ELM Alliance Extended Hours and Out of Hours Service (known as The Star service)

Quality Report

Redcar Primary Care Hospital
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Date of inspection visit: 25 January 2018
Date of publication: 15/03/2018

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 service	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

Key findings

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Letter from the Chief Inspector of General Practice

This service is rated as requires improvement overall. (Previous inspection July 2017 – Inadequate)

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

We carried out an unannounced comprehensive inspection at ELM Alliance Limited on 11 and 12 July 2017. The overall rating for the service was inadequate. This service was placed in special measures in September 2017. The full comprehensive report on the July 2017 inspection can be found by selecting the 'all reports' link for Park Surgery – ELM Alliance Limited on our website at www.cqc.org.uk. A further focussed inspection was undertaken in November 2017, where we followed up concerns from the three warning notices we had issued. That re-inspection was not given a rating but we were satisfied that risks had been sufficiently reduced at that time.

This inspection was an announced comprehensive follow up inspection carried out on 25 January 2018 to confirm that the service had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspections.

Overall the service is now rated as Requires Improvement

Our key findings were as follows:

- The service ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- Patients told us through CQC questionnaires, 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.
- Patients could access treatment and care at any time within a 24 hour period (when referred by NHS111).

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

- **The provider must** establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care
- **The provider must** deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons, ensuring they receive appropriate support, training, professional, development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

Summary of findings

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

- **The provider should** undertake a regular review of the staffing rota, ensuring that staffing numbers are adequate, and closely monitor absence and lateness.
- The provider **should** review the chaperone policy as it did not fully outline the necessary procedures and required some improvement to make it effective.

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

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Key findings

ELM Alliance Extended Hours and Out of Hours Service (known as The Star service)

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team included a CQC Inspection Manager, a GP specialist adviser, two members of the CQC medicines team, a nurse specialist adviser and a second CQC inspector.

Background to ELM Alliance Extended Hours and Out of Hours Service (known as The Star service)

As a response to some safety concerns raised with the Care Quality Commission, we undertook an unannounced inspection of ELM Alliance Limited, (Redcar Hospital, West Dyke Road, Redcar, TS10 4NW) on the evenings of 11 July 2017 and 12 July 2017. At that inspection we gave the provider an overall rating of inadequate. A further focussed inspection was undertaken in November 2017, where we followed up concerns from the three warning notices we had issued. That re-inspection was not given a rating but we were satisfied that risks had been sufficiently reduced at that time.

ELM Alliance Limited is commissioned by South Tees Clinical Commissioning Group (CCG) to operate the extended hours GP service (with appointments during the night) and out of hours service across South Tees. ELM Alliance, a federation of all GP practices within South Tees CCG, took over the operation on 1 April 2017, offering care to around 300,000 patients. The service operates from 6pm until 8am every day. From 6pm until 9.30pm extended hours appointments are available at all four of the locations. At 9.30pm every evening the locations at North Ormesby and Brotton close. The Middlesbrough and Redcar locations continue to deliver services from 9.30pm until 8am every day, as the organisation operates as an out of hours service during these times. It offers urgent care appointments, as well as routine face-to-face and home visit appointments to patients who have been referred to it via their own GPs; or urgent care appointments by the NHS 111 service.

Park Surgery, Linthorpe Road, Middlesbrough TS1 3QY is one of four locations used by ELM Alliance Limited to deliver the enhanced urgent care service across the South Tees area. The additional locations are at Redcar Primary Care Hospital, Hirsell Medical Practice in North Ormesby, TS3 6AL, and Brotton Hospital in Saltburn, TS12 2FF. On the evening of our inspection we visited the Redcar Primary Care Hospital and Park Surgery. The service also has a vehicle which is used to transport clinicians to home visits during the night.

There are 113 staff members working for the provider, many of whom have a zero hours contract or annualised hours arrangement in place. These include 45 GPs, 25

Detailed findings

advanced nurse practitioners, one emergency care practitioner, six treatment room nurses, ten health care assistants and 26 administrative staff. Locums are used on a regular basis, in addition to the contracted staff. Many staff carry out their duties from more than one of the registered locations.

Requires improvement

Are services safe?

