

PELC Out of Hours Service

Quality Report

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

Ratings

Overall rating for this service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Requires improvement



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Partnership of East London Cooperatives Limited (Out of Hours Service) on 3, 6 and 20 March 2017. Overall the service is rated as requires improvement.

Our key findings across all the areas we inspected were as follows:

- Although the governance framework aimed to enable the delivery of good quality care, we noted that medicines management and quality improvement governance arrangements did not always operate effectively.
- Risks to patients were generally assessed and well managed, although we noted the absence of a proactive approach to managing infection risks.
- Safeguarding systems and processes were in place to safeguard both children and adults at risk of harm or abuse but these were not always accessible to staff.
- There was an open and transparent approach to safety and an effective system in place for recording, reporting and learning from significant events.
- Patients' care needs were assessed and delivered in a timely way according to need. The available data showed that the service consistently met the National Quality Requirements and exceeded the commissioner's performance targets.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- There was a system in place that enabled staff access to patient records, and the out of hours staff provided other services with information following contact with patients as was appropriate.
- The service managed patients' care and treatment in a timely way.
- Patients said that they were treated with compassion, dignity and respect by reception staff and that clinicians involved them in decisions about their care and treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.

Summary of findings

- The service had good facilities and base locations were well equipped to treat patients and meet their needs.
- The vehicles used for home visits were clean and well maintained. When we highlighted that some emergency equipment was missing, the provider took immediate action to replace the items.
- There was a clear leadership structure and staff felt supported by management. The service proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider must make improvement are:

- Ensure that arrangements are in place for the safe management of medicines including protocols for checking emergency medicines and equipment at primary care centre base locations and in vehicles.
- Introduce effective governance arrangements for clinical audit, internal audit and risk management.

- Ensure that all staff undertaking chaperone duties have had training and checks through the Disclosure and Barring Service.
- Ensure that all staff have received safeguarding training appropriate to their role and that policies are readily accessible to all staff.
- Introduce reliable systems to prevent and protect people from a healthcare-associated infection including role appropriate staff training.

The area where the provider should make improvement is:

- Ensure that all staff (including self-employed GP contractors) receive annual basic life support training and that there are appropriate monitoring systems in place.
- Ensure that the needs of patients and local communities are identified and acted on.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The service is rated as requires improvement for providing safe services.

- Risks to patients were generally assessed and well managed, although we noted that the absence of a proactive approach to managing risks associated with medicines management and infection prevention and control.
- Although up to date safeguarding systems and processes were in place to safeguard both children and adults at risk of harm or abuse, these were not always accessible to staff.
- There was an effective system in place for recording, reporting and learning from significant events.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- When things went wrong patients were informed in keeping with the Duty of Candour. They were given an explanation based on facts, an apology if appropriate and, wherever possible, a summary of learning from the event in the preferred method of communication by the patient. They were told about any actions to improve processes to prevent the same thing happening again.
- There were systems in place to support staff undertaking home visits.

Requires improvement



Are services effective?

The service is rated as requires improvement for providing effective services.

- The service was consistently meeting National Quality Requirements (performance standards) for GP out of hour's services to ensure patient needs were met in a timely way.
- However, we saw limited evidence of quality improvement activity such as the use of clinical and internal audit to drive improvements.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for some staff.
- Clinicians provided urgent care to walk-in patients based on current evidence based guidance.

Requires improvement



Summary of findings

- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

The service is rated as good for providing caring services.

- Patients fed back to us that their experience of care had been positive and that staff treated them with dignity and respect. For example, patients told us that they were kept informed with regard to their care and treatment throughout their visit to the out-of-hours service.
- Patients said they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw that reception staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Good



Are services responsive to people's needs?

The service is rated as good for providing responsive services.

- The service had reviewed the needs of its local population and engaged with its commissioners to secure improvements to services where these were identified. For example, the provider was also commissioned to provide the local NHS 111 service and a local urgent care centre.
- The service had good facilities and was well equipped to treat patients and meet their needs.
- The service had systems in place to ensure patients received care and treatment in a timely way and according to the urgency of need.
- Information about how to complain was available and easy to understand and evidence showed the service responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Good



Are services well-led?

The service is rated as requires improvement for being well-led.

