Wigan GP Alliance (Ashton Hub)

Inspection report

Ashton Medical Centre
120 Wigan Road
Ashton-in-Makerfield
Wigan
WN4 9SU
Tel: 01942 482848

Date of inspection visit: 25/9/2019
Date of publication: 13/11/2019

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?	Good
Are services well-led?	Good

Overall summary

This service is rated as Good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at Ashton Medical Centre on 25 September 2019. The inspection was carried out as part of or inspection programme.

At this inspection we found:

- The service had effective systems to ensure staff had a consistent approach to the service delivery.
- Communication was taking place and the service co-ordinators were spoken very highly of by all staff the inspection team spoke to. We were told how they were always at hand to resolve any problem, they had great communication skills and the teams felt supported.
- The service had good 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 it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- There were three folders which contained a wealth of information to support all staff, with step by step guidance and printed help sheets. These contained all the information to ensure the service would run smoothly.
- There was a comprehensive quality assurance system in place around policies and procedures, with all staff having access to the systems onsite.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- A clear system was in place for patients accessing appointments, with a chance to be added to a cancellation list.
- Staff involved and treated people with compassion, kindness, dignity and respect
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

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 inspector.

Background to Ashton Medical Centre

Wigan GP Alliance LLP provides the Extended Hours' requirements for the entire Borough of Wigan, which currently has 327,000 registered patients.

They operate out of seven locations within the Borough of Wigan. The service headquarters is located at Cherry Croft Court, Rear of 47a Wigan Lane, Wigan, WN1 2JE.

There are three federations in existence within the Borough of Wigan representing 62 of the 64 Practices. These Federations worked together and created Wigan GP Alliance LLP on 14 April 2016.

Wigan GP Alliance LLP vision is to provide the best care possible, to all registered patients of the borough, at a day and time suitable for the patient, in a location as close to home as possible, whilst also supporting practices. It allows residents of the borough the opportunity to seek medical treatment at a time that is convenient to them, without needing to seek time away from work. It provides pre-bookable routine appointments during the evenings and weekends including Bank Holidays when most of Wigan GP Practices are closed.

Appointments can be booked through the Alliances internal telephony service which operates between the hours of 8am to 8pm. A weekend and mid-week Cervical Screening service is available to patients.

The service operates using either advanced nurse practitioners or GPs to offer patient appointments, and weekend surgeries are staffed by a team of GPs, advanced nurse practitioners, practice nurses and healthcare assistants. Receptionists offer support to these surgeries during their operation. A team of service coordinators are on call during core opening hours and they offer a range of support and guidance to the onsite teams.

Ashton Medical Centre is located at Wigan Road, Ashton-in-Makerfield and is part of and managed by the SSP Health group of practices and is a member of Wigan Borough Clinical Commissioning Group (CCG).

Ashton Medical Centre is one location the Alliance operates the extended hours service for the Alliance. The practice opens between the hours of Monday to Friday 18:30 – 21:00. With weekend services operating on Saturday, Sunday and Bank holidays between the hours of 10:00 – 16:00.

The practice is a two-storey building with all clinical treatment taking place on the ground level which is fully accessible to those with mobility difficulties. There is car parking available with disabled parking spaces.

Wigan GP Alliance is registered with the Care Quality Commission (CQC) to provide the regulated activities at Ashton Medical Centre, of diagnostic and screening procedures, surgical procedures, transport services, triage and medical advice provided remotely and treatment of disease, disorder or injury.

Regulated activities are delivered to the patient population from the following address:

Ashton Medical Centre

120 Wigan Road

Ashton-in-Makerfield

Wigan

WN4 9SU

The practice has a website that contains information about what they do to support their patient population: .

The service does not accommodate walk-in patients or attend home visits.

Good

Are services safe?

We rated the service as good for providing safe services.

