GP Health Partners at The Derby Medical Centre

Inspection report

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Inadequate**

Overall summary

This service is rated as Requires Improvement overall.

The key questions are rated as:

Are services safe? – Requires Improvement

Are services effective? – Requires Improvement

Are services caring? – Good

Are services responsive? – Requires Improvement

Are services well-led? – Inadequate

We carried out an announced comprehensive inspection at GP Health Partners Ltd as part of our inspection programme. This was the first inspection of this extended access service. Our inspection included a visit to the service's headquarters and to three of the locations where the service operated. These were Derby Medical Centre, 8 The Derby Square, Epsom KT19 8AG, Heathcote Medical Centre, Heathcote, Tadworth KT20 5TH and Leatherhead Hospital Poplar Road, Leatherhead KT22 8SD.

Our key findings were:

- Patients were supported and treated with dignity and respect. Services were offered daily from several hub locations across the 19 practices, ensuring the service was accessible to all patients.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- Care and treatment was delivered according to evidence-based guidelines.
- Patients found the appointment system easy to use and reported they were able to access care when they needed it.
- The federation had reviewed the needs of their local population and ensured that additional services were offered. For example, cytology screening, asthma clinics and cardiology services.

However, we also found that:

- The service had not ensured care and treatment was always provided in a safe way to patients.
- The service was unable to assure themselves that people received effective care and treatment.
- The leadership and governance of the service did not assure the delivery of high-quality care.
- The service could not evidence that all the checks required to employ staff appropriately were in place.
- The service could not evidence that some clinical staff had been appropriately trained to undertake the tasks delegated to them.
- The service had not implemented effective systems to ensure appropriate and safe provision of emergency medicines and equipment.
- The service did not have systems and processes in place to ensure that safety alerts were managed effectively.
- We found that policies and procedures were not always written and shared with staff to govern activity and ensure staff were adhering to the same processes.
- The service did not have systems and processes to give assurance that staff would raise, share and record all significant events. There was no clear evidence to demonstrate that any identified learning was shared with the whole service team.
- The service did not always have oversight of the premises from where they delivered services. For example, the service had not reviewed premises management information sent from the host sites and had not followed up areas of non-compliance, so were unaware if the host sites had rectified problems found.

The areas where the provider must make improvements, as they are in breach of regulations, are:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure staff who are suitably qualified, competent, skilled and experienced persons, are deployed to meet the fundamental standards of care and treatment.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.
- Ensure systems and processes for managing significant events and complaints are robust and there are mechanisms for sharing information and learning with all staff to encourage improvements.

Dr Rosie Benneyworth BM BS BMedSci MRCGPChief

Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser, a nurse specialist adviser and a practice manager specialist adviser. The team also included two further CQC inspectors.

Background to GP Health Partners at The Derby Medical Centre

GP Health Partners Ltd is a formal alliance of 19 General Practices who deliver a range of services for the local population. Services include a dedicated children's clinic, chronic disease management, cervical screening, cardiology diagnostics and an extended access GP service (evening and weekend GP face to face appointments and an on line e-consultation service (LIVI) appointments seven days a week). Patients stay registered with their own GP practice but are able to access the enhanced services through a hub of eight GP practices.

The 19 practices which form the federation are:-

Ashley Centre Surgery - KT18 5DD

Ashlea Medical Practice - KT21 2BQ

Cobham Health Centre - KT11 1HT

Derby Medical Centre - KT19 8AG

Eastwick Park Medical Practice - KT23 3ND

Fairfield Medical Centre - KT23 4DH

Fountain Surgery - KT17 1TG

Heathcote Medical Centre - KT20 5TH

Longcroft Clinic - SM7 3HH

Molebridge Practice - KT22 7PZ

Nork Clinic - SM7 1HL

Oxshott Medical Practice - KT22 0QJ

Shadbolt Park House Surgery - KT4 7BX

Spring Street Surgery - KT17 1TG

St Stephens House Surgery - KT21 2DP

Stoneleigh Surgery - KT17 2LZ

The Integrated Care Partnership - KT17 4BL

Tadworth Medical Centre - KT20 5JE

Tattenham Health Centre - KT18 5NU

The practices which form the hub where patients can be seen are (phone lines are open from 8:00 on Saturdays):