Our findings

At our previous inspection on 11 and 12 July 2017, we rated the practice as inadequate for providing safe services as the arrangements in respect of safeguarding, emergency equipment and medicines were not adequate.

We undertook a follow up inspection on 25 January 2018. The practice is now rated as requires improvement for providing safe services.

Safety systems and processes:

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong reviews and investigations were not always thorough enough andthere were delays in feedback systems.
- Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe some of the time.
- The provider conducted safety risk assessments. It had safety policies, including Control of Substances Hazardous to Health and Health & Safety policies, which were reviewed and communicated to staff.
- The service had systems to safeguard children and vulnerable adults from abuse. Policies were reviewed and were accessible to staff. They outlined who to go to for further guidance. All staff during the inspection were aware of who the safeguarding lead was for the organisation and who to contact if they suspected abuse was taking place.
- 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 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. The provider's chaperone policy did not fully outline the necessary procedures and required some improvement to make it effective.
- There was an effective system to manage infection prevention and control.
- 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.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed. However, it was difficult for the provider to ensure GP coverage at the earliest opportunity due to variations in financial incentives and remuneration of GPs. At the time of our January inspection, shifts booked in advance were not paid as highly as those booked at shorter notice.
- Since November 2017 there were nine recorded significant events where staff shortages had been reported. Evidence submitted following inspection states that the provider was in the process of recruiting more staff to the service.
- There was a newly introduced system in place for dealing with surges in demand which had been introduced a few weeks before our inspection to assist the provider in managing the NHS winter crisis. The first evaluation of the system had indicated to the provider that it was working well; however, inspectors did not find evidence that the system had increased efficiency or staffing levels to any significant degree.
- 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.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.

Information to deliver safe care and treatment

Requires improvement

Are services safe?

- 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 use of protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

- Arrangements for managing medicines were checked at the service. Medicines were issued at both the Redcar and Middlesbrough sites for people who required them out of hours.
- Emergency medicines were easily accessible to staff in both locations in secure areas and all staff knew of their location. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were in date and stored securely.
- Policies were in place for medicines management however there were different versions of the policy at the two sites we visited and the clinical lead showed us a further updated version. Also, the policies did not reflect current practice. There was no system in place to confirm that staff had seen the policies and were aware of any updates.
- The service held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had policies in place governing their management. We noted that controlled drugs (CDs) were stored in a suitable cabinet within a locked room. Access to the CD keys was via a key code that was communicated securely and appropriately. We checked entries in the controlled drugs record book and found they were made in line with legislation.
- The service had a stock list that set out which medicines they should stock. We checked medicines stocks at the Park Surgery site and found that systems were in place to ensure that medicines were available in suitable quantities. The Redcar service had boxes which were used to stock the home visit vehicles. There was a system in place to check these boxes to ensure that they contained all the medicines on the stock list and they were in date.
- We checked medicines and equipment in one of the transport vehicles. Vehicles used to take clinicians to patients' homes for consultations were well maintained, clean and contained appropriate emergency medical equipment and medicines. Medicines were removed from the vehicle to safe storage when not in use.
- There was a system in place to monitor the use of blank prescription forms and pads however the system was not effective and we saw discrepancies at both of the sites we visited. In addition controlled stationery was not checked daily by the service lead/ co-ordinator or quarterly by the pharmacist in line with policy. We also saw at one site that some prescriptions were not stored securely. the provider has taken action to reconcile the discrepancies identified on inspection.
- We saw a system in place for managing national alerts about medicines such as safety issues. Records showed that the alerts were assessed then distributed to be actioned as necessary to protect people from harm.However, these were distributed by email and we saw evidence that problems with IT systems prevented staff accessing their emails at times.

Track record on safety

The service was rated as inadequate for safe systems processes at our July 2017 inspection.

- Following our inspection in July 2017, the provider had outsourced the undertaking of risk assessments in relation to safety issues to a specialised company. We found at this inspection some risks had reduced.
- The service had started to monitor and review risk activity. This helped it to understand risks and had led to safety improvements. For example safeguarding training for all staff was prioritised and sanctions were in place if staff did not complete this training.

