King George's EUCC

Inspection report

Barley Lane
Goodmayes
Ilford
IG3 8YB
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Date of inspection visit: 6, 7, 20 and 22 June 2023
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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 to people's needs?	Requires Improvement
Are services well-led?	Requires Improvement

Overall summary

This service is rated as requires improvement overall.

The service had previously been inspected on 20 and 21 October, and 7 November 2022. In this inspection the service was rated as inadequate, and found to be in breach of regulations 12, 17 and 18 of the Health and Social Care Act 2008. The service was rated inadequate, conditions were issued and the service was placed into special measures.

The full reports for previous inspections can be found by selecting the 'all reports' link for King George's EUCC on our website at www.cqc.org.uk

We carried out an announced comprehensive inspection of King George's EUCC on 6, 7, 20 and 22 June 2023. We found that some of the breaches of regulation from the previous inspection had been fully addressed, but for others whilst progress had been made there was more to do. Following this inspection, 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? – Requires improvement

At this inspection we found:

- The rating of the service had improved from inadequate to requires improvement. Significant work had taken place to address the breaches identified at the previous inspections, however in a few areas whilst there was progress there was still more improvements needed.
- The service had begun to monitor more effectively the safety of the care it provided, and its performance was improving, but was still not meeting requirements specified by NHS England. Systems were now in place to monitor the time taken for patients to have their initial clinical assessment. However only 67% of patients were having this assessment within the 15-minute target. This meant there was an ongoing risk of patients needing urgent medical attention not being identified in a timely manner. An action plan was in place to continue to make improvements in meeting this target.
- Patients were not consistently able to access care and treatment at the service in a timely way. The service had a target to provide treatment and discharge the patient within 4 hours. The service was meant to achieve this for 95% of patients but the average was 75-85% so below the target.
- Staffing at the service was not in line with the rotas that workforce planning exercises had deemed necessary. The rotas showed that there was a gap of at least 15% for the urgent care practitioners during the day each month, and in some cases no cover at all overnight. This meant there were times when there were not enough staff working, and there were 277 instances in the last six months where patients had to be referred to another urgent treatment centre due to a lack of suitably qualified staff.
- The service was not consistently monitoring the effectiveness of the work of individual clinicians. Not all the clinicians were receiving consistent regular and high-quality clinical supervision. In addition, the audits of clinicians notes were not taking place as robustly as needed to ensure all clinicians were delivering appropriate clinical care.
- The service did not yet have formal mechanisms to engage with patient groups.

Overall summary

- Whilst governance processes had improved, there was still scope for these to be further strengthened, particularly in terms of ensuring staff performance was adequately monitored.

However, the following areas had been addressed:

- The service had improved the management of incidents and complaints, and mechanisms were in place to share learning.
- Leaders now had the capacity and skills to deliver high-quality, sustainable care.
- The service had developed a clear vision and credible strategy to deliver high quality care.

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 sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.

The areas where the provider should make improvements are:

- Review the detail required in the review of clinical competencies.
- Review storage of medicines at the service.

I am taking this service out of special measures. This recognises the improvements that have been made to the quality of care provided by this service.

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 advisor, a specialist advisor focussing on the corporate function of the organisation, a medicines team inspector, and a second CQC inspector.

Background to King George's EUCC

King George's EUCC is an urgent treatment service available to anyone living or working in Ilford and the surrounding areas in the London Borough of Redbridge and Barking and Dagenham. The service provides treatment of minor injuries and illnesses and provides a streaming service in order that patients are transferred to the right service either within the Urgent Treatment Centre or elsewhere. The streaming service is also the first point of contact for patients attending the emergency department of the hospital at which the centre is based.

The service is co-located on one level with the emergency department of King George's Hospital based at Barley Lane, Goodmayes, Ilford, IG3 8YB. It is accessible to those with limited mobility.

The service is delivered by Partnership of East London Cooperatives (PELC) which is a not-for-profit social enterprise delivering NHS integrated urgent treatment services (including GP Out of Hours and Urgent Treatment Centres), to more than two million people across East London and West Essex.

