Southern Hampshire Primary Care Alliance Limited

GPEA Service, Fareham Hub, Fareham Community Hospital

Inspection report

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Date of inspection visit: 16 and 17 July 2019
Date of publication: 10/09/2019

Overall summary

This service is rated as Good overall. This was the first inspection of this service.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at GPEA Service, Fareham Hub, Fareham Community Hospital, as part of our inspection programme. This was the first time we had inspected this service.

The service provides a primarily extended hours service (patients can access GP and nurse appointments and book in advance to meet their needs) to patients living in the Fareham and Gosport and South East Hampshire Clinical Commissioning Group area. The service also offers an out of hours service until 10.30pm when the out of hours service is handed over to another provider.

There was no registered manager in post at the time of the inspection. The service had appointed one and they were in the process of being registered with the Care Quality Commission. 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 service is run.

During the inspection we collected 41 comment cards and spoke with two patients. Feedback from patients was very positive. Patients found the service to be convenient and helpful, especially those who were working and would have had to take time away from work for a GP appointment.

Our key findings were:

- Staff had the information they needed to deliver safe care and treatment to patients.
- The service learned and made improvements when things went wrong.

Summary of findings

- Patients received coordinated and person-centred care.
- Staff treated patients with kindness, respect and compassion.
- The service organised and delivered services to meet patients' needs.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- There were clear responsibilities, roles and systems of accountability to support good governance and management.

The areas where the provider **must** make improvements are:

- Assess, monitor and improve the quality and safety of services.
- Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users

The areas where the provider **should** make improvements are:

- Plan fire drills to improve staff awareness
- Continue with improved assurances in relation to emergency medicines
- Continue with processes to improve prescription stationery security
- Improve oversight of the waiting area for the monitoring of unwell patients
- Continue with processes to register the registered manager with CQC
- Improve frequency of staff meetings and ways of communicating with staff to ensure staff feel part of a team.
- Instigate a repeat prescribing policy
- Improve mentoring and development opportunities for staff
- Establish a system to provide assurance that locums, not employed in member practices, receive safety alerts and other updates.

Dr Rosie Benneyworth BM BS BMedSci MRCGP Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector**.** The team included a CQC Inspection Manager, a CQC team inspector, a GP specialist adviser and a practice manager specialist adviser.

GPEA Service, Fareham Hub, Fareham Community Hospital

Detailed findings

Background to this inspection

Southern Hampshire Primary Care Alliance (SHPCA) is a federation of GP Practices reaching from Bordon in Hampshire, down the A3 corridor to Fareham and Gosport, and across to Hayling Island. All but three practices in the Fareham and Gosport Clinical Commissioning Groups and South East Hampshire Clinical Commissioning Group (CCG) areas are members. Patients from all practices in these localities, whether members or not, can access the services.

SHPCA provides an extended hours and out of hours GP service and also delivers phlebotomy and cardiology outpatient services. The community specialist services part of the alliance employs health care assistants, a phlebotomy supervisor and a service manager to deliver a phlebotomy service across the Gosport and Hayling Island areas. There is also a clinical lead who is a Director and GP from one of the member practices. The service is available is available through six local hubs and patients access the service by booking in with their own practice. Fareham Community Hospital is one of the six separately registered hubs.

Portsmouth Cardiac Consultants provide consultant cardiologists and cardiac technician staff to the alliance to deliver the cardiology outpatients service. The alliance employs a service manager and healthcare assistant to administer and oversee the service. The cardiology service is intended as a non-urgent service. It can investigate palpitations, dizzy spells, suspected heart murmurs, breathlessness with unidentified cause, atrial fibrillation and pre-existing known cardiac conditions which are deteriorating. Access to the service is via GP referral.

The Integrated Primary Care Access Service (IPCAS) is delivered through five separately registered hubs. The service provides an extended hours service up until 8.30pm which can be accessed by patients via appointments booked in advance with their own GP practice. Between 8.30pm and 10.30pm the service operates an out of hours service which is accessed via NHS 111. Overall SHPCA serves a population of 421,000 patients. SHPCA started a new contract on 1 June 2019 to provide extended hours, out of hours and home visiting services to its population. The home visits and overnight out of hours parts of the contract are subcontracted to another provider. Each hub location has its own service level agreement supported by its own standard operating procedures (SOP).