Lessons learned and improvements made

- There was a system for recording significant events. Staff understood their duty to raise concerns and report incidents and near misses.

Requires improvement

Are services safe?

- Leaders and managers encouraged a culture of reporting. However, feedback to staff was often delayed which was not in line with the provider's own policy.
- One of the GPs produced a thematic analysis which was emailed to staff on a quarterly basis. However, some staff were unable to describe any incidents that they had been made aware of within the service.
- The service learned from external safety events and patient safety alerts. The service had mechanisms in place to disseminate alerts to all members of the team including sessional and agency staff. However there was no evidence of a system which checked that staff had received or read these alerts.
- The provider took part in benchmarking with other organisations. Learning was used to make improvements to the service. For example, senior managers had travelled to the nearby Cumbrian out of hours provider to learn about some of their CQC-rated outstanding practices.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 11 and 12 July 2017, we rated the practice as requires improvement for providing effective services as the arrangements in respect of alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA), clinical audits and staff training needed improving.

We undertook a follow up inspection on 25 January 2018. The practice is still rated as Requires improvement for providing effective services.

Effective needs assessment, care and treatment

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

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. Since our previous inspection in July 2017, hard copies of guidelines had been made available at each of the four locations.
- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

From 1 January 2005, all providers of out-of-hours services have been 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 the clinical commissioning group on their performance against standards which includes audits, whether face to face assessments happened within the required timescales, seeking patient feedback and actions taken to improve quality. Examples of the requirements are as follows:

NQR 4: Providers must regularly audit a random sample of patient contacts and appropriate action will be taken on the results of those audits.

ELM Alliance had undertaken some sampling of patient records on 18 October 2017. Of a sample of 92 medical records, the service indicated that 40 out of 42 clinicians were appropriately recording in patient's notes. Evidence indicated that this sampling had uncovered concerns about two clinicians' competency. There were concerns about the standard of one clinician's clinical notes made after triaging. Recommendations following the sampling included arranging to meet with the clinicians whose records were causing concern. Inspectors saw no evidence that these triage concerns were investigated. There was no evidence that this had been shared with the multidisciplinary team, therefore not meeting the national quality requirement standards.

NQR 12: Face-to-face consultations (whether in a centre or in the patient's place of residence) must be started within the following timescales, after the definitive clinical assessment has been completed:

- Emergency: Within 1 hour.
- Urgent: Within 2 hours.
- Less urgent: Within 6 hours.

Data from the preceding three months showed that the provider achieved 100% compliance when patients were seen in the registered locations. The exception to this was where patients were visited in their own home. Here the provider's results were below the 90% minimum target, the provider's own data indicated that in one weekend in October 2017 there were 39 breeches beyond 90 minutes, out of 60 home visit requests. Some of these had breached 180 minutes. Since the evening of our inspection, these targets have been revised to ensure that the provider is able to operate a safe and effective service in accordance with patient's needs.

- The provider had a contract agreement with the local CCG that it would visit not less than 90% of its patients needing a home visit within 90 minutes of that disposition being made. Data for this indicated that the provider had only achieved a compliance of 82% ranging to 86%, overall, for this key performance area.
- Where the service was not meeting its target, the provider had put actions in place to improve performance in this area, for example, the introduction of an OPEL (operational pressures escalation level) demand surge system.However at the time of our

Requires improvement

Are services effective?

(for example, treatment is effective)

inspection, this system had only been in place for a month and it was too early to assess whether this system would have a direct improvement on the home visiting breaches of performance.

During the inspection we were shown one two-cycle audit that had been completed since our last inspection which was an infection prevention and control audit, completed by the lead nurse. Following the inspection the provider submitted further evidence of audit activity which has led to changes in process and procedure.

Effective staffing

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

- The provider had a newly-introduced induction programme for all newly appointed staff. This covered such topics as fire safety and safeguarding vulnerable people.
- Some of the advanced nurse practitioners made decisions about whether they would see and treat young children. They did this based on their own experience, skills, and scope of practice. The provider assessed We saw no evidence to indicate a robust system of clinical support by the provider, there were some one-to-one meetings (performance reviews) but no staff appraisals, no coaching and mentoring, and no for revalidation.
- There was a documented approach for supporting and managing staff when their performance was poor or variable but we saw no evidence of how this was carried out or monitored over time. Evidence submitted after inspection indicates that almost all appraisals were carried out one or two months after our inspection, and many of the performance reviews had not been completed before 25 January 2018.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate. 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.
- 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. An electronic record of all consultations was sent to patients' own GPs.