The Derby Medical Centre

8 The Derby Square, Epsom KT19 8AG

Monday – Friday: 18:30 – 21:30

Saturday: 09:00 – 19:30

Sunday: 09:00 – 13:00

Leatherhead Hospital

Poplar Road, Leatherhead KT22 8SD

Monday – Friday: 18:30 – 21:30

Saturday: 09:00 – 19:30

Sunday: 09:00 – 13:00

Nork Clinic

63 Nork Way, Banstead SM7 1HL

Monday, Tuesday: 18:30 – 21:30

Tadworth Medical Centre

1 Troy Close, Tadworth KT20 5JE

Monday, Thursday: 18.30 – 21.30

Saturday: 09:00 – 19:30

Cobham Health Centre

168 Portsmouth Road, Cobham KT11 1HT

Monday, Friday: 18.30 – 21.30

Saturday: 09:00 – 19:30

Bourne Hall Health Centre

(Fountain Practice) Chessington Road, Epsom KT17 1TG

Wednesday: 18.30 – 21.30

Saturday: 09:00 – 19:30

Children's Clinics are run 4pm – 8pm from:

Monday (alternate weeks)

Fairfield Medical Centre, Lower Road, Leatherhead KT23 4DH

Fitznells Manor Surgery, 2 Chessington Road, Ewell KT17 1TF

Tuesday

Heathcote Medical Centre, Heathcote, Tadworth KT20 5TH

Wednesday

Nork Clinic, 63 Nork Way, Banstead SM7 1HL

Thursday

Linden House Surgery (Ashlea Practice),

30 Upper Fairfield Road, Leatherhead KT22 7HH

Friday

Derby Medical Centre, 8 The Derby Square, Epsom KT19 8AG

During this inspection we visited:

Derby Medical Centre, 8 The Derby Square, Epsom KT19 8AG,

Heathcote Medical Centre, Heathcote, Tadworth KT20 5TH

Leatherhead Hospital Poplar Road, Leatherhead KT22 8SD

This service is registered with the Care Quality Commission (CQC) under the Health and Social Care Act 2008 and provides the following regulated activities:

- Diagnostic and screening
- Treatment of disease, disorder or injury

The provider has a governing board which includes a Clinical Director, Managing Director, Company Secretary, and three non-Executive Directors. The provider has centralised governance for its services which are co-ordinated by the Clinical Director, Managing Director, Operations Manager, Operational Administrator and a part time Hub Manager.

The Clinical Director is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'.

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

As part of our inspection we asked for CQC comment cards to be completed by clients prior to our inspection visit. In total, across the three sites we visited, we received 58 comment cards which were wholly positive about the service and nature of staff. Other forms of feedback, including patient surveys were positive.

Requires improvement

Are services safe?

Safety systems and processes

The service did not have clear systems to keep people safe and safeguarded from abuse.