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 (COSHH) policies, which were regularly reviewed and communicated to staff. For example, each site prior to hosting the clinics submitted their own practice cleaning schedule. The head office service team also performed other building checks as part of their processes. Reception staff performed daily checks such as observational room check prior to and after each clinic. The head office also requested safety information to be submitted by the practice annually, such as proof legionella testing and electrical safety checks.
- Staff received safety information from the provider as part of their induction and refresher training. An in-depth folder was placed in the host location. This contained a wealth of information for each staff member to carry out their role effectively and efficiently. For example, the folder contained information on fire procedures and risk assessment checks carried out by the head office team.
- 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. For example, we reviewed a clinical safeguarding audit (first cycle) which had taken place in August 2019. The aim was to identify if a child attended the medical service had the accompanying individual (attendee) relationship and full name documented. It showed improvements could be made. A template was designed within the clinical system and all frontline staff made aware. This showed an increase in documentation.
- 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. We observed a notice was placed on the reception desk to inform patients the receptionist was supporting the GP while the frontline staff chaperoned.
- There was a check list provided to staff at each location with a set of tasks to complete before clinics commenced. These checks ensured the premises were clean and there was no infection prevention and control risks.
- All equipment belonging to the Alliance had been Portable appliance testing (PAT) and calibrated as required. This was then checked daily by the reception staff and counter checked by the service team on their regular visits to the practice.
- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. Each clinician was provided with a "Tool Box" which had a range of standard clinical equipment required for daily clinical sessions. One box was provided to each clinician at the start of their session and handed back to the receptionist at the end of their session.
- There were systems for safely managing healthcare waste, which was managed by the practice host.

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. There was an effective system in place for dealing with surges in demand. For example, all staff based at the head office were multi skilled to perform tasks, ensuring if a staff member was sick or on leave the role could be covered confidently.
- There was an effective induction system for temporary staff tailored to their role. We found the induction process to be robust, with all the relevant documentation and checks having taken place prior to the first session. Each new member of staff had signed a confidentially form.
- 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, with the Alliance clinical system "System One" having a tool to help recognition symptoms of Sepsis.
- Systems were in place to manage people who experienced long waits. We observed patients being seen on arrival or waiting no longer than several minutes to be seen by a GP.
- The service utilised a sophisticated online staff management tool and this was used to arrange the filling of shifts and the organisation of staff rotas. We saw that the majority of shifts were filled at the time of inspection and for the rest of the month of September. We were told that in the event of a shift not being adequately staffed then appointments would not be released for booking.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.
- When there were changes to services or staff the service assessed and monitored the impact on safety. Each site was allocated a service coordinator, who would be on call during clinical hours and handle any safety concerns from the team onsite.
- Staff all had access to a lone working policy in case of emergencies. The Alliance process is they do not schedule any location or head office site to be open with only one staff member present. All Hub sites have a minimum of two staff present at all times during operational hours.
- All sites have security locks and intercom systems fitted to all Hub entrance doors to protect the working staff and attending patients. We found on completion of the Hubs' work for the day, both staff members remain and assist with ensuring the practice is secured and also that the locking of the premises is done by at least two people.

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.

- The systems and arrangements for managing medicines, including medical gases, emergency medicines and equipment, and vaccines, minimised risks. The service kept prescription stationery securely in the safe which was provided onsite, and they monitored the usage.
- All emergency medicines were also stored onsite by the Alliance and stored in the safe, with daily checks taking place by staff to monitor.
- The oxygen and defibrillator were provided by the host of the service and checks took place daily by onsite staff.
- The service carried out regular medicines audits to ensure prescribing was in line with best practice guidelines. For example, we reviewed prescribing data provided to the Alliance by the CCG, which was reviewed by clinicians to identify any trends. This also formed part of the regular audits performed.
- 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. We reviewed daily task sheets required to be completed by onsite staff. These tasks included a check of the emergency medicines.
- 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. For example, the internal clinical IT system provided a direct link to the patient's own records, with monitoring and referrals followed up by the head office team, to ensure all relevant information had been received and actioned.

Good

Are services safe?

- Palliative care patients were able to receive prompt access to pain relief and other medication required to control their symptoms.

Track record on safety

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues. Each host was provided with a comprehensive check list of safety certificates annually from the Alliance Head Office and risk assessments were carried out by the service coordinator team at the practice.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements. For example, the directors at head office held regular meetings with the local CCG, where risk, alerts and complaints were discussed, this report was then fed back to the Alliance.
- There was a system for receiving and acting on safety alerts. The head office had a clear process for informing relevant staff by internal communicator system and email.
- Joint reviews of incidents were carried out with partner organisations such as the local CCG.

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 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, the head office had a clear auditable process for significant events. We saw that learning had been shared between all Alliance staff, including frontline staff. If any event involved a patient directly we saw full disclosure was presented to the patient.
- 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 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, we were told of pieces of work taking place to improve the auditable trail within the Alliance by working closely with CCG staff.

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.