Staff supporting the IPCAS service are not directly employed by the alliance but are employed by member practices. They are paid by their own practice for shifts worked delivering the service.

The IPCAS service is provided from:

Forton Medical Centre, Whites Place, Gosport, PO12 3JP

Saturday and Sunday 8am to 10.30pm

Fareham Community Hospital, 233A Brook Lane, Sarisbury Green, SO31 7DQ

Monday to Friday 6.30pm to 10.30pm,

Detailed findings

Waterlooville Health Centre, Dryden Close, Waterlooville, PO7 6AL

Monday Wednesday and Friday 6.30pm to 10.30pm

Saturday and Sunday 8am to 10.30pm

Portchester Health Centre, West Street, Fareham, PO16 9TU

Saturday and Sunday 8am to 10.30pm

The Swan Surgery, Swan Street, Petersfield, GU32 3AB

Tuesday and Thursday 6.30pm to 10.30pm

Saturday and Sunday 8am to 10.30pm

During the inspection we visited Waterlooville Health Centre and Fareham Community Hospital, which are registered locations.

Information about this provider can be found at www.shpca.net.

The inspection took place on 16 and 17 July.

Prior to the inspection we reviewed information we held about the service, publicly available information and information provided as part of the pre-inspection request. This helped us plan the inspection.

We used various methods to carry out our inspection of the various services. These included talking to people using the service, interviewing staff, observations and review of documents. We also reviewed patient records pertinent to the inspection and collected patient comment cards.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Good

Are services safe?

Our findings

We rated safe as Good because:

We found the service was providing safe care in accordance with relevant regulations.

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 appropriate safety policies, which were regularly reviewed and communicated to staff. The service 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 had systems in place to assure that an adult accompanying a child had parental authority.
- Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider had a complex system of staff checks in place which provided some assurance. Staff were employed by member practices and signed up for shifts for the extended hours service provided by the alliance. The provider had a workforce management platform in place to check recruitment and training had been carried out within the staff members' employing practice. However, this system was ineffective as many staff had not uploaded the appropriate documentation. We found the provider was not able to use this platform as a method of assurance. Of the nine staff we checked, we found that five had either not uploaded evidence of full employment history or had uploaded an employment history which included gaps which had not been explained.
- Therefore, the provider had used other methods to assure themselves that staff were safe and able to safeguard patients from abuse. The provider had obtained written assurance from each member practice manager in relation to their staff who had also signed up to work for the alliance. Checks were in relation to recruitment checks and included, for example, confirmation of two references, Disclosure and Barring check (DBS) and professional indemnity insurance. It did not include confirmation of a full employment history. (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).
- A weekly spreadsheet was also maintained to ensure staff working shifts that week had provided evidence of professional registration and revalidation, hepatitis B status, DBS, last appraisal date and levels of child and adult safeguarding training.
- The provider carried out staff checks, for staff directly employed at the time of recruitment and where appropriate, Disclosure and Barring Service (DBS) checks were undertaken where required.
- Records maintained showed that staff supplied from member practices were checked to ensure they had received the appropriate level of safeguarding for their role prior to working for the alliance. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control. We found consultation rooms to be physically clean upon inspection and appropriate personal protective equipment (PPE) was in place.
- The provider ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.
- At the Fareham hub there was reassurance that fire procedures, extinguishers, checks and training were in place. Staff told us that fire drills did not take place in the evening.
- In relation to the risk of legionella we saw evidence of temperature checks and flushing through of pipes and taps. A legionella risk assessment was in place.

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. Staff told us there was always enough staff on shift. The alliance had arrangements in place to ensure the minimum number of staff on a shift was a GP and two receptionists.
- When there were changes to services or staff the service assessed and monitored the impact on safety.

Good

Are services safe?