- There were safety policies in place. However, these were limited and some did not contain comprehensive information to govern activity. The federation was in the process of changing systems for staff to access policies, and policies were split between the two. However, when we asked staff about policies and procedures several were unsure as to how these could be accessed.
- Staff were given an induction to the premises before they commenced their first shift of work.
- The service employed reception staff and GPs who also worked at one of the 19 GP surgeries within the federation and felt this was additional reassurance that they only used fit and proper persons to carry out the regulated activity. However, some of the recruitment files we reviewed did not contain the required information. For example, information to access if they are of good character, full work history, up to date DBS checks and any required training. The service could not always evidence that recruitment information had been reviewed or recorded. We also noted that a few members of staff did not work for any of the other practices within the federation. For example, a member of the reception team.
- The service required staff members to complete training required by the provider. This could be done either at their own practice and evidence of the completed training sent to the head office or through the services' own on line training. The service was unable to evidence that all staff had completed up-to-date safeguarding and safety training appropriate to their role. The service held a training matrix which showed some staff did not have evidence of appropriate training. For example, five GPs on the matrix did not show evidence of having completed level three safeguard training for children and vulnerable adults.
- The service told us that reception staff could act as chaperones. We reviewed the training matrix which showed that all staff had received chaperone training. We also spoke with two receptionists who told us that they had completed the training and had received a DBS check.
- The service requested yearly infection control audits from each of the host sites. However, when we reviewed a sample of these we found that some of the audits had indicated areas for improvement. The service had not followed these up with host sites and were therefore unaware if these improvements had been completed or not. Some of the GPs used their own equipment and there was no record of the cleaning or calibration of this equipment.

Risks to patients

The systems to assess, monitor and manage risks to patient safety were not adequate.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an induction system which involved an introduction to the premises where the staff member would be working.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention.
- The room that echo technicians worked from had not been risked assessed and the echo technician was unaware of where the panic alarm was situated.
- The service did not always have oversight of safety risk assessments that had been undertaken in the host sites. For example, two of the locations had not returned required information on risk assessments completed, infection control monitoring and the PAT testing of equipment. The service told us that this information had been requested.
- There were appropriate indemnity arrangements in place to cover all potential liabilities.

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.

Requires improvement

Are services safe?

- Where patients required referrals, the clinicians requested that the patients' own practice completed these. The clinicians were able to task these referrals back to the practice and checked that these tasks had been received and completed.

Safe and appropriate use of medicines

The service did not have reliable systems for appropriate and safe handling of medicines.

- The service required that each of the host sites supplied emergency medicines. We noted that these differed at the three host sites we visited and items such as pulse oximeters were not readily available. The host site had a folder that contained all of the information that anyone working at the location would need to know and this included a list of the emergency medicines and where they were stored. At the host sites we visited, all emergency medicines were in the locations listed in the folder and were all in date. The service had not considered requesting host sites to provide standard emergency medicines and evidence that the expiry dates were reviewed on a regular basis. At Leatherhead hospital we found no emergency medicines available. We spoke with two GPs who worked at this host site, who were unaware of the lack of emergency medicines at this site. Although there was a risk assessment in place this did not give enough information for staff. The service provided us with an updated risk assessment before the end of the inspection which was more appropriate.
- The service did not administer vaccinations or prescribe high-risk medicines (for example, warfarin, methotrexate and lithium). Patients requiring these medicines were seen by their usual GP practice.
- Staff prescribed and gave advice on medicines in line with current national guidance. The service had reviewed its antimicrobial prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- The service relied on the host sites to supply prescription stationery and assumed it was securely stored and that the host site monitored its use. The three sites we visited showed these were adequately stored and monitored. However, we noted that the prescription pads for written prescriptions stored at Head Office were not monitored adequately.

Track record on safety

The service did not have a good safety record.

- The service did not have robust systems in place to ensure that host sites were providing the required risk assessments or for monitoring the information received. Risk assessments were not always completed adequately to demonstrate compliance. In addition some host sites had not provided required information.
- The service could not evidence that risks were monitored or reviewed to enable them to have a clear and accurate picture of the service which led to safety improvements.
- The service received external safety events and patient safety alerts. However, the mechanism in place to disseminate alerts to all members of the team was not effective. Actions required for alerts received were not recorded. Two staff members we spoke with at Head Office told us it was their job to send alerts but there was no mechanism to record if all staff members had seen them and knew of what actions (if any) needed to be taken. Several staff members we spoke with told us that they had not received any safety alerts. The service also relied on the staff members' usual GP practice to bring alerts to the attention of their staff. However, we noted several staff members who only worked for the Federation and would not receive alerts from other sources.