Helping patients to live healthier lives

Staff supported patients to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice so they could self-care.
- 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.

- 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, however we saw no evidence that any member of staff had undertaken mental capacity act training with ELM Alliance Limited. Evidence submitted after our inspection shows that mental capacity act training was undertaken in February and March 2018.

The service monitored the process for seeking consent appropriately.

Good

Are services caring?

Our findings

At our previous inspection on 11 and 12 July 2017, we rated the practice as good for providing caring services. The practice is still rated as good for caring, as standards have been maintained in this key question.

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 in place to respond to those with specific health care needs such as end of life care and those who had mental health needs. For example, when a patient attended the service with a mental health crisis (who was not registered with a South Tees GP) staff took appropriate action to ensure the patient was admitted to an appropriate mental health hospital. ELM Alliance involved the local mental health crisis team and notified the patient's own GP.
- All five of the patient Care Quality Commission questionnaires we received were positive about the service experienced. This was in line with the provider's own feedback from patients they had surveyed.

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, via Language Line - a telephone system of interpretation. We saw notices in the reception areas, including in languages other than English, informing patients this service was available. Information leaflets were available in easy read formats and other languages, to help patients be involved in decisions about their care.
- Patients told us through CQC questionnaires, 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 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 recognised the importance of people's dignity and respect.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 11 and 12 July 2017, we rated the practice as requires improvement for providing responsive services as the arrangements in respect of recording, investigating and learning from complaints needed improving.

The service is still rated as requires improvement for responsive.

Responding to and meeting people's needs

- The service had not formally reviewed the needs of its local population; it had not put in place a plan to secure improvements for all of the areas identified.
- We found patients were not always treated according to urgency of need; this was corroborated by recorded incidents and home visiting breaches.
- Patients could get information about how to complain in a format they could understand.

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

- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service; this was done through electronic codes on the computer system. Care pathways were appropriate for patients with specific needs, for example those at the end of their life, and babies and young children.
- The facilities and premises were appropriate for the services delivered.
- The provider had not formally undertaken any piece of work to understand the needs of its population and improved services in response to those needs.

Timely access to the service

Patients who attended the service in person were able to access care and treatment within an appropriate timescale for their needs. However on some occasions we saw that there were delays where people had to wait for care or advice.

- Patients could access the service via the NHS 111 service or by referral from a healthcare professional. Patients were also seen by booked appointment via their own GP.
- Patients were able to access care and treatment at a time to suit them. The service operated at Redcar hospital and Park surgery locations throughout Monday to Friday from 6pm to 8am and on Saturdays, Sundays and bank holidays from 8am to 8am.The Brotton and Hirsell locations operated throughout Monday to Friday from 6.30pm to 9.30pm. On Saturdays, Sundays and bank holidays opening hours were 8am to 9.30pm.
- Patients had timely access to initial assessment, test results, diagnosis and treatment with the exception of home visits where average waiting times were beyond the agreed performance indicator time agreed with commissioners.
- Waiting times and delays were not always managed appropriately; this was reflected in the provider's log of significant events. There were a number of incidents where people had to wait for subsequent care or advice. For example, there were ten examples of palliative care patients who had waited between 90 and 216 minutes to receive care and treatment for one weekend in October 2017.
- Patients who attended the service in person were mostly seen in a timely manner and the provider's own patient survey results reflected this.
- An internal audit of significant events done by the service on 17 December 2017 indicated that there had been 236 incidents since the service began recording them. Their audit results show that 46 of these incidents related to rota gaps, 39 related to breaches of telephone triage, 16 were home visit breaches and there were 35 incidents classed as 'other'
- Referrals and transfers to other services were undertaken in a timely way. For example, when a patient arrived at the service and was exhibiting signs of a mental health crisis, they were dealt with in a timely way.ELM Alliance contacted the local crisis team and transferred the patient to a local mental health in-patient unit.