The urgent treatment centre is a 24/7 NHS service for patients who walk-in, self-refer, or are referred by the NHS 111 service.

PELC provides doctors and streaming staff to the service. Other nurses and healthcare support workers are provided by North-East London NHS Foundation Trust who subcontract nurse provision to PELC. Most of the clinical staff working at the service for PELC are either self-employed, bank staff (those who are retained on a list by the provider) or agency staff.

The urgent treatment service is open 24 hours a day. The service sees approximately 4,000-5,000 patients per month.

CQC registered the provider to carry out the following regulated services at the service:

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

The service's website address is http://www.pelc.nhs.uk

Requires Improvement

Are services safe?

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

We previously carried out an announced comprehensive inspection between 20 October and 7 November 2022. At the time of the last inspection the service was not providing safe services, and we found the following:

- At the time of the inspection, the service was providing a full clinical assessment within 15 minutes of arrival less than five per cent of the time, against a target of 100%. Patients were routinely waiting for more than two hours for a clinical assessment.
- Between 10pm and 8am, the service was not measuring the time to initial clinical assessment of patients.
- The organisation continued to have high levels of overdue significant incidents. At the time of the inspection, 80 significant incidents remained overdue, similar to the level at the previous inspection. Staff that we spoke to said that they were not aware of learning being shared.
- Where patients with potentially serious symptoms were being delayed in referral to the emergency department, the issue was not being flagged as an incident on the system used to log incidents of potentially unsafe care.
- The last comprehensive workforce planning exercise had taken place five years ago, at a time when the service saw fewer patients. In the three months prior to the inspection, there has been a rota gap of at least 10% for doctors, and at least 20% for nursing staff. Staff that we spoke to told us that there was insufficient staffing at the service.

At the time of this inspection visit between 6 and 22 June 2023, we found some of the issues had been addressed However, some breaches in regulation remained. Specifically:

- The organisation was not meeting its target for fifteen minutes to initial clinical assessment.
- There were insufficient staff demonstrated by regular gaps in the staff rota at the service.

Safety systems and processes

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

- The provider conducted safety risk assessments. It had safety policies, including Control of Substances Hazardous to Health and Health & 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. 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.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- At the previous inspection we noted that handwashing audits showed poor infection control compliance. At the time of this inspection, regular infection control audits were not taking place, but we observed that clinicians washed hands between patients.
- The premises were clinically suitable for the assessment and treatment of patients and could be expanded during peak periods of activity. Facilities and equipment were safe, and equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

Requires Improvement

Are services safe?

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

- 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. In line with available guidance, patients were prioritised appropriately for care and treatment, in accordance with their clinical need. Systems were in place to manage people who experienced long waits or who had been inappropriately streamed into the service.
- The service had now implemented a streaming measurement service, to measure how it was performing against the NHS England target of initially assessing all patients within 15 minutes of arrival. Since implementation, performance against this target had been improving, although it was not being met. Immediately following the previous inspection in November, at the time that this was first being measured, 16% of patients were being seen in 15 minutes. By the time of the inspection in June, performance had improved to 67% and had been upwardly improving since implementation. The service had an action plan to improve performance in this area, and had implemented a 'never event' policy to prevent extreme waits.
- There were arrangements for planning and monitoring the number and mix of staff needed. In the last three months, there has been a rota gap of at up to 5% for doctors, and between 15 and 25% for urgent care practitioners (UCPs) on day shift. The service had very little cover of UCPs overnight, and the provider reported that injury patients requiring urgent treatment were generally referred to Queens Urgent Treatment Centre.

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.

Safe and appropriate use of medicines

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

- The systems and arrangements for managing medicines, including medical gases, emergency medicines and equipment, and controlled drugs and vaccines, minimised risks. The service kept prescription stationery securely and monitored its use.
- The temperature in the room in which medicines were stored was higher than specified by the manufacturers of the medicines. As a risk mitigation measure, the service had halved the shelf lives of medicines stored at the site. However, Manufactures do not test at these temperature levels, and as such the medicines were technically off license.
- The service carried out medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing, although fewer than usual of these had been carried out as the service chief pharmacist role was vacant at the time of the inspection.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The service had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Processes were in place for checking medicines and staff kept accurate records of medicines.