Lessons learned, and improvements made

The service did not evidence that they learnt and made improvements when things went wrong.

- The service was reviewing and investigating when things went wrong, but were unable to demonstrate that there was a comprehensive system in place.
- The service had a system for recording and acting on significant events. However, some staff members we spoke with were unaware how they would raise a significant event. They told us that they would e-mail any events to head office staff, who would then complete the necessary forms. The service told us they carried out a thorough analysis of significant events and had appropriate systems to manage them but we did not always see written evidence of this. The service was not able to evidence that lessons learnt and improvement made were shared amongst the whole team.

Requires improvement

Are services safe?

- The provider encouraged a culture of openness and honesty. Staff we spoke with understood their duty to raise concerns and report incidents and near misses. However, most told us they had not needed to report any incidents.

Requires improvement

Are services effective?

We rated the service as requires improvement 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.
- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs. This included back to their own GP or to the local Accident & Emergency Department.
- Clinicians had enough information to make or confirm a diagnosis and we saw that care and treatment was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- We saw no evidence of discrimination when making care and treatment decisions.
- There was a system in place to identify patients with particular needs, for example vulnerable or palliative care patients, and care plans were in place to provide the appropriate support.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service collected a range of performance information for the local Clinical Commissioning Group (CCG). This information included appointment utilisation statistics; numbers of patients who did not attend their appointments; secondary care referrals; patient feedback and the number of referrals to the community cardiology clinic.

During the inspection, the provider also shared examples of the most recent performance data submitted to the CCG, this showed that across all hub sites:

- In December 2019, 100% of referrals from the host sites for secondary care referrals, were seen by the patients' own GP within three days and 24 hours for urgent referrals. We noted that this had been consistent across the year.
- For April 2018 to March 2019 the federation had been able to offer 779 face to face appointments with 59 patients who did not attend (DNA).

The service was completing some audits that had a positive impact on the quality of care and outcomes for patients. We noted that most of the audits related to care provided by the nursing and heath care assistants working for the federation. For example, the service had completed a smear test audit, a health check audit and asthma & COPD annual review audit.

Quarterly audits of the GPs consultations had been undertaken using a scoring matrix to determine the range of outcomes, including accurate summarisation, medical examination and the volume of ongoing work back to practices, such as referrals and onward diagnostics. We were informed that this was an ongoing audit and that not all GPs had been reviewed as yet. However, we noted there was a lack of clinical audits.

During the inspection we asked to see the number of two week wait referrals that had been completed. The service was able to run this report but had not done this previously. The same report showed the two week wait referrals for the on line e-consultation service being provided. The service had not previously reviewed if these referrals were appropriate.

Effective staffing

Some staff did not have recorded that they had the skills, knowledge and experience to carry out their roles.

- The service asked that staff complete a list of training they required. This could be done at their main practice of work and evidence sent to the provider. This was recorded on to a spreadsheet. Where staff were due to complete or update their training, the service would contact the staff member and they could use the service's on-line training if needed. We viewed the training spreadsheet and saw that there were gaps in training. For example, 83% of the GPs had completed training in basic life support, 67% had completed dementia awareness training and 56% had completed

training in learning difficulties awareness. For non-clinical staff there was a collective 94% completed rate for all staff. However, we noted that sepsis training had not been included.

- The service had an induction programme for all newly appointed staff. A staff member from Head Office would meet the staff member at one of the host sites and walk them through the location. New staff members were also sent a folder with details of each of the host sites. This included where emergency medicines were stored, key policies and details of people to contact if required. There was also a physical manual for each host site that staff could refer to. However, we noted that this did not always contain up to date information and when asked, one staff member was unsure where this was located.
- Staff worked within scope of their practice and had access to clinical support. However, the service could not evidence that they recorded all qualifications and skills of their staff.
- The service had started to audit the competency of their staff by auditing their clinical decision making through reviewing the patient record. However, we noted this was only for the GPs and not for the other clinical staff including the echo technician.
- Nurses we spoke with were able to show us their most up to date training, for example – HPV screening, cervical screening. However, the service could not evidence that they had seen or recorded this training.