Listening and learning from concerns and complaints

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

The service took complaints and concerns seriously and responded to them appropriately.

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. 26 complaints were received in the last year. We reviewed one complaint in depth and found that this was satisfactorily handled in a timely way.Provider responses to complaints included information about how to access the further support and advice if a patient was dissatisfied with the outcome.

Are services well-led?

Requires improvement

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

Our findings

At our previous inspection on 11 and 12 July 2017, we rated the practice as inadequate for providing well-led services as there was no overarching governance structure.

On the 25 January 2018 we saw some improvement in governance. The service is now rated as requires improvement for being well-led. On the evening of our most recent inspection (25 January 2018) it was difficult to access all of the required evidence due to ongoing problems with the provider's workplace technology and impromptu changes of meeting and interview venues which differed from the inspection team's plans.

Vision and Strategy

- The service had a vision and a strategy but not all staff were aware of this and their responsibilities in relation to it. There was a documented leadership structure and most staff felt supported by management but some staff told us they weren't sure who to approach with issues.
- The service had a number of policies and procedures to govern activity, but there was no effective system in place for the provider to ensure that these had been viewed by staff. Older versions of policies were not always removed after updates were made.
- All staff had received inductions but not all staff had received a performance review. A sample of five files showed that no staff appraisals had been undertaken. Evidence submitted after inspection indicates that almost all appraisals were carried out one or two months after our inspection, and many of the performance reviews had not been completed before 25 January 2018.
- The service did have some effective methods for communicating with its staff, that suited the needs of its workforce, but the IT systems used to deliver them were complex to negotiate and technology was unreliable. We have seen evidence following the inspection that the provider is working hard to address issues with information technology.

Culture

- During our inspection we checked FP10s (a type of prescription stationery) against clinical systems and found some discrepancies in clinical record keeping. The service's significant event matrix also indicated numerous incidents of discrepancies in stock amounts. The discrepancies were identified as part of the pharmacist's monthly audit and action was taken by the provider for poor record keeping.
- Openness and transparency were demonstrated when responding to incidents and complaints. Complaints were dealt with within timescales. 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.
- There were delays in giving feedback to staff about incidents they had reported. This was not in line with the provider's policy for dealing with incidents.
- There was no evidence that staff were given protected time for professional development and evaluation of their clinical work, although overtime payments were available for staff to complete mandatory training.
- The service promoted equality and diversity.
- There were positive relationships between staff.

Governance arrangements

- There was a documented management structure in place. Most staff were aware of their own responsibilities, roles and systems of accountability
- Structures, processes and systems to support good governance and management were not always effective.
- Staff were clear on their roles and accountabilities, including safeguarding and infection prevention and control.
- Staff were not clear about the organisation's objectives.
- Leaders had established some policies, procedures and activities to ensure safety.

Managing risks, issues and performance

- There were processes for managing risks, issues and performance. There was a process to identify, understand, monitor and address current risks including risks to patient safety.

Are services well-led?

Requires improvement

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

- There was no evidence of any GP medical indemnity insurance, with the exception of three out of approximately 45 GPs. There was no system in place for the provider to check and centrally record that this was in place, or that the cover was sufficient for the number of sessions worked. Since our inspection, the provider has submitted evidence that correct indemnity is in place.
- The provider had limited processes to manage current and future performance.
- Performance of employed clinical staff could was demonstrated through sampling of their consultations, prescribing and referral decisions.
- Performance was regularly discussed at senior management and board level. Performance was shared with the local clinical commissioning group as part of contract monitoring arrangements. The key performance indicator for home visiting was regularly and repeatedly breached and we saw no documented action from the provider, at the time of inspection, on how they were to improve this.
- There was limited quality improvement activity. We found only one example of a two-cycle clinical audit (infection and prevention control). Following our inspection, the provider submitted further quality improvement examples.
- The provider had plans in place and had trained some of its staff for major incidents. For example, it had developed a 'battle box'. This contained a packaged mobile phone, some blank prescriptions and a list of contact numbers. However, it was not clear to inspectors how this would effectively assist the provider in the event of a major incident. For example the mobile phone was not charged or ready for use and during the inspection the staff on duty were unable to locate the box in a timely way.
- An internal audit of significant events done by the service indicated that there had been 236 incidents since the service began recording them. Their audit results from 17 December 2017 showed that 46 of these incidents related to rota gaps, 39 related to breaches of telephone triage, 16 were home visit breaches and there were 35 incidents classed as 'other'. On most occasions feedback to the incident reporter had not been given within 20 days, which was not in line with the provider's own policy. Some staff who we interviewed were unable to provide an example of any learning from a significant event.
- Staff feedback indicated some staff felt there is was a staff shortage at the service. Following our inspection, the provider expedited its recruitment drive.
- Narrative discussions around governance issues in the provider's quarterly newsletter did not demonstrate any strategies or sanctions to effectively deal with events such as GPs not turning up for a shift.

