# Cornishway Group Practice

## Inspection report

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

## Ratings

| | |
|---|---|
| Overall rating for this location | Good |
| Are services safe? | Good |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive to people's needs? | Good |
| Are services well-led? | Requires Improvement |

# Overall summary

**This practice is rated as Good overall.**

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an inspection of the South Manchester General Practice Federation (SMGPF). The federation is the provider of enhanced GP access services and also offered support to their constituent practices in other forms, including as an employer of health care professionals (such as paramedics) who work within those practices for the benefit of the local population.

Our inspection included a visit to the service's headquarters at Borchardt medical centre and to all five of the registered locations where the provider (federation) operated their enhanced GP access service from. The reports relate only to the enhanced hours service, not the core GP services operated from these locations. The GP locations are registered and inspected separately.

We carried out an inspection at the enhanced access service delivered from Cornishway Group Practice on 17 August 2023 as part of a larger announced comprehensive inspection of South Manchester GP Federation (SMGPF). This was part of our planned inspection programme.

At this inspection we found:

- The Federation (SMGPF) had systems to manage risk overall, but assurance systems were not in place, as a result they were unable to demonstrate that all actions needed to mitigate risk had been taken at Cornishway Group Practice.
- The federation routinely reviewed the effectiveness and appropriateness of the care they provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity, and respect. Patient feedback was provided for this location as part of wider feedback obtained by the Wythenshawe Primary Care Network (PCN). Feedback overall from patients using all locations in the PCN was positive.
- Leadership of the federation was well established and working to ensure services were delivered within a comprehensive framework of governance that would provide high-quality services. Although this framework was in place, we found several areas where assurance systems were absent or poorly embedded. Clinical areas of service delivery were safe and generally effective, however further development was still required.

Although we found no breaches of regulation, the provider should:

- Take action to embed over-arching governance systems across a range of areas including risk management, staff recruitment, training, staff appraisal and medicines management to be assured that there is effective central oversight by leadership at the federation on an ongoing basis, across all of its registered locations.

# Overall summary

- Take action to seek patient feedback on their experience of using the enhanced hours service at the location to inform future service planning.
- Continue to consider how staff, patients and stakeholders can inform the future strategy of the organisation.

**Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA**

Chief Inspector of Health Care

## Our inspection team

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

## Background to Cornishway Group Practice

South Manchester GP Federation (SMGPF - the provider) was formed in 2014 and registered with the CQC the same year. The provider is registered for 3 regulated activities of 'diagnostic and screening procedures', 'transport services, triage and medical advice provided remotely', and 'treatment of disease, disorder or injury'.
They are commissioned through the NHS Greater Manchester Integrated Care Board (ICB) through the 4 Primary Care Networks they support;

- Withington & Fallowfield PCN
- Didsbury, Chorlton & Burnage PCN
- Northenden & Brooklands PCN
- Wythenshawe PCN

Through this tiered structure, SMGPF supports and is supported by 22 individual practices throughout the 4 PCNs. These practices are members and shareholders in the federation.
SMGPF has a board of 6 directors and 1 non-executive director and is equal shareholder of Manchester Primary Care GP Federation, along with the other 2 federations that cover the rest of the Manchester area (North and Central).

SMGPF directly employs 68 employees in various roles including at the main site, Borchardt Medical Centre (mainly in management roles), and in those employed to support practices through the Additional Roles Reimbursement Scheme (ARRS). The ARRS staff are employed by the federation but are deployed to the individual practices in which they work and support. SMGPF also sub-contracts staff to run their enhanced access service, which is operated from 5 locations;

- Burnage Health Care Practice
- Barlow Medical Centre
- The Park Medical Centre
- Maples Medical Centre
- **Cornishway Group Practice**

These subcontracted staff consist of GPs, nurses, and healthcare assistants (HCAs) and are subcontracted from these 5 location practices by the federation. We visited all 5 GP practices as part of our inspection over three days, 14, 15 and 17 of August 2023.

Services are run from the enhanced access locations between 4.30 (and 6.30 – dependant on the site) and 8.30pm and also from 9am until 5pm on Saturdays and between 9.30am until 2pm on Sundays. Booking of appointments into the enhanced access services is completed by the patients' individual practice. Available telephone appointments slots are available for NHS111 to book into. Patients are unable to attend without an appointment.