- Although the governance framework aimed to enable the delivery of good quality care, we noted that medicines management and quality improvement governance arrangements did not always operate effectively.

Requires improvement



Summary of findings

- There was a clear leadership structure and staff felt supported by management. The service had a number of policies and procedures to govern activity and held regular governance meetings.
- The provider was aware of and complied with the requirements of the duty of candour. The provider encouraged a culture of openness and honesty at all levels of the organisation. The service had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The service proactively sought feedback from staff which it acted on.
- We saw evidence of continuous learning and improvement.

Summary of findings

What people who use the service say

We looked at various sources of feedback received from patients about the out-of hours service they received.

The national GP patient survey asks patients about their satisfaction with the out-of-hours service. We looked at the latest published results from the July 2016 publication (collected during July to September 2015 and January to March 2016) and noted that for the four CCG areas where the provider's out of hours service operated:

- The level of positive overall feedback regarding the NHS services used when patients' GP surgery was closed ranged from 45% to 74% for the four CCG areas where PELC's six bases were located (compared with the 70% England CCG average).

- The level of confidence and trust in the last person spoken to ranged from 83% to 87% (compared to the 90% England CCG average).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 30 comment cards which were all highly positive about the standard of care received and the overall patient experience. For example, people told us that receptionists treated them with compassion, that facilities were clean and that clinicians were communicative and respectful.

The provider was unable to respond to our request for recent patient survey data and could not evidence that this information was included in contract monitoring reports.

Areas for improvement

Action the service **MUST** take to improve

- Ensure that arrangements are in place for the safe management of medicines including protocols for checking emergency medicines and equipment at primary care centre base locations and in vehicles.
- Introduce effective governance arrangements for clinical audit, internal audit and risk management.
- Ensure that all staff undertaking chaperone duties have had training and checks through the Disclosure and Barring Service.
- Ensure that all staff have received safeguarding training appropriate to their role and that policies are readily accessible to all staff.

- Introduce reliable systems to prevent and protect people from a healthcare-associated infection including role appropriate staff training.

Action the service **SHOULD** take to improve

- Ensure that all staff (including self-employed GP contractors) receive annual basic life support training and that there are appropriate monitoring systems in place.
- Ensure that the needs of patients and local communities are identified and acted on.

PELC Out of Hours 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 GP specialist adviser, a service nurse specialist adviser and a service manager specialist adviser.

Background to PELC Out of Hours Service

Partnership of East London Cooperatives (PELC) Limited is a not for profit organisation which was formed in 2004 by a group of GPs who wished to share resources to provide quality out of hours GP services for their local communities. The organisation is a certified social enterprise which reinvests all profits into improving services and communities served. There are no shareholders.

PELC provide GP out of hours services in City & Hackney, Newham, Tower Hamlets, Barking and Dagenham, Redbridge, Havering, Waltham Forest and West Essex Clinical Commissioning Group (CCG) areas to approximately 1.1 million patients.

PELC is also commissioned to provide NHS 111 and urgent care services for this locality (excluding West Essex). The findings of this inspection report relate only to PELC's out of hours service.

The opening hours are seven days a week from 6:30pm to 8am and 24 hours at weekends and bank holidays. Patients access the service via the NHS 111 telephone service.

Depending on their needs, patients may be seen by a GP at one of the service's six primary care base locations, receive a telephone consultation or a home visit. The service does not normally accommodate walk in patients.

PELC's primary care base locations are located at:

- King George Hospital

Barley Lane

Goodmayes

Essex IG3 8YB

- Queens Hospital

Rom Valley Way

Romford

RM7 0AG

Grays Court

- John Parker Close

Dagenham

Essex

RM10 9SR

- St Margaret's Hospital

The Plain

Epping

CM16 6TN

- Wych Elm Clinic

1a Wych Elm

Harlow

CM20 1QP

Uttlesford

Detailed findings

- The Community Clinic

58 New Street

Dunmow

Essex

CM6 1BH

The service is staffed by a team of 137 whole time equivalent staff, comprising a chief executive officer, a medical director, a head of governance, drivers, nurses and GPs. The service employs sessional (self-employed contractor) GPs directly and occasionally through agencies.