- There were appropriate indemnity arrangements in place to cover all potential liabilities. GPs provided their own professional indemnity insurance, and this was checked prior to any shifts being undertaken. Nurses and health care assistants were covered by a group policy put in place by the alliance.
- GPs assessed patients to identify if they were at risk of sepsis. Templates were used to guide GPs which automatically flagged up patients at risk once completed. However, National Institute of Clinical Excellence (NICE) guidance in relation to sepsis was not displayed in consulting rooms and GPs told us there had been no clinical discussion in relation to sepsis within the alliance.
- Emergency equipment was provided and maintained by the host site, Fareham Community Hospital This was checked at the start of each shift by staff working for the alliance to ensure intact.

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.
- Patient records were the responsibility of individual member practices. When a patient booked a consultation with the extended hours service, the patient's record was opened for 28 days. This allowed the attending clinician access to all of the patient's medical notes to support clinical judgement. In addition, the consultation was added directly into the patient notes and therefore immediately available for the patient's own GP to view. This ensured accurate records and continuity of care.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- The service had a system in place to retain medical records in line with DHSC guidance in the event that they cease trading.
- 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 did not always have reliable systems for appropriate and safe handling of medicines.

- There were systems and arrangements for managing medicines, emergency medicines and equipment minimised risks. The service did not hold vaccines or controlled drugs.
- The service was unable to carry out regular medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing, because medical records belonged to individual member practices and were only open to the service for 28 days.
- The alliance did not have its own repeat prescribing policy. This meant that GPs were following their own practices policy leaving a risk of inconsistency.
- At the time of the inspection, SHPCA relied on Fareham Community Hospital to provide emergency medicines and equipment. SHPCA did not provide a list of its own requirements and check these were in place. Following the inspection, the alliance amended its service level agreements and standard operating procedures with all host sites to be specific about which emergency medicines and in which quantities they required to be in place. They informed us they had carried out further checks and were happy that emergency medicines in hub locations met the requirements of the alliance.
- Staff prescribed and administered medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. Processes were in place for checking medicines and staff kept accurate records of medicines.
- The service relied on late opening or 24-hour pharmacies to supply medicines prescribed, and did not hold any medicines to dispense to patients.
- There were effective protocols for verifying the identity of patients including children.
- SHPCA did not have complete assurance in relation to the security of prescription stationery. Prescription stationery was provided by the hosts of the same day service operating at Fareham community hospital. Reception staff were responsible for loading printers at the start of the session and locking away at the end of the session. Prescription numbers were not recorded by staff, so it was not clear, if there was a discrepancy with prescriptions, who was responsible at the time or which serial numbers might be involved. Printers were not locked at the time of the inspection although the

Good

Are services safe?

provider told us they had obtained quotes and were in the process of ensuring printers were locked. Standard operating procedures required clinicians to lock their consulting room door if they are not in the room.

- Due to the above arrangements with prescription security, nurse prescribers were not able to sign prescriptions as they would in their usual employing practice. This meant they had to create and print prescriptions and then arrange for the GP at the hub site to sign them. The provider had tested a sample of these to check that it was recorded in the patient's notes who had signed the prescription and a recorded discussion with the signing GP. They were assured by this process.

Track record on safety

There was limited evidence in relation to the service's safety record, due to the way the service was set up.

- The service had a limited ability to monitor and review activity, because it used the premises and staff of its member practices.
- The alliance had sought assurances from hub practices in relation safety for example, fire, electrical and gas safety.

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. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned, and shared lessons identified themes and took action to improve safety in the service.
- SHPCA had prepared an annual review of complaints and incidents. There had been 13 incidents across all sites, in the year to 31 March 2019, all of which demonstrated appropriate actions and dissemination of learning. For example, one incident was in relation to inappropriate redirection from a hospital emergency department. As a result, redirection criteria had been changed.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents
- The service received external safety events as well as patient and medicine safety alerts, however there was no system in place to disseminate these to staff. It was assumed that GPs and practice nurses would access these through their own practice. However, four staff members were locums and not working in member practices.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

We rated effective as Requires improvement because:

- There was a lack of quality monitoring and clinical audit
- There was a lack of assurance in relation to staff training.

