral. However, we would expect this to be part of usual good practice and neither audit cycle described a method of delivering clinical quality improvement. We also noted the audit made reference to a specific NICE guideline (Osteoarthritis: care and management CG59) that was published in 2008; however, this guidance was replaced by new NICE guidance (CG177) in February 2014.
- The steroid injections audit documentation was not precise or clear. For example, the audit undertaken in 2017 that appeared to intend to refer to patients for the year 2016 referred to patients covering the year 2015. Recommendations following the first cycle audit undertaken in 2016 included to introduce patient selection criteria for steroid injections on an either one trigger or another, and explore the duration of any numbness patients experienced after receiving the injection. However, the second cycle audit did not measure the duration of numbness patients experienced and the effect of introducing each of the patient selection criterions could not be ascertained.

Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. The service did not meet this standard and there was no evidence of any other clinical quality improvement activity.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The service had an induction programme for newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The service could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for specialist GPs in orthopaedics, and chronic and acute pain including back pain.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of service development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. Staff had received an appraisal within the last 12 months.

Are services effective?

(for example, treatment is effective)

- Staff received training that included: safeguarding, fire safety awareness, and basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the service's patient record system and their intranet system.

- This included medical records and investigation and test results.
- From the sample of documented examples we reviewed we found that the service shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other relevant health care professionals such as hospital consultants to understand and meet patients' needs and to assess and plan ongoing care and treatment. Information was shared between services, with patients' consent, using a shared care record. Specialist musculoskeletal care team meetings took place with other health care professionals on a monthly basis when care plans were routinely tailored to patient's needs.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and advised us this had not been applicable in the scope of its care to patients so far.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.

The patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the service offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with two patients that told us they were satisfied with the care provided by the service and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

The service survey undertaken in July 2017 did not specifically address the question of whether patients felt the service was caring; however, results showed 89% of patients were satisfied or very satisfied with the care they had received.

Involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us 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 such as for pain management or acupuncture. Patient feedback from the comment cards we received was also positive and aligned with these views.

The service provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Patients were also told about multi-lingual staff that might be able to support them.
- Information leaflets were available in easy read format.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The service was set up in response to patient needs within the local population profile and in collaboration with its consortium partners and was commissioned by the local CCG as part of the National MSK (musculoskeletal) improvement programme. The practice provided us with data from public health England that showed there were around 65,000 to 70,000 people with a musculoskeletal problem known to GPs in Newham, as at May 2017.

- All patients attending the clinic were referred by their own GP.
- The length of some appointments varied as they were based on the therapy, treatment or procedure the patient was receiving.
- There were disabled facilities and all consultation and treatment rooms were on the ground floor.
- There were accessible facilities, which included a hearing loop and interpretation services available.

Access to the service

The services' opening hours were Monday to Friday from 9am to 5pm.

There were a variable amount of clinics provided, approximately between two and seven sessions per week according to patient need such as from GP referrals. On an average week there were likely to be a combination of five clinics including consultant anaesthetists, physiotherapy, cognitive behaviour therapy (CBT) for patients with chronic pain, and specialist GP appointments including musculoskeletal, rheumatology, chronic pain and orthopaedics.

Results from the practice patient satisfaction survey July 2017 indicated 92% of patients were satisfied or very satisfied with the length of time it took to be seen at the clinic. The practice saw all patients within eight weeks of referral which was in line with its performance targets and it was working on decreasing this to six weeks.

Listening and learning from concerns and complaints

The service had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The operations manager was the designated responsible person who handled all complaints in the service.
- We saw that information was available to help patients understand the complaints system such as a summary leaflet.

We looked at two complaints received in the last 12 months and found they were satisfactorily handled and dealt with in a timely way. The service demonstrated an open and transparent approach in dealing with complaints. Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, after a patient complained they had seen an alternative clinician when they had been expecting to see the same clinician to continue their treatment. The service apologised to the patient and undertook to let them know in future if it was not possible for their regular clinician to see them for any reason they would arrange to rebook with the regular clinician according to the patient's choice. Complaints were discussed with staff with actions agreed and learning shared.

Are services well-led?

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement, it was not displayed in the waiting areas but staff knew and understood the values.
- The practice had a clear strategy and supporting business plans which reflected the vision and values and were monitored.

Governance arrangements

The service had an overarching governance framework:

- There was a clear staffing structure and staff were aware of their own roles and responsibilities.
- Service specific policies were in place and implemented but were not always clearly or immediately available to all staff due to the file name or location such as safeguarding of vulnerable adults and chaperoning policies.
- There was no programme of continuous clinical and internal audit to monitor quality and to make improvements.
- Information received from the service indicated they were out of date with a specific best practice guideline that was fundamentally applicable to its services provided.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions with the exception of effective processes to ensure clinician's medical indemnity insurance.
- The service was in the process of scanning some of its paper based records onto its electronic patient record system and envisaged this would be fully completed within six months. Clinicians referred to paper notes in the interim.
- The service arrangements for patients requiring prescribed medicines entailed delay and potential patient difficulty such as for those in pain. Staff told us these circumstances had been beyond their control when agreements were drawn up to arrange MSK services. There was no evidence of a method to evaluate impacts of arrangements for prescribed medicines on patients.

Leadership and culture

On the day of inspection the lead GP and all staff told us they prioritised safe, high quality and compassionate care. Staff told us the GPs and managers were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The service had systems in place to ensure that when things went wrong with care and treatment:

- The service gave affected people reasonable support, truthful information and a verbal and written apology.
- The service kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the service held regular team meetings and we saw evidence this was the case.
- Staff told us there was an open culture within the service and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted regular team social events were held.
- Staff said they felt respected, valued and supported, particularly by the partners in the service. All staff were involved in discussions about how to run and develop the service, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the service such as improvements to filing systems.

Seeking and acting on feedback from patients and staff

The service encouraged and valued feedback from patients and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

The service had gathered feedback from patients through surveys and complaints received. Staff told us they would

Are services well-led?

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

not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the service was run.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance **How the regulation was not being met:** The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • Clinical quality • To ensure clinicians medical indemnity insurance The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to evaluate and improve their practice in respect of the processing of the information obtained throughout the governance process. In particular: • Best practice clinical guideline This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.