Durham Dales Health Federation

Inspection report

Unit 26, Innovation House
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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 service is rated as Good overall. (Previous inspection July 2019 – Good)

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 announced comprehensive inspection at Durham Dales Health Federation as part of our inspection programme. This was the first time we had inspected this service at this address. We inspected the service under a different location's registration (prior to them moving premises) in July 2019, when they were rated as good overall.

We looked at the key questions; is the service safe, effective, caring, responsive and well-led.

How we carried out the inspection

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

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

This included:

- Reviewing patient records to identify issues and clarify actions taken by the provider
- Requesting evidence from the provider
- Sending out and receiving questionnaires completed by staff working at the service
- A short site visit

On the day of the inspection we interviewed; the chief operations officer, the business support manager, the GP Medical Director/clinical lead, the clinical services manager, two advanced practitioner nurse leads, a GP, an advanced nurse practitioner and a receptionist at the providers sites.

Our finding

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

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

Overall summary

We have rated this provider as good overall.

At this inspection we found:

- There were gaps in the oversight of some systems and processes to demonstrate effective governance. In particular, there were gaps in assurance around safeguarding training; the safety and effectiveness of premises; the risks of substances hazardous to health; infection prevention and control arrangements.
- The service had some systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes.
- The service routinely reviewed the effectiveness and appropriateness of the care they provided. They ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff had the skills, knowledge and experience to deliver effective care. However, assurances processes to check staff had received updated training in key areas was not always effective.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- There was a focus on continuous learning and improvement at all levels of the organisation. However, some aspects of assurance in the governance framework had not operated effectively.

The area where the provider **must** make improvements as they are in breach of regulations is:

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

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

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

Background to Durham Dales Health Federation

The provider of this service is Durham Dales Health Federation, which is a federation serving the needs of the population of the Durham Dales area. The Federation is made up of 12 general practices, with a population of 93,000 patients, spanning three Primary Care Networks (PCNs) in the County Durham Clinical Commissioning Group (CCG). Further details can be found on the provider's website at www.ddhf.co.uk

They provide an extended GP access service from the following sites;

- Bishop Auckland Hospital, Cockton Hill Road, Bishop Auckland, DL14 6AD.
- University Hospital of North Durham, North Road, County Durham, DH1 5TW. (This site was set up to provide additional support to the local population during the covid-19 pandemic).

As part of this inspection we visited both clinical sites above, as well as the administrative base at:

- Unit 26, Innovation House, Longfield Road, South Church Enterprise Park, Bishop Auckland, DL14 6XB

The extended access services are located in existing hospital accommodation. They use the hospital accommodation to provide this service. The federation employs its own staff.

They provider also provides other supporting primary care functions, such as a community wellness team, care navigation, clinical pharmacists, healthcare coordinators, social prescribing link workers, integrated diabetes service and practice aligned mental health services.

The service employs three GPs (one female and two male, including the GP Medical Director/clinical lead), a nurse clinical services manager and a team of advanced nurse practitioners, junior practitioners, nursing associates and trainee nurse associates. There is a chief operations officer and a business support manager, who are supported by a team of administrative staff. The services use bank and locum staff when necessary. The provider also employs staff on behalf of local practices and primary care networks, such as clinical pharmacists, healthcare coordinators, social prescribing link workers and nursing associates/trainee nurse associates.

The extended hours and overflow (if extra capacity is needed by local GP practices) services operates at both sites as follows:

- Monday to Friday 12 noon to 8pm.
- Weekends and bank holidays 8am to 8pm at Bishop Auckland Hospital and 8am to 1pm at University of North Durham.

These services are provided by GPs and advanced nurse practitioners.

Patients can access appointments via the NHS 111 service; they can arrange either face to face appointments or telephone triage appointments (known as warm transfers). GP practices in the areas covered can book patients into the overflow service. The service for patients requiring urgent medical care outside of these and the GP surgery hours is provided by the NHS 111 service.

Good

Are services safe?

We rated the service as good for providing safe services.

People were protected from avoidable harm, however some of the assurance processes around this could be strengthened.