- Each clinical appointment time ran for 15 minutes per person.
- 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. One of the board members monitored any changes and sent relevant guidance as required. There was also information available to all frontline staff on the service provider's shared computer drive and emails were sent when required.
- Telephone assessments were carried out using a defined operating model. The head office had a dedicated team of 12 call handlers who provide this service 363 days each year. Patients could access the service between the hours of 8am to 8pm. In January 2019 the Alliance received 11,096 calls, with the most recent figure from August 2019 being 9162 call received.
- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- Care and treatment was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. For example, we saw a template had been designed to capture all patients under 16 years old so there was clearer documentation of who attend the appointment with them.
- We saw no evidence of discrimination when making care and treatment decisions.
- There was a system in place to identify frequent callers and patients with particular needs, for example palliative care patients, and care plans/guidance/ protocols were in place to provide the appropriate support.
- When staff were not able to make a direct appointment on behalf of the patient clear referral processes were in place. These were agreed with senior staff and a clear explanation was given to the patient or person calling on their behalf. This included providing clear instructions to unfamiliar practices or locations.
- Technology and equipment were used to improve treatment and to support patients' independence. For example, patients were provided with a list of seven available locations to access their appointments from.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service had a comprehensive programme of quality improvement activity and routinely received the effectiveness and appropriateness of the care provided. Where appropriate clinicians took part in local and national improvement initiatives.

- Clinical appointments were 15 minutes in duration, to allow the clinician time to familiarise themselves with the patients notes and to allow time to discuss matters with the patient.
- From 1 January 2005, all providers of out-of-hours services were required to comply with the National Quality Requirements (NQR) for out-of-hours providers. The NQR are used to show the service is safe, clinically effective and responsive. Providers are required to report monthly to their clinical commissioning group (CCG) on their performance against the standards which includes audits, response times to phone calls, whether telephone and face to face assessments happened within the required timescales, seeking patient feedback and actions taken to improve quality.
- We saw the most recent NQR results for the service (2019-2020) which showed the provider was meeting the following national performance indicators:
  - During quarter one (April 2019 – July 2019), the quality details of service was rated by patients at 98% would either likely (11%) or extremely likely (87%) to recommend our service to other people.
- The service made improvements through the use of completed audits. 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. For example, the Alliance had an audit plan which this year had completed a number of audits.

Good

Are services effective?

We spoke with two GPs who were given protected learning to perform an audit they had wanted to commence. They told us they were fully supported to perform the audit. We also reviewed:

- Clinical safeguarding audit (first cycle) which had taken place in August 2019. The aim was to identify when a child attended the medical service and the staff document who accompanies them in clinic. A new IT template was developed which had shown to be effective for front line staff and increased the documentation.
- Consultation Audit had taken place in March 2019, using a 10-point assessment tool. The aim was to ensure high quality documentation of the consultations were recorded. Areas of learning where required were discussed with the clinician direct and the clinicians were written to with the findings.
- We reviewed first cycle audit (dated April 2018 - March 2019) of high-risk medicines audit, which was to review the appropriateness of prescribing.

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.
- We saw that copies of essential documentation for all head office staff and frontline staff, which were stored on the staff members personnel file. These files were detailed and contained vital documentation such as training records, insurance and registration checks.
- 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. Up to date records of skills, qualifications and training were maintained.
- 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 it ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.

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.
- Staff communicated promptly with patient's registered GP 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. There were established pathways for staff to follow to ensure callers were referred to other services for support as required.
- 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 ensured that care was delivered in a coordinated way and took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- The head office managed all staff booking requests by using a clinical tool called Rotamaster. The tool ensured that all available shifts were offered to clinicians and non-clinicians on a timely basis. In addition, the computerised tool highlighted gaps which had not yet been filled.

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.
- 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.

Good

Are services effective?

- 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.
- The service gave patients timely support and information. Call handlers gave people who phoned into the service clear information.
- All the 44 patient Care Quality Commission comment cards we received were positive about the service experienced. We were told from one patient that they were unable to get an appointment at their own surgery and were seen within 24 hours at a location suitable to their needs. Another card stated the service was helpful, efficient and caring. This was in line with the results of the NHS Friends and Family Test and other feedback received by the service, which identified 98% positive feedback about the Alliance feedback from patients.

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.
- 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. Some patients also stated they preferred using this service over their own GP service due to the quick access to appointments.
- 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. We saw a service leaflet available in Braille for visually impaired patients.

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. It took account of patient needs and preferences.

- The provider understood the needs of its population and tailored services in response to those needs. For example, we saw there were extra appointment times and locations provided, where service needs increased.
- The provider engaged with commissioners to secure improvements to services where these were identified. For example, the board had undertaken a programme of organisational development through the NHS Leadership Academy. The resulted in the development of a 'Plan on a Page' (page of the Alliances services and future) which was presented at a borough event.
- The provider improved services where possible in response to unmet needs. For example, the Alliance implemented in-house telephony service, on the back of "Did Not Attend" (DNA) rates and results from a patient satisfaction surveys from the outsourced call handling service they previously used.
- The provider had cytology screening clinics at weekends and on Wednesdays. This was set up as a request from the practices and from some local patients.
- The facilities and premises were appropriate for the services delivered. For example, a full health and safety risk assessment was in place.
- The service made reasonable adjustments when people found it hard to access the service. For example, the call handlers would identify any adjustments on the phone and accommodate to suit the patient's requirements.