The service's head office is located at:

- Third Floor, Becketts House, 2-14 Ilford Hill, Ilford, Essex, IG1 2FA

The provider is registered to provide two regulated activities:

- Treatment of disease, disorder or injury;
- Transport services, triage and medical advice provided remotely.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We previously inspected this service in 2014 at which time, the provider was judged to have breached regulations regarding the safe and secure storage of medicines and prescription pads. At this inspection, we noted that the required improvements had taken place but also that additional medicines management concerns had been identified.

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the service and asked other organisations to share what they knew including commissioners of the service. We carried out an announced visit on 3, 6 and 20 March 2017 to the provider's headquarters and six primary care base locations. During our visit we:

- Spoke with a range of staff including Chief Executive Officer/Medical Director, Director of Operations, base clinicians and base receptionists.
- Inspected the six out of hours premises, looked at cleanliness and the arrangements in place to manage the risks associated with healthcare related infections.
- Looked at the three vehicles used to take clinicians to consultations in patients' homes, and we reviewed the arrangements for the safe storage and management of medicines and emergency medical equipment.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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?

Please note that when referring to information throughout this report, for example any reference to the National Quality Requirements data, this relates to the most recent information available to the CQC at that time.

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- The service carried out analyses of significant events and ensured that learning from them was disseminated to staff and embedded in policy and processes. For example, we were told that quarterly GP education events included discussion and learning from significant events. Non clinical staff were advised of significant events by email.
- Base staff told us they would inform the Director of Operations of any incidents and there was a recording form available on the service's computer system which we were shown at base locations. The incident recording form supported the recording of notifiable incidents under the duty of candour (a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, offered an apology, provided with an explanation and also told of any actions to improve processes and prevent the same thing happening again.

We reviewed audits, safety records, incident reports, patient safety alerts and minutes of 2015 and 2016 quarterly governance meetings where significant events were discussed. We saw evidence that lessons were routinely shared and actions taken to improve or maintain safety in the service.

For example, in 2016 after a GP failed to call an ambulance for a suspected stroke victim, records showed that the interim Chief Executive had emailed all GPs to remind them, in such cases, of the need for prompt hospital admission. The interim Chief Executive had also attached National Institute for Health and Care Excellence (NICE) guidance regarding the treatment windows for suspected stroke victims and the need for prompt medical attention.

Overview of safety systems and processes

We looked at systems, processes and services in place to keep patients safe and safeguarded from abuse.

- There was a lead member of staff for safeguarding and contributions were made to safeguarding meetings

when required. Staff demonstrated they understood their responsibilities and clinical staff had received training on safeguarding children and vulnerable adults relevant to their role.

- Before our inspection we were sent copies of the provider's children and vulnerable adults safeguarding policies (which were in date and confirmed that arrangements were in place which reflected relevant legislation and local requirements). For example, clearly outlining who to contact for further guidance if staff had concerns about a patient's welfare. However, staff at one of the base locations we inspected were unable to locate copies of these policies.
- Notices in reception and waiting room areas advised patients that chaperones were available if required. However, when we looked at the personnel records of three non clinical staff members who undertook chaperone duties, we noted that only one staff member had received chaperone training. We also noted that one staff member had not received a Disclosure and Barring Service (DBS) check. 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.
- Infection prevention and control- The service generally maintained appropriate standards of cleanliness and hygiene although in one base location we noted that the fabric of a reception office chair was ripped. Records confirmed that the provider had escalated this issue to the NHS landlord of the base location in question. Patient waiting areas in all base locations were clean and tidy. There was an infection control lead for the service and an infection control protocol in place. Annual base location infection control audits had taken place in October and November 2016 but we noted that some improvement areas had not been actioned.

We looked at the availability of blood spillage kits at each of the six base locations. At one location, the blood spillage kit's supply of chlorine solution (used to clean up blood spillages) had been used and not replaced. We noted that the service's IPC policy stated that blood spillage kits should be checked on a daily basis. When we highlighted the absence of chlorine solution, the service took immediate action and arranged for two new blood spillage kits to be transported from its headquarters to the base

Are services safe?

location in question and we were told that the daily check list protocol would be reviewed. At another location, we noted that sharps bins were not being replaced after three months and that the sharps Injury Protocol was not displayed adjacent to sharps bins.