Safety systems and processes

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

- The provider had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance. There was a lead member of staff for safeguarding processes and procedures. Staff we spoke with confirmed they knew how to access these. There were systems to identify vulnerable patients on the clinical record system. Staff we spoke with knew how to identify and report concerns.
- The safeguarding lead described local safeguarding arrangements, which were outlined in the safeguarding policies. The provider told us there had been no safeguarding children and 40 adult referrals in the past 12 months.
- Although we found no concerns with the arrangements for safeguarding vulnerable adults and children, we found the provider had not assured themselves that staff had undertaken update training in these areas. Managers told us the service had struggled to access in-person safeguarding training to the appropriate level for clinical staff due to the pandemic. They had recently identified on-line training in adults and children safeguarding and were in the process of rolling this out to staff. They provided some information prior to the site visit, which showed gaps in training for staff but told us they thought this was out of date. Following the site visit, they provided more updated information which demonstrated staff had received appropriate training in safeguarding, but much of this training had taken place the week after the CQC site visit to the service.
- All staff received safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. The service had identified staff required basic life support training, and this had been arranged to take place in May 2022.
- The service worked with other agencies to support patients and protect them from neglect and abuse. For example, they had access to and could update records to ensure information was shared with the patients' own GP. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. 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). In addition, the service asked staff to provide a signed declaration every three years to confirm there were no changes to criminal history.
- The service did not have in place assurance processes to check clinical staff remained registered with their professional regulator. They told us they supported staff with revalidation and therefore assumed they remained registered but did not have a process in place to check this. Following the CQC site visit, the service provided us with evidence they had checked staff clinical registrations and had added this to their personnel assurance processes.
- The provider conducted safety risk assessments. They had safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction and refresher training. However, the service did not have in place any documentation to detail the Control of Substances Hazardous to Health (COSHH). They told us the majority of cleaning was carried out by host premises and were in accordance with the hosts' policies, procedures and risk assessments. They had not assured themselves of the control of potential hazards associated with small number of products used by employed staff including the substances used by clinicians to clean between patients and by the cleaners to clean the premises.

Good

Are services safe?

- There were mostly effective systems to manage infection prevention and control, however, there were gaps in assurance processes. The extended access service was contracted to operate from two host hospital locations. The hospital Trust was responsible for the cleaning and maintenance of the clinical premises. We visited both sites and observed the premises to be clean and tidy. We saw there were systems and processes in place to manage infection prevention and control (IPC), including IPC audits. However, the service had not identified that an audit of the arrangements at the University Hospital of North Durham had not been carried out. The provider had nominated an IPC lead. However, they were new to post and had not picked up all the responsibilities associated with the role at the time of the CQC site visit. There was lack of clarity as to the scope of this role and whether it was site specific or covered all the Durham Dales Health Federation sites.
- Premises and facilities were managed by the host Hospital Trust. We saw evidence the service had requested documents of premises maintenance and premises records prior to the CQC inspection. However, the provider did not have ongoing systems or processes in place to assure themselves the facilities management undertaken by the host sites were compliant. After the inspection, the provider told us they were creating a system to ensure there was oversight of premises and facilities management.
- The arrangements for managing waste and clinical specimens at the host sites kept people safe.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed. The number and times of consultations were fixed, in line with the provider's contract. There were no walk-in or non-pre-booked appointments. Consequently, there was no requirement for any system for dealing with surges in demand. Some staff reported to us that shortages and high turnover of staff led to difficulty in filling rotas and placed extra demands on staff.
- There was an effective induction system for temporary staff tailored to their role.
- Staff 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.
- Receptionists were provided with training to help them identify and take action if they encountered a deteriorating or acutely unwell patient.
- The provider held a risk register. We saw that all identified risks had been assessed to define the level of risk by considering the category of probability against the category of impact on the service. All risks had been allocated a risk score rating based on this assessment. We saw that the provider regularly monitored this.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Appropriate and safe use of medicines

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

Good

Are services safe?

- Our interviews with clinical staff demonstrated medicine was prescribed and medicines advice given to patients in line with current national guidance.
- The service had carried out regular medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing. For example, the service regular audited the prescribing of antibiotics to ensure they were clinically indicated and in line with local and national guidance. Following the CQC site visit, they also provided clinical audits of the prescribing of hypnotics and controlled drugs. The service told us they had added these to their audit schedule following a discussion with the CQC GP specialist advisor.
- The service monitored the prescribing of its clinicians through clinical notes reviews.
- The service had access to all the appropriate emergency medicines at all sites. We saw that there was a system in place to check these.
- The service did not dispense any medicines and did not hold any controlled drugs.