Good

# Are services safe?

**Safety systems and processes**

The federation had systems in place to keep people safe and safeguarded from abuse.

- Systems to safeguard children and vulnerable adults from abuse were in place. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance. Staff we spoke with confirmed that they were aware of what procedures to follow and who to go to should they need to.
- The federation worked with other agencies to support patients and protect them from neglect and abuse. They were part of a larger framework including individual practices comprising of 4 Primary Care Networks (PCNs), presenting a coordinated system for the benefit of patients accessing healthcare in South Manchester. Staff we spoke with could articulate how they would take steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The federation carried out staff checks at the time of recruitment and directly on an ongoing basis where appropriate for staff they employed. These staff received safety information from the federation as part of their induction. 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). The federation told us that they had a process to ensure that minimum documentation for GPs (and this is used for other clinical staff if needed) was in place in a shared 'Manchester wide' folder shared with the North and Central Manchester GP Federations. This enabled GPs to provide their documentation once but be able to work across the 3 federations. Staff files we reviewed contained appropriate recruitment information.
- Training and ongoing supervision was the responsibility of the PCN members (usually a nominated lead practice) as well as ongoing supervision. The federation had a system of appraisals in place, but we were told these hadn't taken place, as planned, due to the pandemic, and management capacity issues, which the provider had recognised prior to the inspection. We saw plans were in place to address this. Following the inspection, the provider shared evidence with us that several appraisals had already been completed and others were planned throughout the end of 2023 and into the beginning of 2024.
- The federation had ensured that staff employed directly by them, who would be expected to act as chaperones, in the individual practices where they worked, had received a DBS check upon recruitment.
- The practice owned the buildings from which the enhanced service was being operated and were responsible for conducting all safety risk assessments. The federation had safety policies, including control of substances hazardous to health (COSHH), health and safety (H&S) and infection, prevention, and control (IPC), which were regularly reviewed and communicated to staff on their central computer system and through email.
- IPC remained the responsibility of the building managers (NHS property services). Clinical waste collection arrangements were in place and staff we spoke with told us this was working well.
- Clinical specimens were transported using taxis, the risk of which, the federation had not considered. During the inspection, they supplied us with a newly established risk assessment and mitigating actions.
- The premises were clinically suitable for the assessment and treatment of patients as all patients were expected, and the federation had planned sufficient facilities, with the practice, to accommodate them. In our review of cleaning processes, we saw that although facilities and equipment were safely managed, the federation was unable to provide assurances of any cleaning schedules or evidence of oversight by the building managers.
- In relation to fire, staff we spoke with at the location told us that fire drills had occurred 2 weeks before the inspection. We saw that fire extinguisher checks had been completed in September 2022.
- During the inspection, the federation supplied us with a risk assessment concerning general oversight of environmental risks and associated included mitigating actions, which included arranging meetings with property services to ensure proper oversight was in place going forward.

**Risks to patients**

Good

# Are services safe?

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

- There were arrangements for planning the number and mix of staff needed at recruitment. For the enhanced access the provider agreed a workforce plan with PCNs and put this in place, ensuring that there is a GP on site to cover for HCA and nurses. Where a session was cancelled, for whatever reason, the provider aimed to re-provide the hours and same clinician within 2 weeks, where possible. This plan was maintained indefinitely as there was no need to increase or decrease staffing as a practice might have to, to manage demand. Senior staff were easily identifiable and available for staff to escalate their concerns.
- There was an effective induction system in place at recruitment for all types of staff used by the service, tailored to their role.
- Staff we spoke with understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis. In line with available guidance, patients were prioritised appropriately for care and treatment, in accordance with their clinical need. The federation employed 4 care coordinators to ensure that patients from three out of the four PCNs received coordinated and seamless delivery of care and treatment.
- Systems were in place to manage people who experienced long waits or who had been inappropriately streamed into the service. Feedback was completed during and following each period of operation to ensure practices that booked in patients knew what was appropriate to book and what was not.
- Staff we spoke with knew when to tell patients where to seek further help. They were able to advise patients what to do if their condition got worse.
- The federation had adapted well to circumstances affecting operational delivery.