- We reviewed the personnel files of three GPs and three non clinical staff members to see whether recruitment checks had been undertaken prior to employment.

The GPs' personnel files confirmed registration details with the appropriate professional body, details of out of hours indemnity insurance, checks through the Disclosure and Barring Service (DBS) and safeguarding training to the appropriate level.

- All three of the non clinical staff members' personnel files contained proof of identity but one file did not contain a DBS check and there was no evidence that this decision had been risk assessed against the duties of the staff member. For example, we were advised that all three staff undertook chaperone duties.

Medicines Management

- We reviewed the arrangements for managing medicines and how the service ensured that patients were kept safe.
- The service held a comprehensive range of emergency medicines at each base location and we noted that these were in date. However, the service could not demonstrate that, in accordance with its Emergency Medicines policy, it was regularly checking emergency medicines or equipment. Consequently when we checked emergency equipment, we noted that, at one base location, oxygen airways had expired in 2011 and that oxygen masks were not available. At another base location, the defibrillator and pads had expired in 2014. We immediately highlighted these areas of concern and, during our inspection, we saw or were sent confirming evidence that replacement equipment had been transported from headquarters to the relevant base locations.

We also noted that the system for checking the emergency medicines and equipment transported in vehicles was not robust. For example, the vehicle's pre shift and end of shift equipment check lists only required staff to check that the emergency oxygen and defibrillator were physically in the vehicle; as opposed to additionally checking the oxygen cylinder's level and functionality; and the availability of

oxygen masks and airways. The check list also failed to include a defibrillator test and confirmation that defibrillator pads were available. Consequently, when we checked the emergency equipment contained in two vehicles, we noted that adult and child oxygen masks were either not available or were past their expiry date. We also noted that one of the vehicles did not display signage indicating that it was carrying compressed medical oxygen. During our inspection, we were sent confirmation that replacement equipment had been provided for these vehicles and that vehicle check protocols had been amended.

- When we inspected in 2014, we noted that prescriptions were not stored securely at the service's headquarters building. At this inspection we noted that prescriptions were stored securely at headquarters and at all base locations. However, the base locations lacked an adequate system for monitoring prescription logging in, logging out and usage. For example, on day one of our inspection, we noted a number of blank prescriptions in the safes at two base locations. These prescriptions did not have an accompanying log and staff could not explain their status. The service took prompt action to improve monitoring and on Day 3 of our inspection we were shown a new protocol for keeping a clear record of prescription stationery stock received and distributed.
- We looked at how the service used Patient Group Directions (PGDs) to ensure safe and lawful prescribing. PGDs are written instructions from a qualified and registered prescriber giving someone (such as non prescribing nurses) the legal right to supply or administer prescription only medication.

We were told that the service employed four such non prescribing nurses at two bases. However, the Patient Group Directions (PGDs) kept on file by the service were not signed by the individual nurses and counter signed by a PELC qualified prescriber which meant that the nurses were not legally able to supply or administer prescription only medication. When this was highlighted, the service took immediate action to ensure that appropriately signed PGDs were on file.

- When we inspected in 2014 we looked at the processes for checking medicines and noted that cases of

Are services safe?

medicines prepared at headquarters for distribution to base locations were not sealed or securely stored. This increased the risk of unauthorised people having access. We asked the provide to take action.

At this inspection, we were told that an external contractor had been commissioned to maintain appropriate stock levels at each base location. This entailed the contractor visiting each base location on a weekly basis to record usage and medicines cases awaiting replenishment with new, sealed cases.

However, the medicines case at the first base location we inspected was not sealed and the stock record did not reconcile with the quantity of medicines contained in the cases. Staff were unable to explain the discrepancy.

We brought this to the immediate attention of the provider on Day One of our inspection and on Day Two we were advised that the external contractor had visited all of the provider's six base locations to audit and replenish stocks with sealed medicines cases. This was confirmed during the inspection and when we later discussed the incident with the provider and their external contractor, we were advised that contract monitoring arrangements were being reviewed in order to clarify roles and responsibilities. We were also advised that the service would shortly be recruiting an in-house pharmacist in order to improve medicines management protocols.