Requires Improvement

Are services safe?

- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

The service had a good safety record as relates to risk assessments and management of alerts.

- There were comprehensive risk assessments in relation to safety issues.
- There was a system for receiving and acting on safety alerts.
- Joint reviews of incidents were carried out with partner organisations, including the co-located emergency department, GP out-of-hours and NHS 111 service.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- The service had improved reporting of incidents and the timely management of processes in order that learning could be shared with staff. 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.
- 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.
- 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, including the provider which employed the service's nursing staff and the local 111 service.

Requires Improvement

Are services effective?

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

We carried out this announced comprehensive inspection between 6 and 22 June 2023. We had previously carried out an announced comprehensive inspection between 20 October and 7 November 2022. At the time of the last inspection the service was not providing effective services, and we found the following:

- We interviewed a range of GPs, streamers, nurses, managers and administrative staff at the site. Staff told us that there were insufficient staff at the site for the service to deliver its key performance objectives.
- The organisation was not meeting its four-hour target for patients to be discharged by the service as agreed with the commissioners. The four-hour target had been under 86% for the past six months.
- Clinical supervision at the location was unclear outside of clinical guardian audits.
- The computer systems at the urgent treatment centre and the emergency department at the hospital were not compatible, so where patients were streamed to the emergency department, information could only be sent by data packet. This data was therefore not as easily accessible.

At the time of the inspection visit between 6 and 22 June 2023, some of the issues had been addressed, however some breaches in regulation remained. Specifically:

- The service was not up to date with clinical guardian audits at the site.
- The service employed a number of doctors who were not GPs. The service asked the doctors to self-certify compliance for the areas covered by the post. The Medical Director had oversight of this process, although it was not formally documented.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence-based practice. However, assessment and delivery of care was not consistently 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 directed to the urgent treatment centre were streamed into urgent or routine. However, we saw instances of patients with potentially serious conditions not being seen sufficiently quickly at clinical assessment to ensure they were safely managed.
- There was a system in place to identify frequent callers and patients with particular needs, for example palliative care patients, and care plans, guidance and protocols were in place to provide the appropriate support. We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. However, the service was not up to date with its primary clinical guardian audit tool.

- Prescribing audits were led by the lead pharmacist, a position that was vacant at the time of the inspection. The findings of audits were shared with staff. We saw a variety of two cycle audits where recommendations were shared through an organisational newsletter.

Requires Improvement

Are services effective?

- One of the clinical leads with responsibility for clinical guardian audits (audits of individual clinicians' notes) told us that their time dedicated to management work did not allow them time to complete clinical guardian audits. Clinical guardian audits were not completed for some staff.
- The sign off of competencies for streaming and GP staff was complete, but in both cases was brief, and did not contain relevant information relating to performance.

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.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- Staff were provided with ongoing support. Managers told us that this included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation.
- The service employed a number of doctors who were not GPs. The service asked doctors to self-certify compliance for the areas covered by the post. The Medical Director had oversight of this process, but it was not formally documented. In addition, it was unclear how the service had determined that the training undertaken by non-GPs was sufficient for the role, in the absence of GP revalidation, Royal College frameworks and GP appraisal.

Coordinating care and treatment

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

- The provider had developed a patient record handover pathway to the emergency department in conjunction with the hospital provider to better facilitate patient records transfer. This was awaiting final sign off prior to implementation at the time of the inspection.
- 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. This included when they moved between services, when they were referred, or after they were discharged from hospital. Care and treatment for patients in vulnerable circumstances was coordinated with other services.
- Staff communicated promptly with patients registered 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. An electronic record of all consultations was sent to patients' own GPs.
- 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 service had formalised systems with the NHS 111 service with specific referral protocols for patients referred to the service.
- The service took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

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.

- Where appropriate, staff gave people advice so they could self-care. Systems were available to facilitate this.

Requires Improvement

Are services effective?

- 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 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.
- Relevant staff had been provided with training in the Mental Capacity Act.
- 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.
- The service 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 end of life care and those who had mental health needs.
- We observed both clinical and non-clinical staff treating patients with care, dignity and patience.