Track record on safety

The service had a good safety record.

- There were risk assessments in relation to safety issues in most areas.
- The service monitored and reviewed activity. This helped them to understand risks and gave a clear and current picture that led to safety improvements. Although we found no evidence of any actual safety concerns, there were several gaps in assurance processes which impacted on the ability of the provider to proactively identify and act on potential risks.
- There was a system for receiving and acting on safety alerts.
- The service recorded all incidents, including those involving other agencies and organisations, on the local Safeguarding Incident and Risk Management System (SIRMS) to support joint learning and safety improvement.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service. For example, through their incident management process the service identified there was a risk that the pathway for reviewing patients prescribed anticoagulants in care homes who had a fall was not being followed. This was discussed internally and raised with the local clinical commissioning group. Working with partner organisations it was identified the pathway process was being followed, but there were different terms being used in different organisations to record this. This was shared with the clinical team to ensure there was a joint understanding locally. Another example was the service changed their standard operating procedures to reduce the risk of a clinician attending a prearranged home visit when there had been a change, for example the patient had died or been admitted to hospital.
- The service learned from external safety events and patient safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.
- The provider took part in end to end reviews with other organisations. Learning was used to make improvements to the service. For example, there was a joint agency evaluation of the pilot to test the impact of providing a primary care navigator in the Emergency Department (ED) front door to ensure patients were redirected to the most appropriate service, where this was not assessed as not being the ED.

Good

Are services effective?

We rated the service as good for providing effective services.

Effective needs assessment, care and treatment

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

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed.
- Guidance was available through a clinical decision support tool integrated into the clinical system and updates were discussed at clinical meetings.
- We spoke with clinicians and reviewed some clinical records. We found from those reviewed that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance.
- The service monitored that these guidelines were followed through audits and random sample checks of patient records.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support

Monitoring care and treatment

The provider had a programme of quality improvement activity, including clinical audit, and routinely reviewed the effectiveness and appropriateness of the care provided.

- There was evidence of quality improvement, including clinical audit. We saw that the provider had undertaken antibiotic prescribing audits.
- There was a schedule of clinical notes and prescribing reviews. Outcomes were fed back to clinicians. Clinicians we spoke with confirmed this.
- Clinicians we spoke with told us they had access to local prescribing guidelines.

Effective staffing

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

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff. This covered such topics as details of service provided by the provider, health and safety and use of the clinical systems.
- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required.
- The provider understood the learning needs of staff and provided protected time and training to meet them.
- Prior to the CQC site visit, the service provided us with a copy of their staff training matrix. We found there were gaps, particularly in relation to training on the safeguarding of children and vulnerable adults, basic life support and Mental Capacity Act. They provided an updated matrix to us following the CQC inspection site visit, which demonstrated staff had received appropriate safeguarding training; the majority of which had been carried out following the CQC site visit. They told us training on basic life support was planned to take place on 18 and 24 May 2022 and that staff had been asked to complete online training on the Mental Capacity Act by the end of May 2022.
- Although the assurance processes for statutory and mandatory training were not always effective, we did find staff were encouraged and given opportunities to develop.

Good

Are services effective?

- The provider provided staff with ongoing support. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The provider could demonstrate how they ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing. However, the provider did not offer employed GPs an appraisal specific to their support and development needs in relation to their work in the service. These staff still received their statutory appraisal as part of the requirement to remain registered with the General Medical Council (GMC).
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- Staff working at the service had access to each patient's full clinical record. Staff were able to view correspondence and test results within the record, and order further tests or make referrals when appropriate.
- Information was relayed to patients' own GPs via the clinical system. Tasks were used in the clinical system to support the follow up of blood test results, referrals and other clinical tasks which needed follow up by the patient's own GP.
- Patients with vulnerability factors were identified via a 'flagging' system on the patient record and could be viewed by staff.
- We saw that details were entered into patients' electronic records at the time of the consultation.
- There were arrangements in place for booking appointments. All appointments were pre-booked by the patient's own GP practice or via the 111 service. There were no walk-in patients.