- The service held stocks of Controlled Drugs (medicines that require extra checks and special storage because of their potential for misuse) and had standard operating procedures in place that set out how controlled drugs were managed in accordance with the law and NHS England regulations. These included auditing and monitoring arrangements, and mechanisms for reporting and investigating discrepancies. The provider held a Home Office licence to permit the possession of controlled drugs within the service. There were also appropriate arrangements in place for the destruction of controlled drugs.

Monitoring risks to patients

We looked at systems in place for assessing and managing risks to patients.

- There was a health and safety policy available with a poster in areas accessible to all staff that identified local health and safety representatives. The service had up to date fire risk assessments and carried out regular fire

drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. Clinical equipment that required calibration was calibrated according to the manufacturer's guidance.

- We looked at systems in place to ensure that equipment was maintained to an appropriate standard. We noted that medical devices such as blood pressure monitors had been calibrated within the last 12 months. However, we were told that some GPs used medical devices from their respective in hour's GP practices. Our concern was that the service could not be assured of the maintenance or calibration history of the devices. Shortly after we highlighted this concern, the service emailed clinical staff prohibiting the use of any medical device which it had not supplied.
- The service had a variety of other risk assessments in place to monitor safety of the premises such as Legionella (Legionella are bacteria which can contaminate water systems in buildings).
- We looked at systems in place to ensure the safety of the out of hours vehicles. Checks were undertaken at the beginning of each shift. These checks included tyre pressure, oil and fuel levels. Records were also kept of MOT and servicing requirements.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. The inspection team saw evidence that the rota system was effective in ensuring that there were enough staff on duty to meet expected demand and periods of peak demand such as Saturday and Sunday mornings, and the third day of a Bank Holiday weekend (for which rotas were planned six weeks in advance). Contingency policies were in place for those circumstances in which the service might be unable to meet unexpected demand.

Arrangements to deal with emergencies and major incidents

- There was an effective system to alert staff to any emergency.

Are services safe?

- We were told that 81% of non clinicians and 86% of clinicians had had basic life support within the previous 12 months. The provider was unable to confirm whether performance for clinicians included self-employed GP contractors.
- The base locations had defibrillators available on the premises and oxygen with adult and children's masks. We highlighted that one of the defibrillators had expired and it was immediately replaced. A first aid kit and accident book were available.
- Emergency medicines were easily accessible and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The service had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The service assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best service guidelines.

- The service had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The service monitored that these guidelines were followed.

Management, monitoring and improving outcomes for people

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, response times to phone calls, whether face to face assessments happened within the required timescales, seeking patient feedback and actions taken to improve quality.

- For the period April 2016 to December 2016, the provider's performance on starting emergency, urgent, or less urgent consultations respectively within one hour, two hours or six hours ranged between 92% - 100%. The commissioners' performance target was 95%.

We asked for evidence of quality improvement activity (including clinical and internal audit) and of how the findings were used to improve services and drive improvements in patient outcomes:

- We were shown the provider's Clinical Audit Policy whose stated aim was to assess patient care, identify improvement areas and implement change. The policy stated that a number of audits should take place on a quarterly basis including auditing 2% of the clinical notes of sessional GPs. However, the provider was unable to demonstrate that these audits were taking place.
- Two clinical audits had started in 2016 but these were not complete two cycle audits and so the provider could

not demonstrate how they had been used to drive quality improvement. For example, we were shown one audit which had been triggered by NICE guidelines and aimed to assess the care of patients under five who had been treated for fever like systems. However, the audit simply comprised a list of all of the patients who constituted the sample group and did not include audit objective, proposed interventions or a timetable.

- We saw evidence of participation in monitoring activities, such as reviews of services and benchmarking. For example, in October 2016, a CCG had conducted an unannounced inspection of one of the provider's base locations. The report highlighted that prescription security was good but also that staff needed to be aware of how to access safeguarding policies. This area of quality improvement was also identified during our inspection.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The service had an induction programme for all newly appointed staff including locum staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. New staff were also supported to work alongside other staff and their performance was regularly reviewed during their induction period.
- The service could demonstrate how they ensured role-specific training and updating for relevant staff. For example, training for telephone consultations included theory and practical training.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of service development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, and clinical supervision. Most staff had received an appraisal within the last 12 months.
- Staff received training that included: fire safety awareness, basic life support and information governance.