Effective needs assessment, care and treatment

The provider did not have systems to keep clinicians up to date with current evidence-based guidance. This was provided through clinicians' own individual practices.

- We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance.
- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- Clinicians had enough information to make or confirm a diagnosis
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed patients' pain where appropriate. GPs used a pain score of (1-10) or a smiley face system for patients with communication impairment.

Monitoring care and treatment

There was limited quality monitoring of the service. The provider told us this was because the service did not own the patient records and had only restricted access to them.

- The service had carried out some limited reviews of individual patient records and had plans to carry out further reviews. It was not possible to use these to improve the service as they did not relate to the service as a whole.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles, however, the provider did not have assurance that staff were up to date with required training modules.

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC)/ Nursing and Midwifery Council and were up to date with revalidation
- There were gaps in the monitoring of staff training. The provider had a workforce management platform in place to check recruitment and training had been carried out within the staff members' employing practice. However, most members of staff had not uploaded evidence of training. Of the nine we checked, three had uploaded some evidence but this was not complete.
- The CCGs had developed an essential skills document for nurses, healthcare assistants and clerical staff, however, monitoring was not in place to ensure staff employed by member practices had completed essential training. Although it was likely that most training had been completed through their own practices training program, the alliance did have assurance of this.
- Each hub site had a duty manager available to staff during opening hours. Staff reported they were easily contactable and supportive.
- We did not see evidence that staff whose role included immunisation and reviews of patients with long term conditions had received specific training. This was most likely supplied by staff members own practices however there was no assurance of this because documentation had not been uploaded to the workforce management platform.
- There was limited clinical supervision and limited opportunities for training and development provided by SHPCA. This was due to the way the service was set up. Staff were employed by member practices and had a role within the employing practice. Staff signed up for shifts with the alliance during evenings and weekends and this left little time for training and mentoring to be provided by the alliance. Staff we spoke to confirmed they received clinical supervision, training and development from their employing practice.

Coordinating patient care and information sharing

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

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate. GPs had direct access

Requires improvement

Are services effective?

(for example, treatment is effective)

to patient records for patients registered within the two CCG areas. This meant the consultation was recorded directly into the record and the patient's own GP had immediate access.

- For patients who were registered elsewhere (for example holiday makers) and using the out of hours service, details of the consultation were printed off and the patient was asked to hand them in to their own GP practice upon return. In addition staff also made direct contact with the patients registered practice the following working day to share the patient notes electronically via secure email.
- One practice in the local area used a different system. Patients registered with this practice were requested to hand over printed details of the consultation to their GP practice. For anything urgent, SHPCA staff called the practice the next morning.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history.
- All patients were asked by their own practice, at the time of booking the appointment, for consent for the alliance to access their medical records prior to the consultation. If consent was not given the patient was not able to use the extended access service as the consulting GP would not be able to access their records.
- Referrals to secondary care were made where appropriate and the patient's own practice made aware. The patient's own practice then followed up on the referral.

Supporting 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. For example, nurses gave patients in receipt of wound care, dietary and other health advice.
- 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.
- The alliance had started to set up clinics, for example asthma clinics, to enable patients to book in for long term condition reviews, as part of the extended hours service.

Consent to care and treatment

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

- 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 caring?

Our findings

We rated caring as Good because:

We found the service was caring in accordance with relevant standards and regulations.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people. We collected 41 comment cards in relation to the service, all of which were overwhelmingly positive.
- Patients described staff as helpful, gentle, welcoming and compassionate.
- 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.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

- Interpretation services were available for patients who did not have English as a first language.
- Patients told us through comment cards and interviews, 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.
- 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 available.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated responsive as Good because:

We found the service was responsive in accordance with relevant regulations.

Responding to and meeting people's needs

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

- The alliance was set up to help meet ever-increasing demands on the health service and to use working at scale to ensure the continuity of Primary Care Services for the future. Working collaboratively with stakeholders, the alliance planned to meet and continue to meet the changing needs of the population.
- The facilities and premises were appropriate for the services delivered.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. Staff had access to language line if required.

Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment. Standard appointments were 15 minutes.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.
- Referrals and transfers to other services were undertaken in a timely way.
- We found appropriate security arrangements in place. Patients accessed the service through locked doors which were opened and relocked for each individual patient by reception staff.
- There was a potential risk to patients whilst waiting in the waiting area for their care and treatment. The waiting area was approximately 30 metres away from the reception area and although the clinical rooms were near the waiting area, there was no direct oversight of patients. This meant that an emergency may not be immediately noticed and responded to by staff. The provider was aware of this and had entered discussion with the community hospital to relocate the clinical rooms and waiting areas.
- The extended hours service finished at 8.30pm. The out of hours service was from 8.30pm to 10.30pm. There was a daily review of the availability and need for appointments and the site manager was able to flex the arrangements between the two types of service as needed. For example, if an out of hours patient needed to be seen earlier this could be arranged. The alliance worked with its out of hours subcontractor to predict the need for services.

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. Staff treated patients who made complaints compassionately.
- The service informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint.
- The service had complaint policy and procedures in place. The service learned lessons from individual concerns, complaints and also from analysis of trends. It acted as a result to improve the quality of care.
- The alliance had prepared an annual review of complaints and incidents. This demonstrated that complaints had been dealt with appropriately, actions had been taken where necessary and learning had been disseminated back to the practices involved.

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Our findings

We rated well-led as Good because:

We found the service was well led in accordance with relevant regulations.

Leadership capacity and capability;

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

- Leaders 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.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.
- The provider had recently appointed a Chief Operating Officer who demonstrated an appropriate level of skill and understanding to lead the service and was supported by an external mentor. The executive board understood the needs of the population and had plans to develop a financially sustainable plan for the service to meet population needs.
- There was no registered manager in post at the time of the inspection. The alliance had appointed a new registered manager, however, changes in registration with CQC had delayed the registration of the new registered manager.

Vision and strategy

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

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities. The vision and values were displayed on the provider's website.
- The provider acknowledged that due to the unique way the service was set up, it was sometimes difficult to support staff to live the values. Further work was required to ensure staff felt part of the alliance team.
- The service developed its vision, values and strategy jointly with external partners. The alliance vision and detailed plan had been co-produced with Fareham and Gosport and South Eastern Hampshire CCGs. There was a quality strategy backed by a detailed plan for delivery.
- The service monitored progress against delivery of the strategy.

Culture

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

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- Training and development was not provided by the alliance as this was expected to be provided through the staff member's own practice. There was limited opportunity for coaching and mentoring for staff. Nurses said they felt supported by the GP during their shift. Training was provided for GP registrars.
- There was a strong emphasis on the safety and well-being of all staff. There was a policy in place to ensure minimum staff in any hub was a GP and two receptionists, this ensured staff were not placed at risk by lone working.
- The service actively promoted equality and diversity. Staff felt they were treated equally.
- 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.

- Structures, processes and systems to support good governance and management were clearly set out,

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- There was a clear system of supporting meetings such as the quality operational group and the information governance oversight committee reporting directly into a monthly board meeting.
- Staff were clear on their roles and accountabilities. Each director was responsible for a key area for example infection control, safeguarding, mental capacity and deprivation of liberty, information governance and patient safety. Role descriptions were being developed for each director.
- Directors were voted onto the board by member practices. Each member practice had one vote per thousand list size rounded up.
- 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.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- There was a risk management strategy in place supported by a risk management staff protocol and a risk assessment tool kit. This gave staff clear guidance in the identification, assessment and management of risk.
- Leaders had oversight of safety alerts, incidents, and complaints.
- Due to the unique way the service was set up, using hub locations and staff from member practices coupled with access to patient records limited to 28 days, this made access to clinical data and clinical audit challenging. The provider had completed some limited reviews of individual patient records following an incident and had a clinical governance process plan in place to carry out further limited reviews of patient consultations. At the time of the inspection the alliance was not in a position to review and improve clinical care through the use of clinical audit.
- The provider had plans in place and had trained staff for major incidents.
- There was a risk register in place which appropriately reflected the risks of the current culture and environment and supported our inspection findings.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used where possible to improve performance. The service sought feedback from patients and staff and acted on it to improve the service.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The provider information used information about the service to hold management and staff to account. There were plans to address any identified weaknesses.
- 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.