**Information to deliver safe care and treatment.**

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

- The federation had established a data sharing agreement with their 22 member practices in relation to sharing information freely and allowing access to all patient records. Patients' consent had been considered and provided in their agreement to use the enhanced access service.
- Individual care records were added to 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. Their system allowed an added layer of safety in relation to clinical risk. Patients' notes were accessible to GPs working in the enhanced hours service, and to the patient's own GP following the operational period.
- They had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. Staff at the enhanced access service emailed both the provider and the individual practice (at the end of the service period), from which the patient came, to ensure that they had knowledge of the consultation and any referrals that had been made. They also demonstrated that practices were prompted to ensure that tasks sent in relation to referrals had been actioned.
- In records we reviewed, we saw that clinicians subcontracted to the federation from the individual practice to run the enhanced access service had made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

**Safe and appropriate use of medicines**

- There were effective systems and arrangements for managing medicines, including medical gases, emergency medicines and equipment.
- The federation kept prescription stationery securely at Cornishway Group Practice but was unable to demonstrate that they effectively monitored their use. Prescription pads were pre-printed with the providers details and there was

evidence that the serial numbers of the prescriptions issued to each location were documented, but the federation acknowledged that they wouldn't know how many had been used, or for what, only knowing that all had been used when the location asked them for more. During the inspection, the federation supplied us with a risk assessment and mitigating actions, which included establishing a system to monitor prescription usage going forward. Following the inspection, the provider explained that their system was reliant on the GPs remembering to log the use of these prescriptions. They told us that administration staff were now required to remind GPs to inform the provider if any prescription stationary was used and would monitor serial numbers.

**Track record on safety**

- The federation was unable to demonstrate that systems were in place to assure them that comprehensive risk assessments in relation to safety issues at the location were working as intended or monitored in line with service level agreements (SLAs). They established new systems during the inspection to ensure this was in place going forward. We have told the provider they should review these systems to be assured they are operating as intended.
- They monitored and reviewed care and treatment delivered and had established a safe system of feedback and follow-up. Environmental assurance checks, however, were limited. This failed to enable them to understand risks or give a clear, accurate and current picture that could lead to safety improvements or remedial actions.
- There was a system for receiving and disseminating safety alerts. The federation facilitated this as an extra level of safety for clinicians and patients. Although individual clinicians subcontracted to them received this information from their usual place of work, those in ARRS roles also benefited from this.

**Lessons learned and improvements made.**

The federation learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff we spoke with understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. The federation supplied us with evidence that these significant events and incidents were recorded, actioned, and analysed for themes to aid learning.
- There were systems for reviewing and investigating when things went wrong but these did not always identify concerns. When the federation became aware of concerns, they learned and shared lessons, identified themes and took action to improve safety in the service.
- They learned from external safety events and patient safety alerts and had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.

Good

# Are services effective?

**Effective needs assessment, care, and treatment**

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

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The federation had systems to ensure that they monitored that these guidelines were followed.
- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. Where patients' need could not be met by the enhanced access service, as a result of a patient being inappropriately booked in, staff redirected them back to their own GP. They had protocols in place should the needs of the patient require more immediate action.
- Care and treatment were delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. There was a hearing loop in place, although there were small numbers of patients in the waiting room at any one time. Staff we spoke with were able to articulate how they would use translation services when patients who required it attended the service. Staff were also knowledgeable about how they would support any patients that had vision impairments or physical disabilities. These patients would, however, tend be seen by their usual GP.
- There was a system in place to identify and support other patients with particular needs, for example vulnerable patients. This was highlighted by the booking practice and staff working in the enhanced access service had appropriate levels of information from their familiar clinical systems. We saw no evidence of discrimination when making care and treatment decisions.
- Clear referral processes were in place, these were agreed with senior staff and clear explanations were given to patients. This was then fed back to the provider's head office and to the persons own GP.