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.

- As an extended access service, the provider was not able to provide continuity of care to support patients to live healthier lives in the way that a GP practice would. However, we saw the service demonstrated their commitment to patient education and promotion of health and well-being advice.
- Staff we spoke with demonstrated a knowledge of local and wider health needs of patient groups who may attend the extended access services.
- Clinicians told us they offered patients general health advice within the consultation and if required they referred patients to their own GP for further information. Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their need.

Consent to care and treatment

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

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

Good

Are services caring?

We rated the service as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- We saw equality and diversity training formed part of the provider's mandatory training schedule.
- As a result of the pandemic and in line with National guidance the service had not carried out any patient surveys or gathered patient feedback through the NHS Friends and Family Test (FFT). They continued to gather feedback and from patients through complaints and compliments. The majority of feedback was positive about the service.

Involvement in decisions about care and treatment

Staff 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.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

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

Good

Are services responsive to people's needs?

We rated the service as good for providing responsive services.

Responding to and meeting people's needs

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

- The provider understood the needs of their population and tailored services in response to those needs. For example, they understood the complexity of the patch they covered and delivered the Community Wellness and social prescribing services in a way to meet the needs of patients living in both rural and urban type areas. The provider engaged with commissioners to secure improvements to services where these were identified.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service. Care pathways were appropriate for patients with specific needs, for example those at the end of their life, babies, children and young people.
- The facilities and premises were appropriate for the services delivered.
- The service made reasonable adjustments when people found it hard to access the service.

Timely access to the service

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

- The extended hours and overflow (to provide extra capacity if needed by local GP practices) services operated at both sites as follows:
- Monday to Friday 12 noon to 8pm.
- Weekends and bank holidays 8am to 8pm at Bishop Auckland Hospital and 8am to 1pm at University of North Durham.
- Patients could access the out of hours service via NHS 111. The service did not see walk-in patients and a 'Walk-in' policy was in place which clearly outlined what approach should be taken when patients arrived without having first made an appointment, for example patients were told to call NHS 111 or referred onwards if they needed urgent care. All staff were aware of the policy and understood their role with regards to it, including ensuring that patient safety was a priority.
- Access was also via the patient's own GP practice who could book appointments on behalf of patients.
- Over the twelve months April 2021 to March 2022, the service had offered 14,896 appointments, of which 10,904 were used. Patients had booked but not attended 478 appointments.
- Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Three complaints were received in the last year. However, two of these also related to other agencies involved in the patient care. We reviewed one complaint and found that it was 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.

Good

Are services responsive to people's needs?

- The service learned lessons from individual concerns and complaints and also from analysis of trends. They acted as a result to improve the quality of care.

Requires Improvement

Are services well-led?

We rated the service as requires improvement for providing well-led services.

Assurance systems were not always effective. In particular, we found gaps in training for staff; the provider had not assured themselves of the safety of host premises; there were gaps in the assurance of infection prevention and control procedures. Although the provider had started to address these as part of their planning and response to initial feedback from the CQC inspection. We were concerned that improvements were reactive rather than the provider proactively identifying improvements of this sort through their own governance processes. These systems need to become embedded.

Leadership capacity and capability

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

- Leaders 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 service delivery and future of services. However, gaps in assurance impacted on the ability of leaders to have oversight and to manage and mitigate emerging risks.
- 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.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service. However, several staff told us that staff turnover was high. They told us that because the skills and knowledge training provided by the service were highly valuable in the health economy, staff were able to leave for other jobs.

Vision and strategy

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

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- The service developed their vision, values and strategy with external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The provider planned the service to meet the needs of the local population.
- The provider monitored progress against delivery of the strategy.

Culture

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

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.

Requires Improvement

Are services well-led?

- Staff told us they were able to raise concerns and were encouraged to do so. However, some staff who completed the CQC questionnaire reported that where issues had been raised in the past, these were not addressed, and no feedback was given as to why.
- Half of the staff (8 out of 16) who completed the CQC questionnaire reported either they did not know or were unsure who the Freedom to Speak Up Guardian was for the service.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional development and evaluation of their clinical work.
- Some assurances processes were ineffective and did not alert the provider to potential emerging issues or help in managing risks. For example, assurances around safety of host premises, control of substances hazardous to health; and, infection prevention and control.
- The service actively promoted equality and diversity. They identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- Most staff reported positive relationships between teams.