- The provider had developed a joint engagement plan with the CCGs to engage local people in understanding the services available to them and providing feedback about the type of services they would like access to.
- The provider presented monthly at the CCG clinical assembly to ensure local practices were kept up to date with alliance developments such as feedback from patients, changes to services and the impact on the care system.
- Following feedback from the CCG, in relation to patients who were unable to access a dressings service on a Sunday, the alliance had put a dressings service in place on Sundays and bank holidays at two hub locations. This reduced the need for patients requiring this service to attend emergency departments at local hospitals inappropriately.

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

- Patient feedback was collected through feedback cards and collated. Feedback about the service was over 98% positive. Feedback was also collected about the impact on the wider system, for example, what patients would have done if the service had not been available to them.
- A clinical staff experience survey had been carried out with mixed feedback from staff. Staff were asked for suggestions about the quality of care they were able to deliver, the environment they were working in and how supported they felt to deliver the care. The alliance had used this feedback to plan improvements to the service. For example, in response to concerns about patient dressings, a broader range to stock was put in place at each hub site.
- The service was transparent, collaborative and open with stakeholders about performance.
- Due to the way the alliance was set up with staff from member practices and the logistical problems in getting staff together for regular meetings, there had been difficulty in ensuring staff felt they were part of the alliance team. The provider wanted to develop a workforce 'brand' to support staff in identifying as part of a well-supported team.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement.
- The service made use of internal and external reviews of incidents and complaints to make improvements.
- There were systems to support improvement and innovation work.
- The alliance had recently updated and modernised their website. The website clearly described the services provided, the opening hours and explained what a patient could expect from the service. There was a plan to develop the website further to enable patients to book appointments directly through the website reducing administration time.
- The integrated primary care access service (IPCAS) was an innovative project, co-produced with Fareham and Gosport and South East Hampshire CCGs. The project started without a detailed service specification and the service was built up from scratch incorporating feedback from subcontractors and stakeholders, ensuring the member practices were genuine partners in the process.
- A staff portal had been developed and was due to go live the week following the inspection, to help overcome the difficulties of staff communication and teamwork and to support staff wellbeing. The portal included a general noticeboard, documents library, details of late-night pharmacy opening, staff and patient feedback 'You said, we did' and a social media platform.
- A quality strategy delivery action plan was in place ensuring the agreed strategy was monitored and improvements made. The plan was measured against CQC methodology to support the alliance in achieving CQC compliance. For example, one of the strategy improvements was to develop a mock CQC programme over a year.
- The alliance played a key role in shaping the future the local care system. The clinical chair sat on the Unified Executives Committee for the integrated care system.
- The future plan was to provide more effective services at scale through partnership working Portsmouth City Primary Care Alliance, acute and community providers and local CCGs.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems or processes must enable the registered person to assess, monitor and improve the quality and safety of services and to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. 1.The provider used a workforce management platform to manage staff information however we found gaps in recruitment data and staff training. The workforce management platform could not be used to provide assurances in relation to staff. 2. Due to the way the service was set up there was limited scope for GPs to have clinical discussion and in particular around the treatment of sepsis. 3. The service told us they were not able to carry out medicines and clinical audit because they did not own the medical records and had access for only a limited period. 4. There were not systems in place to keep GPs up to date with evidence-based guidance and safety alerts. This was because the alliance relied on GPs own practices to do this. The provider did not have oversight and assurance. 5. There was limited scope for quality monitoring due to the way service was set up and operated. The provider was unable to demonstrate they were actively monitoring the quality of the service, apart from patient feedback. 6. The provider relied on the GPs own practices to provide training. They could therefore not be assured that GPs had received training in line with their own requirements.