**Monitoring care and treatment**

- The federation confirmed that their focus on quality centred on collecting information and using this to improve the service. This information included incidents, issues and complaints, feedback from practices (using a form that was developed in early 2023) and patient surveys (which were commenced in late July 2023 following agreement of the content with the PCN clinical directors). They designed a survey themselves after recognising that resources were unavailable to commission external organsiations to perform this. Clinical audits that looked at the quality of consultations against RCGP (Royal College of General Practitioners) guidance were also conducted and reported back. The federation did not provide any examples of this, although we saw that the documentation was in place to support this. They supplied us with unverified utilisation data that was shared with service commissioners (PCNs and ICB). Following the inspection, the provider told us that they were unable to benchmark due to the unique way they were commissioned, primarily through the PCNs, whose requirements were limited to the data they were able to share with us. Enhanced access data was not available nationally to benchmark against in the areas they reported on.
- The federation made improvements to the delivery of their services through the use of these various tools, although not all their systems were working as intended or had been fully rolled out.

**Effective staffing**

Staff, whose files we reviewed, had the skills, knowledge, and experience to carry out their roles, but there were gaps in relation to ongoing assurances.

Good

# Are services effective?

- All staff, whose files we reviewed were appropriately qualified. The federation had an induction programme for all newly appointed staff. This covered such topics as information on the various locations as well as safety and first aid.
- They could not always demonstrate over-arching assurances that:
  - All staff worked within their scope of practice and had access to clinical support when required,
  - They understood the ongoing learning needs of staff,
  - Up to date records of skills and qualifications beyond those gathered at recruitment were maintained,
  - Staff were encouraged or given opportunities to develop, or that,
  - Clinical supervision and support for revalidation were in place or that they ensured competence of staff employed in advanced roles by way of audit of their clinical decision making, including those in non-medical prescribing roles.
- The federation demonstrated that appropriate assurances had been sought at recruitment. Although some staff were directly employed and others subcontracted, the structure of the organisation necessitated the provider delegating responsibility of these ongoing areas to the member practices, or PCNs where appropriate through a network of SLAs. During the inspection, they developed a risk assessment that addressed this and put in place mitigating action plans to ensure assurances were sought going forward.
- There was a clear approach for supporting and managing staff when their performance was poor or variable, but this was also delegated to the member practices initially. More complex human resources (HR) issues could be referred back to the federation as the employer.

**Coordinating care and treatment**

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

- We saw records that showed that all appropriate staff, including those in different teams, services, and organisations, were involved in assessing, planning, and delivering care and treatment. The federation had established a comprehensive system of oversight in relation to clinical delivery.
- Patients received coordinated and person-centred care. This included when they moved between locations, or when they were referred. Systems were in place to ensure that staff communicated promptly with patient's registered GPs following the operational period, so that the GPs were aware of the need for further action. Staff also referred patients back to their own GP to ensure continuity of care, where necessary. There were established systems of follow-up to ensure patients seen in the enhanced access service would receive the care they would expect from their interactions with the service.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- The federation ensured that care was delivered in a coordinated way and took into account the needs of different patients, including those who may be vulnerable because of their circumstances. We saw that if patients with vulnerabilities were booked into the enhanced access service by their usual GP practice, appropriate information on their vulnerabilities was apparent to staff working in the appropriate location. Staff we spoke with also told us of occasions where patients had been inappropriately booked with them and had to be referred back, along with correctional feedback to the booking practice. If this action had to be taken, safety was considered, and patients seen where necessary. Staff we spoke with told us that this was rare.
- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that require them. Staff told us they were empowered to make direct referrals for patients with other services where necessary.

**Helping patients to live healthier lives.**

Staff were consistent and proactive in empowering patients and supporting them to manage their own health and maximise their independence.

Good

# Are services effective?

- The federation was aware of patients who may be in need of extra support as this was identified by the booking practice. Actions were taken to ensure these patients were able to access services unimpeded, such as the presence of a translation service.
- Where appropriate, staff gave people advice so they could self-care. Systems were available to facilitate this.
- Clinical risk factors, where identified, were highlighted to patients and their normal care providers so additional support could be given.
- Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs.

**Consent to care and treatment**

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The federation monitored the process for seeking consent appropriately.

Good

# Are services caring?

**Kindness, respect, and compassion**

Staff treated patients with kindness, respect, and compassion.