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.
- Patients received coordinated and person-centred care. Staff communicated promptly with patients' own GPs so that the GP was aware of the need for further action. Staff also referred patients back to their own GP to ensure continuity of care, where necessary. Before providing treatment, clinical staff at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history.
- The provider ensured that details of any treatment provided to patients was received by the patient's own GP practice and then recorded electronically in the patient's own medical record to ensure continuity of care.
- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that required them.
- Staff tasked the patients' practice in making referrals and referrals made were followed up by the provider to ensure the practice had completed the task.

Helping patients to live healthier lives

- As a GP extended access service, the provider was not required to deliver continuity of care to support patients to live healthier lives in the same way a GP practice would. However, we saw the provider demonstrated their commitment to patient education and the promotion of health and well-being advice. Staff we spoke with demonstrated a good knowledge of local and wider health needs of patient groups who may attend the service. Patients typically attended the service with non-life threatening health conditions, injuries and illnesses. Healthcare promotion advice was available in the waiting rooms of the various host sites and staff told us that patients could be referred to appropriate specialists, for example for smoking cessation guidance and treatment.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support.
- Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs. GPs and nurses told us they offered patients general health advice within the consultation and if required they referred patients to their own GP for further information.

Consent to care and treatment

- The provider 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. Staff training in consent issues was part of the provider's mandatory training. All patients were required to consent to the GP viewing their clinical record and this was recorded.

Requires improvement

Are services effective?

- 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.
- Feedback from patients was positive about the way staff treated people.
- The provider gave patients timely support and information.
- All of the 58 patient Care Quality Commission comment cards we received were positive about the service experienced at the host sites we visited. This was in line with feedback received by the service. Patients reported the service provided was excellent and staff were friendly and helpful.

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. Information leaflets were available to help patients be involved in decisions about their care.
- Patients told us through comment cards, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- Staff communicated with people in a way that they could understand.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff respected confidentiality.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Requires improvement

Are services responsive to people's needs?

We rated the service as requires improvement for providing responsive services.

Responding to and meeting people's needs

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

- The provider understood the needs of its population and improved services in response to those needs. The provider engaged with commissioners to secure improvements to services where these were identified. For example, the provider was also delivering children's clinics, cervical screening, asthma clinics and a cardiology clinics. There were also plans to deliver clinics for long term conditions such as diabetes.
- The provider had systems in place that alerted staff to any specific safety or clinical needs of a person using the service. For example, alerts were in place on the clinical system to identify patients at risk or on any safeguarding registers.
- The facilities and premises were appropriate for the services delivered. The provider made reasonable adjustments when patients found it hard to access services. Patients had access to translation services.
- The service was advertised in all of the 19 GP practices within the federation.
- The provider carried out cervical screening during the evening and the weekends to help improve access for patients and increase the uptake of screening in the CCG area.
- The provider had a monitoring system that enabled them to determine which practices were booking in patients to be seen at the services. This allowed the provider to ensure that there was a fair distribution of appointments.
- The facilities and premises were appropriate for the services delivered. We visited three locations and found that the waiting areas were large enough to accommodate patients with wheelchairs and prams, and allowed for access to consultation rooms. There was enough seating for the number of patients who attended on the day of inspection. Toilets were available for patients attending the service including accessible facilities. Baby changing, and breast-feeding facilities were available.