Timely access to the service

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

- Patients were able to access care and treatment at a time to suit them. The service operated Monday to Friday 6.30pm to 9pm and Saturday and Sunday from 8am till 8pm.
- Patients could access the service via one central number between the hours of 8am and 8pm seven days a week. Access to appointments were booked by the call handlers and clinics populated at head office.
- Patients could access the out of hours service via NHS 111. The service did not see walk-in patients.
- Patients were seen by appointment system. 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. The receptionists informed patients about anticipated waiting times. However, we observed patients being seen on arrival.
- In 2017/2018 the Alliance's delivery of the service was rated in the top 10 in England.
- We reviewed the most recent results for the service. For example, quality details of the Alliance service for Quarter 1 of 2019 rated by patients was 98% are either likely (11%) or extremely likely (87%) to recommend our service to other people.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- The appointment system was easy to use and patients comment cards and patients who we spoke with confirmed this.
- Referrals and transfers to other services were undertaken in a timely way.

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. Six complaints were received in the last year to date. We reviewed all six complaints and found that they were satisfactorily handled in a timely way.
- Issues were investigated across relevant providers, and staff were able to feedback to relevant parties. For example, all complaints were directly presented to the board of clinicians. The complainant was provided with an apology and explanation of the events that led to the complaint. If there were lessons learned or reminders needed they were shared between all staff that would be able to use the information.

Good

Are services responsive to people's needs?

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.

Good

Are services well-led?

We rated the service as good for leadership.

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.
- The Alliance had a clear organisational structure to ensure both the clinical and organisational governance was met. For example, each board member encompassed a wide range of skills to enhance the service user's experience.
- 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.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of 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.

Wigan GP Alliance LLP vision is to provide the best care possible, to all registered patients of the Borough, at a day and time suitable for the patient, in a location as close to home as possible, whilst also supporting practices.

- 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.
- The strategy was in line with health 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. For example, the alliance carried out a questionnaire to patients on the key three important factors on providing the service to the borough. The outcome was not what the board had discussed. The board amended the original plan to align with the patient's needs and each hub location reflected the top three outcomes.
- 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. For example, we saw systems had been amended or changed due to reflected learning from incidents or complaints.
- There were processes for providing all staff with the development they needed. 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.
- There was a strong emphasis on the safety and well-being of all staff.
- 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 equally.
- There were positive relationships between staff and teams.

Good

Are services well-led?

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management. We observed the head office processes were clearly communicated to front line staff and this was reflected in the systems and processes we reviewed.

- 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. For example, each site had three folders which contained a wealth of information to support all front-line staff. Each folder contained step by step guidance, which included multiple printed help sheets for staff, with a wealth of front-line information to ensure the service ran smoothly.
- We saw communication was effective with the Alliance service co-ordinators, we were told how they were always at hand to resolve any problem and they had great communication skills.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Leaders had established a core selection of tailored 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. For example, we found the service had effective systems and staff working in the Hub had a consistent approach to the service delivery.
- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- 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, prescribing and referral decisions. 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 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. For example, we saw several head office audits taking place on the quality of care and consultations taking place. We also were told that frontline clinical staff were able to conduct clinical audits with protected learning time offered.
- The providers had plans in place and had trained staff for major incidents. For example, each location had a folder with a business continuity plan enclosed and staff we spoke directly to were aware of this process.
- 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.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- There was a well thought out induction process for new clinical and non-clinical staff. This involved a service co-ordinator supporting the staff during their first shift and providing all the relevant equipment and information to make the make new member of staff feel comfortable.
- There was a step by step guidance available to front line staff on accessing the clinical IT system and how to submit referral requests were readily available to front line staff.

Good

Are services well-led?

- 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. For example, we reviewed quarterly reports from meetings with the local CCG, where reviews of patient experiences and appointment data were benchmarked and discussed.
- 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, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example, each patient at each hub was presented with a questionnaire on arrival and on leaving the service, to ensure the views of the patients were being captured.
- Staff were able to describe to us the systems in place to give feedback.
- 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.

- There was a focus on continuous learning and improvement at all levels within the service. For example, the Alliance had started exploring various systems with external organisations, to enhance and improve the governance and audit trail process within the Alliance.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.