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. We saw notices in the reception areas, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them. Information leaflets were available in easy read formats, to help patients be involved in decisions about their care.
- A hearing loop was in place at the service for those patients for whom it would be of benefit.
- 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 as far as the layout of the premises allowed.
- 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.

Requires Improvement

Are services responsive to people's needs?

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

We carried out this announced comprehensive inspection between 6 and 22 June 2023. We had previously carried out an announced comprehensive inspection between 20 October and 7 November 2022. At the time of the last inspection the service was not providing responsive services, and we found the following:

- The service had received 155 comment cards about the service in the past two years. Of these patient feedback forms, 48 specifically mentioned extremely long waits for patients either to be streamed, to be treated, or both.
- Delays were routine at the service, with most patients having to wait longer than targets in place for the service. We were told by staff, and several patients fed back to the provider, that they often left without being seen due to long waits, and that this impacted on the data integrity for the service. The exact times that patients were waiting were unclear, as the service was not measuring performance against the 15 minutes to be clinically assessed standard.
- At the time of the inspection, the service had a significant number of overdue complaints.

At the time of the inspection visit between 6 and 22 June 2023, some of the issues had been addressed, however some breaches in regulation remained. Specifically:

- The organisation was not meeting its four-hour target as agreed with the commissioners, The four-hour target had been under 95% for the past six months, and had been consistently under 85%.
- The service provided an injuries service. However, due to the lack of urgent care practitioners overnight, we were told that patients with minor injuries requiring urgent treatment were being referred to another service managed by the provider overnight. There were 277 instances in the last six months where patients had to be referred to another urgent treatment centre due to a lack of suitably qualified staff.

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 engaged with commissioners to secure improvements to services where these were identified.
- The urgent treatment centre offered step free access and all areas were accessible to patients with reduced mobility.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service, including those who were included on local safeguarding registers. Care pathways were appropriate for patients with specific needs, for example those at the end of their life, babies, children and young people.
- The premises in which the service was based was fit for purpose.
- The service provided an injuries service. However, due to the lack of urgent care practitioners during night shifts, we were told that patients with minor injuries requiring urgent treatment were being referred to another service managed by the provider at that time. There were 277 instances in the last six months where patients had to be referred to another urgent treatment centre due to a lack of suitably qualified staff.

Timely access to the service

Patients were mostly able to access care and treatment from the service within an appropriate timescale for their needs, although the service was not meeting targets for four hours to discharge.

- The service had received 162 comment cards about the service in the past year. The cards detailed that patient waits remained a concern at the service. The service had analysed and acted on the feedback, and had provided a "you said, we did" method of feedback.

Requires Improvement

Are services responsive to people's needs?

- The organisation was not meeting its four-hour target of 95% as agreed with the commissioners. The four-hour target had been consistently under 85% for the past six months. In mitigation the provider stated that it was contracted to see 65% of patients who attended the front door of the service, but due to changes to wider services, this was now over 75%.
- Patients could access the service either as a walk in-patient, via the NHS 111 service or by referral from a healthcare professional. Patients did not need to book an appointment.
- Patients were able to access care and treatment.
- The service operated 24 hours a day, seven days a week.
- Patients were generally seen on a first come first served basis, although the service had a system in place to facilitate prioritisation according to clinical need where more serious cases or young children could be prioritised as they arrived. The reception staff had a list of emergency criteria they used to alert the clinical staff if a patient had an urgent need. The criteria included guidance on sepsis and the symptoms that would prompt an urgent response.

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. We reviewed a sample of complaints and found that they were managed in line with this guidance.
- The service learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care.

Requires Improvement

Are services well-led?

We rated the service as requires improvement for leadership.