Are services effective?

(for example, treatment is effective)

Coordinating patient care and information sharing

- For the period April 2016 to January 2017, the provider's performance on sending details of all OOH consultations (including appropriate clinical information) to the practice where the patient was registered by 8.00 a.m. the next working day ranged from 97% to 100%. The commissioner's performance target was 95%.
- The provider was unable to provide performance data on systems in place to support and encourage the regular exchange of up-to-date and comprehensive information (such as agreed processes in place with GP practices to manage end of life care, safeguarding vulnerable adults and safeguarding children).

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the service's patient record system and their intranet system.

- This included access to required 'special notes'/summary care records which detailed information provided by the person's GP. This helped the out of hours staff in understanding a person's need.

- The provider had been commissioned to provide the local NHS 111 service in the area and an urgent care centre; and we saw evidence of collaborative working (for example regarding sharing learning from significant events across services).

The provider also worked collaboratively with other services. Patients who could be more appropriately seen by their registered GP or an emergency department were referred. If patients needed specialist care, the out-of-hours service, could refer to specialties within the hospital.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear clinical staff assessed the patient's capacity and, recorded the outcome of the assessment.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed reception staff and clinicians were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

We noted that all of the 30 patient Care Quality Commission comment cards we received were highly positive about the service experienced. Patients said they felt the service offered an excellent service; and that staff were compassionate, caring and respectful.

Comment cards also highlighted that reception staff at primary care bases responded compassionately when patients needed help and provided support when required. When we asked receptionists how they ensured that anxious patients were treated with dignity and respect, they stressed the importance of recognising each patient's individual needs.

Care planning and involvement in decisions about care and treatment

Patient feedback from the comment cards we received highlighted that they felt listened to and supported by staff and had sufficient time during consultations.

The service provided facilities to help patients be involved in decisions about their care:

- We were told that translation and interpreting services were available for patients who did not have English as a first language.
- Information leaflets were available in easy read format.

Hearing aid loops were available for people with hearing impairments.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The service reviewed the needs of its local population and engaged with its commissioners to secure improvements to services where these were identified. For example, the provider was also commissioned to provide the local NHS 111 service and a local urgent care centre.

- Home visits were available for patients whose clinical needs resulted in difficulty attending the service.
- There were accessible facilities, a hearing loop and interpreting services available.
- The provider offered a phone based service which allowed text-based communications between callers with a hearing impairment and call handlers.
- The provider's primary care centres were all located in purpose-built single storey buildings which offered step free access and which were wheelchair accessible.
- Staff prioritised patients with complex, potentially urgent needs for home visits (such as those with palliative care needs).

Access to the service

The opening hours are seven days a week from 6:30pm to 8am and 24 hours at weekends and bank holidays. Patients could access the service via NHS 111. The service did not see 'walk in' patients and those that came in were told to phone NHS 111 unless they needed urgent care in which case they would be stabilised before being referred on.

Feedback received from patients from the CQC comment cards and from the National Quality Requirements scores indicated that in most cases patients were seen in a timely way.

The service had a system in place to assess whether a home visit was clinically necessary; and the urgency of the need for medical attention.

Patients accessed the service via NHS 111 who would make an assessment as to whether a patient's clinical needs could not wait until their GP practice was next open. If this

was the case, the patient's details were passed to PELC OOH who would then carry out a further assessment either by a registered nurse or GP which may result in a home visit, self-care advice, referral to another service such as accident and emergency or the offer of an appointment to be seen by a doctor or nurse at one of the service's primary care centres.

Listening and learning from concerns and complaints

The provider had an open and transparent approach to complaints management.

- Its complaints policy and procedures were in line with the NHS England guidance and their contractual obligations.
- There was a designated responsible person who co-ordinated the handling of all complaints in the service.

We saw that information was available to help patients understand the complaints system. For example, leaflets and posters in base reception areas and also a complaints page on the provider's web site.

Records showed that complaints were reviewed by the provider's Learning Group. Records showed that 36 complaints had been received between January 2016 and December 2016. We found that complaints were satisfactorily handled and dealt with in a prompt, open and transparent manner.