- Staff we spoke with understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The federation gave patients timely support and information. There were arrangements and systems in place to support staff to respond to people with specific health care needs such as those who had mental health needs.
- The federation had facilitated the surveying of patients through all 4 PCNs in relation to the extended access service. This location was a member of the Wythenshawe Primary Care network (PCN) whose results were generally positive in relation to their overall experience with the extended access services.

**Involvement in decisions about care and treatment**

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

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available, but these were not in other languages, this assistance was available should patients require it, and booking practices would provide this information to the service. Information leaflets would be available in easy read formats, to help patients be involved in decisions about their care.
- In relation to patients with complexities, these were usually not booked in with the extended access service, as their usual GP would prioritise their care and treatment, including those with learning disabilities, end of life care or multiple complex comorbidities.

**Privacy and dignity**

The federation respected and promoted patients' privacy and dignity.

Good

# Are services responsive to people's needs?

**Responding to and meeting people's needs**

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

- They understood the needs of their population and tailored services in response to those needs.
- They had systems in place to improve services where possible in response to any identified unmet needs, should they be identified, but these were not always fully effective as the federation did not demonstrate any actions as a result of any negative patient feedback.
- The federation had a system in place that alerted staff to any specific safety or clinical needs of a person using the service. This was flagged by the booking practice, but as they had organised access to the patients records through a memorandum of understanding, they were able to see this information. Care pathways were appropriate for patients with specific needs, for example, babies, children, and young people.
- The facilities and premises were appropriate for the services delivered.
- The federation and Cornishway Group Practice had made reasonable adjustments when people found it hard to access the service. All clinical areas that we saw were on the ground floor and accessible for people with physical disabilities and communication aids were available. The enhanced access service itself was designed to provide care and treatment to those people who found it difficult to access primary care during usual operational hours (8am to 6.30pm).
- Unverified data from July 2022 was supplied to us by the federation in relation to take up of the COVID support service (provided prior to the enhanced access service) and indicated what proportion of appointments were conducted on the telephone or face-to-face. These data indicated that in a typical week, 73% to 100% of telephone appointments offered were used and 0% to 50% of face-to-face appointments were used. At this time, the locations were still being classified as hot and cold clinics, a name designated to those sites seeing and not seeing suspected COVID-19 patients respectively. The number of conversions from telephone appointments to face-to-face ranged from 0% to 21%.
- At Cornishway Group Practice, in a typical week, there were anywhere from 5 to 28 telephone slots and 4 to 11 face-to-face slots available. Utilisation could be as high as 100% or as low as 0% and conversion rates could be as high as 40%.

**Timely access to the service**

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

- Patients were able to access care and treatment at a time to suit them. The enhanced access service operated 7 days a week, at Cornishway Group Practice the opening times for this service were between 4.30pm and 8.30pm on two weekdays, 9am and 5pm on Saturdays and 9.30am to 1.30pm on Sundays.
- The service did not see walk-in patients and a policy was in place which clearly outlined what approach should be taken when patients arrived without having first made an appointment. Patients were referred back to their own GP, or seen by the enhanced access GP if they needed urgent care (which was discretionary based on clinical need). All staff were aware of the policy and understood their role with regards to it, including ensuring that patient safety was a priority.
- Waiting times, delays and cancellations were minimal and managed appropriately. There were a small number of patients that did not attend (DNA) their appointments, but the provider was unable to offer those appointments to other patients, due to the booking system and no walk-in policy. Available telephone slots could be booked by NHS 111.
- The service engaged with people who were in vulnerable circumstances and took actions to remove barriers when people found it hard to access or use services.
- The appointment system was managed by a patient’s usual GP surgery.

Good

# Are services responsive to people's needs?

- Referrals and transfers to other services were undertaken in a timely way.

**Listening and learning from concerns and complaints**

The federation took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. We saw 2 complaints had been received in the last year. We reviewed both complaints and found that they were satisfactorily handled in a timely way.
- Issues were investigated across relevant providers, and staff were able to feedback to other parts of the patient pathway where relevant.
- The federation learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, they ensured that all information communicated to the patient was fed through them to ensure appropriate channels were used.
- Patient feedback was generally positive in relation to access from the unverified data supplied to us by the federation, facilitated through the PCNs. As this location feedback had been included with the rest of Wythenshawe PCN.