Appropriate and accurate information

The service had plans to act on appropriate and accurate information.

- Quality and sustainability were discussed in relevant senior management and board meetings but not all staff had sufficient access to this information.
- The service used performance information but it was not clear how this was monitored over time, and management and staff were not always held to account.
- The service used information technology systems to monitor and improve the quality of care, but these systems were problematic for staff and managers at all levels. During the inspection staff had difficulty accessing the computer system and the central drive where key information was shared and stored by the provider. Since our inspection the provider has demonstrated that it is making efforts to address IT problems.
- The service had not submitted any notifications to external organisations and there have been no serious adverse events reported since the service began in April 2017. However, on analysis of some significant events that had been investigated by the provider, some should have been reported externally. For example, a safeguarding referral in respect of a child.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. However, on the evening of

Are services well-led?

Requires improvement

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

our inspections on 11 July 2017 and 25 January 2018 inspectors observed that a smart card was left in a computer in an unlocked clinical room, which was contrary to information governance policy.

- Information governance training was not apparent in about 50% of files which we sampled, despite some apparent significant events about information governance. Following our inspection, the provider submitted evidence that information governance training had been undertaken by staff.

Engagement with patients, the public, staff and external partners

The service involved staff in gathering views about the service.

- Staff were able to describe to us the systems in place to give feedback, for example at a team huddle at the start of every shift. Although staff felt some communication was better since our July 2017 inspection, we were told that communication from management was not always good enough.
- We saw evidence of the most recent staff survey and how the findings were fed back to staff via a quarterly newsletter. A survey of 44 staff showed that:

65% looked forward to going to work.

70% felt the team worked well together.

75% felt communication between staff and senior management was effective.

76% were clear about their line management and who they should contact if they had an issue.

90% felt confident to report an incident.

Although we have seen some evidence that identified risks have reduced over recent months, the systems and processes in place to assess and monitor the quality and safety of the services provided were not embedded or operating effectively. The overarching governance and leadership of the service requires strengthening to ensure that the necessary improvements continue to be made.

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 Family planning services Maternity and midwifery services Surgical procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • **SMART cards (a unique user system for accessing electronic patient records) were not always protected.** • Blank computer prescriptions were not kept securely. The system for the tracking of blank prescription pads was not adequate

This section is primarily information for the provider

Enforcement actions

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 Family planning services Surgical procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** • A CQC review of five staff files found no evidence of an appraisal or personal development plan. Two staff out of the five sampled had received one performance feedback discussion, (one on 05/12/17 and one on 25/10/17). Feedback received by CQC from eight members of non-clinical staff identified nil appraisals since April 2017. • The registered provider did not do all that was reasonably practicable to assure themselves that clinicians had adequate and appropriate insurance or indemnity. A CQC review of five staff files and found that was no evidence of medical indemnity for any of the five sampled clinicians. Further checks done by SS demonstrated that only three out of 45 GPs employed by the provider had provided evidence of their insurance. • Inspectors were informed that staffing the rota was difficult for the provider, to ensure GP coverage at the earliest opportunity. There were ten significant events regarding staff shortages logged on the service incident matrix between 05/11/2017 and 01/01/2018. • A CQC review of five staff files found no evidence of any Mental Capacity Act training in any of the sampled files. Inspectors were informed during inspection that this had not been undertaken by staff.