We also saw evidence of how learning from complaints had been used to improve the service. For example, in 2016, the Parliamentary and Health Service Ombudsman upheld a patient complaint about care received because the brevity of the consultation notes meant that the Ombudsman was unable to conclude whether there were failings in the clinician's consultation or decision making. Records showed that following this decision, the interim chief executive had sent a "lessons learned" email to all clinical and non clinical staff highlighting the learning from the complaint and the importance of following best practice when record keeping.

Are services well-led?

Requires improvement 

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

Our findings

Vision and strategy

We noted that the provider had recently come through a period of organisational change; resulting in the Medical Director also currently serving as interim Chief Executive. The interim Chief Executive told us that their immediate aim was to provide visible leadership and organisational stability for the provider's Urgent Care Centre, GP Out Of Hours and NHS 111 services.

- The service had a mission statement and staff knew and understood the values.
- The service had a strategy and supporting business plans which reflected the vision and values and were regularly monitored.
- Our discussions with staff indicated the vision and values were embedded within the culture of the service.

Governance arrangements

The service had an overarching governance framework which aimed to support the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was an open culture in which safety concerns raised by staff and people who used services were highly valued as integral to learning and improvement.
- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- The provider had a good understanding of their performance against National Quality Requirements.
- Performance was shared with staff via staff bulletin and local CCGs as part of contract monitoring arrangements.

However, we also noted that the provider's governance arrangements did not always operate effectively regarding medicines management and the protocols in place for checking emergency medicines/equipment at primary care centre base locations and in vehicles. We also saw limited evidence of quality improvement activity such as the use of internal audits and that some policies were not easily accessible to staff.

Although the provider had taken prompt action to address the patient safety concerns we identified on our inspection, we noted that the governance arrangements in place had failed to proactively identify, manage and address these risks.

Leadership and culture

The interim Chief Executive told us that their immediate aim to provide organisational stability and visible leadership. Staff told us that there were clear lines of responsibility and that they were aware of their responsibilities. Records confirmed that there were clear lines of communication and that management information was routinely shared.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. This included training for all staff on communicating with patients about notifiable safety incidents. The provider encouraged a culture of openness and honesty. The service had systems to ensure that when things went wrong with care and treatment:

- The service gave affected people reasonable support, truthful information and a verbal and written apology.
- The service kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management.

- Staff told us there was an open culture within the service and they had the opportunity to raise any issues and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported.

Seeking and acting on feedback from patients, the public and staff

The service encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- Patients were provided with an opportunity to provide feedback, and if necessary complain.

Are services well-led?

Requires improvement 

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

- Staff told us that they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the service was run.
- Staff told us that they were proud of the service being delivered and that they felt engaged in decisions relevant to how the service might be delivered in the future. Staff also told us that the team worked effectively together.

- Staff were proud of the organisation as a place to work and spoke highly of the culture.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the service. For example, we noted that the provider took prompt action to address concerns we identified regarding medicines management and the calibration of medical equipment, such that when we inspected its Urgent Care Centre service on 30 March 2017, these concerns had been addressed.

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
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment</p> <p>How the regulation was not being met:</p> <p>The provider did not do all that was reasonably practicable to ensure there were proper and safe arrangements in place for the management of medicines by failing to have in place protocols for checking emergency medicines and equipment at primary care centre base locations and in vehicles; and did not do all that was reasonably practicable to protect people from a healthcare-associated infection by failing to have reliable systems in place.</p> <p>This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	<p>Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment</p> <p>How the regulation was not being met:</p>

This section is primarily information for the provider

Requirement notices

The provider did not do all that was reasonably practicable to protect service users from abuse and improper treatment by failing to ensure that role appropriate staff safeguarding training had taken place and that policies were accessible to staff.

This was in breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.: Good governance

How the regulation was not being met:

The provider did not do all that was reasonably practicable to ensure good governance by failing to have in place effective governance to ensure the effective delivery of clinical audit, internal audit and effective risk management.

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

Regulated activity

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Fit and Proper Persons Employed

Requirement notices

How the regulation was not being met:

The provider did not do all that was reasonably practicable to have in place appropriate recruitment procedures by failing to ensure that

staff undertaking chaperone duties had had appropriate checks through the Disclosure and Barring Service and chaperone training.

This was in breach of regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.