We carried out this announced comprehensive inspection between 6 and 22 June 2023. We had previously carried out an announced comprehensive inspection between 20 October and 7 November 2022. At the time of the last inspection the service was not providing well led services, and we found:

- A review of the governance procedures at the service undertaken by an external consultant in August 2022 found that organisational objectives were not clear and was not reflected in meetings. It also noted duplication of process and procedure across meetings.
- Staff that we spoke to were unaware of the strategic aims of the provider, and told us that they were disconnected from the senior management team. Systems for the planning and delivery of both addressing known areas that need development, and developing the strategic plan for the urgent care patient pathway were unclear.
- The service was not collecting sufficient performance information (for example safe time to stream), to determine if it was delivering against its core aims.
- There are longstanding items on the risk register, and we asked about the mechanisms for managing and removing risks, and the mechanisms for doing so were not clear.
- Staff reported that poor performance and instances of bullying and harassment were not managed at the service.
- Patient engagement at the organisation was not well developed. There was no patient representative on the Council, and the organisation had not yet developed working relationships with its local patient groups.
- Senior staff in key management positions at the organisation were on part time contracts of a limited number of hours. It was unclear how their time had been planned to ensure that they had sufficient capacity.

At the time of the inspection visit between 6 and 22 June 2023, some of the issues had been addressed, however some breaches in regulation remained. Specifically:

- Clinical governance procedures at the service were not sufficiently robust to ensure that a small minority of staff were suitable for their role. Staff performance was not sufficiently monitored.
- Some oversight processes at the service were not sufficiently clear.
- Patient engagement at the organisation was not well developed. There was no patient representative on the Council, and the organisation had not yet developed working relationships with its local patient groups.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care. However, some roles remained unclear.

- Leaders had the experience, capacity and skills to deliver the service strategy and address risks to it. The service had reviewed management responsibilities since the last inspection to ensure that they had sufficient time for their roles.
- Some oversight processes at the service were not sufficiently clear. For example, the company secretary, whose role in companies is to hold the board to account for governance purposes, was not fulfilling this role. This role had been delegated to another member of the Council, but this was not formalised.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- 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.

Vision and strategy

Requires Improvement

Are services well-led?

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 its vision, values and strategy jointly with patients, staff and 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.
- 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.
- 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.
- 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.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equitably.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management, but we saw that in some areas governance processes were not sufficiently clear.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Clinical governance procedures at the service were not sufficiently robust to ensure that a small minority of staff were suitable for their role. Staff performance was not sufficiently monitored.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

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

Requires Improvement

Are services well-led?

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. The risk register at the service was up to date and was monitored regularly.
- The provider had processes to manage current and future performance of the service. Leaders had oversight of MHRA alerts, incidents, and complaints. Leaders also 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. Performance was shared with staff and the local CCG as part of contract monitoring arrangements.
- 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 providers had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. 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.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service used information technology systems to monitor and improve the quality of care.
- 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, staff and external partners to support high-quality sustainable services. However, the service had not engaged patients in service delivery.

- The service met regularly with other partners within the urgent and emergency care framework in the local area.
- There were staff council members in place from all levels of the organisation who could contribute to the strategic vision of the organisation.
- Staff were able to describe to us the systems in place to give feedback.
- Patient engagement at the organisation was not well developed. There was no patient representative on the Council, and the organisation had not yet developed working relationships with its local patient groups.

Continuous improvement and innovation

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

- Staff knew about improvement methods and had the skills to use them.
- The service made use of internal and external reviews of incidents and complaints.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** • There were regular rota gaps in place at the service in order that the service might meet its targets. • The service employed a number of doctors who were not GPs. The service asked doctors to self-certify compliance for the areas covered by the post. The Medical Director had oversight of this process, although it was not formally documented. This was in breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** • The organisation was not meeting its target for fifteen minutes to initial clinical assessment. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** • The service was not up to date with clinical guardian audits at the site.

This section is primarily information for the provider

Requirement notices

- The organisation was not meeting its four-hour target as agreed with the commissioners, The four-hour target had been under 95% for the past six months, and had been consistently under 85%
- Clinical governance procedures at the service were not sufficiently robust to ensure that a small minority of staff were suitable for their role. Staff performance was not sufficiently monitored.
- Some oversight processes at the service were not sufficiently clear.
- Patient engagement at the organisation was not well developed. There was no patient representative on the Council, and the organisation had not yet developed working relationships with its local patient groups.

This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.