Requires Improvement

# Are services well-led?

**We rated the federation requires improvement for overall governance because they had been unable to demonstrate that systems and processes in place had effective oversight or assurances to ensure they were working as intended. The provider had begun to address these areas, but this was an ongoing process.**

**Leadership capacity and capability**

Leaders could were able to demonstrate they had the capacity and skills to deliver high-quality, sustainable care.

- Leaders we spoke with had the experience, capacity, and skills to deliver the service strategy and address risks to it. They were knowledgeable about issues and priorities relating to the quality and future of services. They understood that there were challenges, acknowledged the shortfalls in overarching oversight and were addressing these. The provider told us this was due to management capacity issues, which they were also addressing. Following the inspection, the provider provided evidence that they had taken the following actions in relation to employed staff including ARRS staff:
  - Received documentation for the latest recruit in relation to their 3- and 6-month probation.
  - Completed and planned a significant number of appraisals with the relevant supervisors to catch up;
  - Reviewed training records and made contact with employed staff to promote the completion of Bluestream training (and then follow this up at the appraisal meetings)
  - Tracked leave to ensure staff had recorded this and took their leave entitlements before the end of the leave year;

For service location operation assurance

  - Completed 8 visits from the 11 sites (6 more were registered following the inspection) where services are delivered from. Developed location specific action plans (including infection prevention and control audits) to inform risk assessment of each location (in addition to the electronic documents that are requested from the site managers in addition to the site visits)
- They were candid and transparent about the challenges they had experienced and what systems and process they had put in place to address them. These were not always fully embedded but had been newly established; we identified gaps at some of the organisations' registered locations including Cornishway Group Practice.
- According to staff we spoke with, leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- Senior management was accessible throughout the operational period, with an effective on-call system that staff were able to use. Staff we spoke with confirmed this and that although they didn't require on-call often, they were confident that support and advice would be forthcoming from senior managers on-call.
- The federation had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service. There was an effective management structure with areas of governance covered by individual managers including recruitment and training as well as overall leadership, from the organisations nominated individual and registered manager.

**Vision and strategy**

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

- There was a clear vision and set of values, although the organisation had grown organically and had adapted to the shifting demands of primary care as well as the needs of their patients and their constituent practices. They acknowledged that this was a challenge, but they maintained that they knew what their purpose was, although it had

changed regularly. They had a strategy and supporting business plans to achieve priorities and purpose that remained in flux. We saw that business continuity plans were in place and had been developed in 2020 with a review date in 2021 but had not yet been reviewed. The provider told us that this was due to management capacity issues and that plans were in place to address this.

- We asked the federation if its vision, values, and strategy had been developed jointly with patients, staff, and external partners. They told us that this had not been the case as there had been a large number of changes since the inception of this vision in 2014.
- Staff we spoke with were aware of and understood the vision, values and current strategy and their role in achieving them.
- The organisation's current strategy was in line with health and social priorities across the region guided by their conversations with local commissioners and their members, including individual GP practices and their primary care networks (PCNs), who subcontracted the provider's services. They planned the service in conjunction with their stakeholders to meet the needs of the local population.
- The federation monitored progress against delivery of the strategy. They did this by submitting data to the commissioners. Unverified utilisation data was submitted to us in relation to all areas of service delivery and demonstrated that the enhanced access service was well-used by the patients in the area. The provider told us they relied on feedback from their members and patients to determine if their services were being successfully delivered along with feedback from stakeholders.
- The federation ensured that staff who worked away from the main base felt engaged in the delivery of the provider's vision and values. Although no team meetings were held, the staff we spoke with told us that they received regular updates and communications through email and could contact the service managers whenever they felt it necessary. They also told us that they found the provider was responsive to their needs. We asked the provider about team meetings, but employing so many sessional staff and lack of meeting space was a challenge. Their solution was providing remote and online support structures that appeared to be working well.