Timely access to care and treatment

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

- Patients had timely access to initial assessment, diagnosis and treatment.
- Waiting times and delays were minimal and managed appropriately.
- Patients were able to access extended access services seven days a week from host sites (Monday to Friday 6.30pm – 8.30pm – Saturday 9am – 7.30pm and Sunday 9am – 12.30pm).
- The provider had an on line service called LIVI that patients could access. LIVI is an app that allows patients to book an online face to face appointment with a GMC-registered GP who can give medical advice and prescriptions for a wide range of symptoms. If the symptoms required a physical examination, the GP would refer the patient to other medical services or specialists, for example back to the patients own GP. This was available to all patients from the 19 practices seven days a week from 7am- 10pm Monday to Friday and 9am to 5pm during the weekend.
- The appointment system was easy to use. Patients could access the service through their own GP practice or by phoning a dedicated number during the evening to book appointments. Information about how patients could access help out-of-hours was available on all of the practice's website.
- The service did not see walk-in patients. However, we did not see a policy or protocol for staff that clearly outlined what approach should be taken if a patient arrived without having first made an appointment.
- Where a patient's needs could not be met by the provider, staff redirected them to the appropriate service for their needs.
- Referrals were tasked back to the patient's GP. Head Office staff reviewed those tasks to ensure that the referrals were undertaken in a timely way. However, we noted that in the service level agreements there was not a specified time frame given to the practices to action those referrals to ensure they could be held to account if required. We also noted that the two week wait referrals were not audited.

Listening and learning from concerns and complaints

- The provider took complaints and concerns seriously and told us that they responded to them appropriately

to improve the quality of care. However, we were unable to see evidence of responses back to patients and any shared learning. There was also some confusion as to who complaints should be sent to.

- Information about how to make a complaint or raise concerns was available to staff. However, staff we spoke with were unsure of the process to follow. For example, the policy indicated that staff were to use the host sites own complaints and comments patient information leaflet but staff we spoke with were unaware of this.
- The provider could not evidence that they learned lessons from individual concerns and complaints or from analysis of trends.

Inadequate

Are services well-led?

Leadership capacity and capability

Leaders did not have the capacity to deliver high-quality, sustainable care.

- Leaders demonstrated they had knowledge about issues and priorities relating to the quality and future of services. They understood the challenges. However, the capacity to address these issues was challenging.
- The service informed us that funding for the extended access was on a short term basis and this in itself created problems in being able to plan for the future for the service. Including employing staff for Head Office roles to help with the capacity to deliver services.
- Staff told us leaders were visible and approachable. However, there was lack of knowledge of the roles of some of the leaders and staff were unaware of who else to contact and therefore relied on the same one person.
- Senior management was accessible throughout the operational period, with an effective on-call system that staff were able to use. However, this included a limited number of people who were also working throughout the day to manage the service.

Vision and strategy

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

- There was a clear vision and set of values. The service had developed its vision, values and strategy jointly with staff and external partners.
- 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 did not have a culture of high-quality sustainable care.

- Staff we spoke with felt respected, supported and valued. They were proud to work for the service.
- Staff told us they felt that the service focused on the needs of the patients.
- Leaders and managers did not have the systems and processes in place to show that they would recognise behaviour and performance inconsistent with the vision and values.
- The service was not able to evidence whether openness, honesty and transparency was demonstrated when responding to incidents and complaints.
- Staff told us they could raise concerns. However, they were not aware of the process to do this but informed us that they would address their concerns in an e-mail.
- Most staff were either locums or classed by the provider as bank staff and so the provider felt that formal appraisals would not be appropriate. The provider relied on patient satisfaction surveys and would ensure that for any specific staff comments these were reviewed and passed on to the team member where appropriate.
- The provider failed to demonstrate there was a strong emphasis on the safety and well-being of all staff. The provider did not have sufficient oversight of the premises the staff worked in.
- Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

Responsibilities, roles and systems of accountability to support good governance and management were inadequate.