Governance arrangements

There not always clear responsibilities, roles and systems of accountability to support good governance and management. Some assurance processes did not operate effectively.

- There were some gaps in assurance processes and managers did not always have access to information to effectively identify areas for improvement. For example, the service had not identified:
- gaps in safeguarding training;
- the lack of assurance of the safety and effectiveness of premises;
- the absence of any documentation of the controls in place to minimise the risks of substances hazardous to health;
- gaps in the assurance of infection prevention and control arrangements.
- There were incomplete checks made on the registration of clinical staff with professional regulators.

They had identified some of these areas as part of the planning for the CQC inspection and had started to implement plans to address these. The service developed an action plan to address concerns raised in the initial feedback provided by the CQC following the site visit.

- In the main, structures, processes and systems to support good governance and management were clearly set out, understood and were mostly effective.
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Leaders had established proper policies, procedures and activities to ensure safety and however, some of the assurance processes did not operate as intended.

Managing risks, issues and performance

There were processes for managing risks, issues and performance. However, the gaps in assurance impacted on the ability of the provider to have oversight and to manage and mitigate emerging risks.

Requires Improvement

Are services well-led?

- There were gaps in the provider's operational systems and processes which impacted on the provider's ability to identify, manage and mitigate risk. In particular, training, infection prevention and control, and premises and facilities oversight.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality.
- The service had a business continuity plan (BCP) in place which outlined incidents which could impact on service delivery. However, there were some gaps in the plan. It did not contain sufficient detail to enable it to be enacted in the case of an emergency. It was developed as an action plan to identify what actions needed to be completed but did not provide details of how to undertake each of the actions. For example, it identified obtaining access to clinical systems as an action, but there were no details of how this would be achieved or contact details for the suppliers of IT support/ clinical systems to help achieve this in an emergency.
- The provider implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.
- The provider had processes to manage current and future performance of the service. Performance of employed clinical staff could be demonstrated through audit of their consultations, referral decisions and some of their prescribing. Leaders had oversight of patient safety alerts, incidents, and complaints.

Appropriate and accurate information

The gaps in some of the providers assurance processes meant there was not always access to appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information, which was reported and monitored, and management and staff were held to account. However, as some of the assurance processes were ineffective, information was not always up to date and reliable.
- The service submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners to support high-quality sustainable services. However, the pandemic had interrupted the collection and analysis of the views of people who used the service. The service had made use of other information available in the interim, such as complaints and compliments.

- The provider continued to contribute to the local health agenda and work in partnership with stakeholders to deliver patient care.
- Staff were able to describe to us the systems in place to give feedback. However, some staff reported to us they felt disengaged and were not consulted on the development of the service and future strategies.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

Requires Improvement

Are services well-led?

- There was a focus on continuous learning and improvement at all levels within the service.
- The service made use of internal and external reviews of incidents and complaints.
- Learning was shared and used to make improvements.
- The provider used an integrated IT infrastructure to deliver the service. This included a clinical decision support tool integrated into the clinical system and prescribing formulary which provided efficiency, consistency, clinical effectiveness and safety.

There was a culture of innovation evidenced by the number of pilot schemes the provider was involved in. For example, they were delivering a front door navigation pilot to support signposting patients to other services, where attendance at the Emergency Department was not appropriate, to alleviate pressures on the urgent and emergency care systems. They were working with partners to support improve care for patients with diabetes and those experiencing poor mental health to reduce pressures in primary care.

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
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured that effective systems and processes were in place to ensure good governance in accordance with the fundamental standards of care. In particular, we found that governance systems had failed to identify that: • There were gaps in core training and frequency of training updates. • There were gaps in the business disruption and continuity plan. • There was insufficient oversight of premises and equipment facilities management undertaken by the host landlords. • There was an absence of any documentation of controls in place to minimise the risks of substances hazardous to health. • There were gaps in the assurance of infection prevention and control arrangements. • The provider was not always carrying out checks on the registration of clinical staff with professional regulators. • Not all staff were aware of how to raise concerns through the Freedom to Speak Up Guardian. **How the regulation was not being met:** This was in breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.