**Culture**

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

- Staff we spoke with felt respected, supported, and valued. They were proud to work for the service. The federation focused on the needs of patients and their member practices. Leaders and managers had systems in place to act on behaviour and performance inconsistent with the vision and values.
- 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.
- Openness, honesty, and transparency were demonstrated when responding to incidents and complaints. The federation showed us an example of a complaint they had addressed and were able to demonstrate that they had done so in line with good practice guidance. They were aware of and had systems to ensure compliance with the requirements of the duty of candour.
- There were processes for providing all staff with the development they needed. Staff were able to approach the provider (federation) should they need additional training and were supported to meet the requirements of professional revalidation where necessary. We were unable to verify if those staff subcontracted to the federation, or employed in ARRS roles, had access to this, as systems of assurance were lacking. Leaders told us that staff could approach them anytime if they had any concerns, but nothing had yet been raised. We were given a list of training that all employees (including ARRS and subcontracted staff) were encouraged to have completed between the first 3 and 9 months of employment or involvement. Following the inspection, the provider share evidence with us that demonstrated oversight of this area.
- The federation had SLAs with the practices on behalf of whom they employed staff, that outlined those practices' responsibilities in relation to staffing. Staff development included appraisal and career development conversations.

Requires Improvement

# Are services well-led?

We saw that not all staff had received a regular annual appraisal in the last year, but leaders demonstrated they had begun completing these in a structured fashion and would have completed all their employed staff by the first months of 2024. All new starters going forward, were to have inductions, 3-month and 6-month appraisals, followed by annual appraisals thereafter.

- Clinical staff, including nurses, were considered valued members of the team. Practices, where they had federation employed staff, had agreed to provide protected time for continuing professional development and evaluation of their clinical work as part of the SLA.
- Leaders we spoke with acknowledged, when asked, that they had not successfully established over-arching assurance systems to ensure that SLAs were being adhered to. They had begun a process to address this prior to the inspection, but this had not yet been fully rolled out. The provider demonstrated that a new appraisal system was beginning to be rolled out which would be capable of providing the necessary assurances in relation to staffing. The provider developed a risk assessment during the inspection to account for the lack of assurance system that were place in relation to the supervision of staff working throughout the practice network the federation supported.
- There was a limited emphasis on the safety and well-being of all staff given that assurances had not been sought in relation to the lack of safety and environmental risks assurances sought concerning the operational areas. We were told that staff would be supported should they were involved in a traumatic incident, complaint, or investigation. Staff we spoke with were confident that they would be supported during challenging circumstances as they were during 'business as usual' periods.
- Leaders actively promoted equality and diversity. They identified and addressed the causes of any workforce inequality. All employed staff had received equality and diversity training at recruitment. Staff we spoke with felt they were treated equally.
- From the conversations we had with staff, it was apparent that there were positive relationships between staff and teams.

**Governance arrangements**

- The federation demonstrated that structures, processes, and systems to support good governance and management were in place but were complex and were not always complete or effective. For example, assurance systems were missing in a number of areas of service delivery, and we saw that environmental assurance tools had been newly developed and tested but were yet ineffective. We saw that systems of assurance regarding staffing had begun to be rolled out but were not yet fully in place.
- There were 3 layers of governance in relation to the 68 employees with different contracts and roles deployed by the service. Firstly, staff employed directly by the provider to work in the main office, which mainly included managers for the various aspects of running the services. Secondly, there were staff employed by the federation on behalf of the individual practices (under direction of the PCNs). These staff roles, known as additional roles reimbursement scheme (ARRS), included, clinical pharmacists, physician associates and paramedics. Thirdly, there were those employed by the individual practices (not included in the 68) who were then subcontracted to the federation to work during the hours of operation to run their enhanced access service, including GPs and reception staff. The provider had Service Level Agreements (SLAs) in place to ensure that ARRS staff and those subcontracted from the individual practices to run the enhanced access services, were overseen, and supervised appropriately and had provided all necessary employment checks, at recruitment and on an ongoing basis.
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff we spoke with were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Leaders had established proper policies, procedures and were in the early stages of establishing activities to ensure safety and to assure themselves that systems and processes outlined in SLAs were being adhered to and operating as intended.