- The structures, processes and systems to support good governance and management responsibilities were not clearly set out, understood and effective.
- Staff we spoke with were unclear of the leaders' roles and accountabilities.
- Leaders had not always established proper policies, procedures and activities to ensure safety and assurances that they were operating as intended. The provider was in the process of moving all policies to a shared platform that all staff could access. However, staff we spoke with were unsure how policies could be accessed.
- The echo technicians printed out reports for the patients' GPs to review. These were not stored securely and could be inappropriately accessed by staff not employed by the service.

Managing risks, issues and performance

Inadequate

Are services well-led?

The process to identify, understand, monitor and address current and future risks including

risks to patient safety was not always adequate.

- The process to identify, understand, monitor and address current and future risks, including risks to patient safety was not always effective.
- The provider had some processes to manage current and future performance.
- The provider was reviewing the performance of clinical staff through auditing consultations, prescribing and referral decisions. However, not all staff had been reviewed and the echo technician consultations were not audited.
- Leaders had oversight of safety alerts, incidents, and complaints but could not evidence that processes were being followed and that learning was disseminated to all staff.
- Leaders had a good understanding of service performance against the national and local key performance indicators. The service's performance was discussed at senior management and board level meetings, as well as with the local CCG, as part of contract monitoring arrangements.
- The provider did not conduct a diverse range of clinical audits to ensure there was a positive impact on quality of care and outcomes for patients.
- Written minutes of the operations team meetings were not recorded and so the provider could not evidence that any actions resulting from these discussions had been completed.

Appropriate and accurate information

The service did not always have appropriate and accurate information.

- The provider collected performance information but this was not always reviewed or monitored, and management, staff and host sites were not always held to account. For example, the provider told us that they had requested training updates from staff. However, not all of the staff passed on evidence that they had completed the required training. The staff members although chased were not held to account for not sending on the required information.
- The provider had not considered different ways to monitor performance to promote the delivery of quality care. For example, there was a limited number of audits being completed, including for the two week wait referrals.
- The provider submitted data or notifications to external organisations as required.
- There were arrangements for data security standards for the availability, integrity and confidentiality of patient identifiable data and records. However, we saw issues in relation to general data protection regulations which the service were unaware of. For example, a host practice had sent inappropriate information to the provider regarding all members of their staff performing a certain role. This included staff that were not working for the federation.

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners to support sustainable services.

- A range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- Patients were encouraged to provide feedback about the service. The provider had a process of recording patient feedback. The data showed a high percentage of patients were satisfied with the services provided.
- Staff we spoke with told us that they were happy with the systems in place to give feedback. They told us that they would contact staff at Head Office if required and were confident that any comments or concerns would be responded to.
- The provider was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was a strong culture of innovation, evidenced by the number of pilot schemes the provider was involved in. For example, the provider had piloted a home visiting service from January 2019 to March 2019, had provided an on line e-learning package for all of the 19 practices to use, and had provided an on line e-consultation service (LIVI) for all patients to use seven days a week.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person's recruitment procedures did not ensure that only persons of good character were employed. In particular: Recruitment procedures were not fully established and operating effectively.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular: The provider failed to evidence that staff were suitably qualified, competent, skilled and experienced persons were deployed to meet the fundamental standards of care and treatment.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: There was a lack of clinical audits

This section is primarily information for the provider

Requirement notices

Lack of oversight for infection prevention including reviewing risk assessments, cleaning of equipment and infection control audits.

Not auditing two-week wait referrals.

Not reviewing /auditing the echo technician's quality of work.

Not ensuring that a standard list of emergency medicines and equipment was available at each host site, including pulse oximeters.

Not ensuring that when GPs used their own equipment, this had been calibrated and PAT tested.

Not monitoring the risk assessments from the host practices.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: There was a lack of systems and process in place to ensure good governance in accordance with the fundamental standards of care. For example, Safety alerts processes Significant events processes Complaints process Leadership structure and accountability Governance arrangements and data protection Information in the service level agreements to hold people / host sites to account Policies and procedures Yearly risk assessments from host sites Monitoring of prescriptions Oversight of LIVI