Requires Improvement

# Are services well-led?

**Managing risks, issues, and performance**

The federation had well established processes in place for managing risks, issues, and performance in terms of policies, procedures, and service level agreements (SLAs). They had newly established processes for gaining assurances from individual locations that had been tested but were not yet effective. We found gaps in the Cornishway in breach of the SLAs that the provider was yet unaware of.

- Processes to identify, understand, monitor, and address current and future risks including risks to patient safety were in place and tested but not yet effective.
- Processes were in place to manage current and future performance of the service and provided data that demonstrated utilisation of the booked appointments and 'did not attend' (DNA) rates.
- Leaders told us that performance of the GP workforce could be demonstrated through audit of their consultations, prescribing and referral decisions. Our review of clinical records highlighted no concerns in relation to these and they were found to be comprehensive and safe.
- Leaders had oversight of MHRA alerts, incidents, and complaints and had a good understanding of service performance against the national and local key performance indicators. Performance was regularly discussed at senior management and board level and was shared with staff and the local integrated care board (ICB) as part of contract monitoring arrangements.
- Clinical audit was not directly completed by the federation as they had no responsibility directly for a patient list, however, this was delegated to individual locations (practices) through SLAs. As in all reviewed areas, the federation had not yet gained assurances that these were completed in relation to their employed staff and for their service.
- The federation had plans in place and had trained staff in the main office for major incidents. Staff employed on behalf of and who worked in individual locations were to be trained in location specific emergency procedures. We found that emergency procedures were in place for all the locations we reviewed. Staff we spoke with in those locations were knowledgeable and able to articulate emergency procedures for the specific location, in which they worked.
- The federation implemented service developments and where efficiency changes were made this was following opportunities for clinicians to provide input to understand the impact of the changes on the quality of care.

**Appropriate and accurate information**

The federation acted on appropriate and accurate information.

- They told us that operational information about the quality of the service, was used to ensure, and improve performance where necessary in relation to local and national indicators. Unverified data supplied to us was limited to utilisation data and patient feedback. The federation was unable to provide the other areas of performance and quality when asked. Performance information was combined with the views of patients to drive change and improvements. Following the inspection, the provider explained that although information was fed back through the ICB, the information they were commissioned to provide was through the PCNs, whose requirements were limited to that information that was shared with us.
- Quality and sustainability of the enhanced access service were discussed in relevant meetings where all senior staff had sufficient access to information. Service staff were provided with this information through email.
- The federation had as yet limited over-arching systems in place to monitor and improve the quality of care provided. Following any period of operation, staff working within the individual locations would email both the federation and the necessary individual practices with all information from patients that had been seen (booked in by the individual practices). This information included, DNAs, referrals or any concerns. This was to ensure that both the federation and

the individual practices were aware of this information and were prompted to follow-up should that be necessary (particularly in the case of referrals). The federation also directed their sub-contracted staff to feed back to practices if patients had been inappropriately booked into the enhanced access service and where they would be more safely seen by their own GP.

- There were effective 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.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard, and acted on to shape services and culture. The federation demonstrated that it was able to adapt to the needs of patients, the member practices, and commissioners, but retained a purpose and plans to achieve them.
- Staff we spoke with were able to describe to us the systems in place to give feedback. For example, patients could submit complaints and feedback more generally. Those who needed additional support were provided with aids where necessary and staff were knowledgeable about how they could facilitate this for patients. Staff who worked remotely were engaged and able to provide feedback through email.
- We saw evidence of the most recent staff survey from June 2023 and how the findings were fed back to staff and the board. We also saw staff engagement in responding to these findings. Findings were categorised and had been acted upon and we saw that for each question, the majority of respondents were happy with the service.
- The federation had systems in place to ensure transparency, collaboration, and openness with stakeholders about performance.

**Continuous improvement and innovation**

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

- There was a focus on continuous learning and improvement at all levels within the organisation. Although there were systems to support improvement and innovation work, not all systems in place were operating at capacity in order to support this.
- The federation made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- They demonstrated innovative solutions to a continuingly evolving operational space and demands, within primary care and the wider health system. For example, they adapted to the creation of PCNs by taking over the HR functions of this new group and providing them with staff that they could then use to improve access for their patients.