Nestor Primecare Services Limited

Primecare - Primary Care - Hereford Hereford Out of Hours

Inspection report

Rural Enterprise Centre
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Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Overall summary

We carried out an announced comprehensive inspection at Primecare – Primary Care – Hereford on 24 May and 27 May 2017. Overall the service is rated as **good**.

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

- There was an open and transparent approach to safety and an effective system for recording, reporting and learning from significant events.

Summary of findings

- The service could not provide assurance that all GPs were trained to the appropriate level in safeguarding children and young people.
- Patients' care needs were assessed and delivered in a timely way according to need. The service met the National Quality Requirements.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- There was a system in place that enabled staff access to patient records. The out of hours staff provided other services, for example the local GP and hospital, with information following contact with patients where appropriate.
- The service managed patients' care and treatment in a timely way.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their 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.
- The service worked proactively with other organisations and providers to develop services that supported alternatives to hospital admission where appropriate and improved the patient experience.
- The service had good facilities and was well equipped to treat patients and meet their needs. The vehicles used for home visits were clean and well equipped.
- There was a clear leadership structure and staff felt supported by management.
- Patient feedback was not routinely obtained, recorded and reported by the provider on an ongoing basis.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider must make improvements are:

- To ensure there are effective systems for all clinical staff to be trained to an appropriate level in safeguarding children and young people.
- To ensure there are effective systems to seek and act on patient feedback in order to improve the quality of service.

The area where the provider should make improvements is:

- To ensure there are systems to support a programme of continuous clinical improvement.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

The service is rated as good for providing safe services.

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- There was an effective system for recording, reporting and learning from incidents significant events
- Lessons were shared to make sure action was taken to improve safety in the service.
- 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.
- The service had some systems and processes in place to keep patients safe and safeguarded from abuse. However the service could not provide assurance that all GPs were trained to an appropriate level in safeguarding children and young people level 3.
- When patients could not be contacted at the time of their home visit or if they did not attend for their appointment, there were processes to follow up patients who were potentially vulnerable.
- Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Are services effective?

Good

The service is rated as good for providing effective services.

- The service was meeting most National Quality Requirements (performance standards) for GP out of hours services to ensure patient needs were met appropriately and in a timely way.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- There was some evidence of quality improvement including audit, but none of the audits were two-cycle audits where improvements were implemented and monitored.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Summary of findings

Are services caring?

Good

The service is rated as good for providing caring services.

- Feedback from patients was positive.
- Patients said they were treated with compassion, dignity and respect and 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 staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Patients were kept informed with regard to their care and treatment throughout their visit to the out of hours service.
- The service provided facilities to help patients be involved in decisions about their care.

Are services responsive to people's needs?

Good

The service is rated as good for providing responsive services.

- Service staff reviewed the needs of its local population and engaged with its commissioners to secure improvements to services where these were identified.
- The service had good facilities and was well equipped to treat patients and meet their needs.
- The service had systems 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 stakeholders

Are services well-led?

Requires improvement

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

- The service had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- 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.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- There was no system in place to ensure that all GPs were trained to an appropriate level in safeguarding children and young people.

Summary of findings

- The provider was aware of and complied with the requirements of the duty of candour. The provider encouraged a culture of openness and honesty. The service had systems for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The service did not have an effective system in place to seek and act on feedback from patients for the purpose of improving services.

Primecare - Primary Care - Hereford Hereford Out of Hours

Detailed findings

Background to this inspection

Our inspection team

The inspection took place over two days. On both days the inspection team was led by a CQC lead inspector.

On 24 May 2017 we visited the head office and one of the primary care centres (at Hereford County Hospital). The team consisted of GP specialist advisor, a practice manager specialist advisor, and four CQC inspectors.

On 27 May 2017 we visited two of the three further primary care centres (at Leominster Community Hospital and Kington Court Community Care Centre). These visits were carried out by the CQC lead inspector.

We did not visit the primary care centre at Ross-On-Wye Community Hospital as part of this inspection.

Background to Primecare – Primary Care – Hereford

Primecare – Primary Care – Hereford provides primary care medical services outside usual GP practice working hours (out of hours or OOH). The provider holds a contract to provide out of hours services with the NHS Herefordshire Clinical Commissioning Group (CCG) within the county of Herefordshire. The population covered by this CCG is approximately 190,000.

Patients access the OOH provision by calling the NHS 111 telephone service. Call handling for the service is carried out by Care UK. The service sees 'walk-in' patients wherever possible especially if they were judged to be vulnerable. Reception staff are trained to assess patients and report concerns to clinical staff. Where this is not possible to see these patients they were directed to telephone NHS 111 to book an appointment. Reception staff told us they would assist patients in calling NHS 111 if this was necessary.

The service's headquarters are located at the Rural Enterprise Centre in Hereford, which is used for administrative and governance purposes. There are no clinical facilities at this site, and no patients are seen.

There are either two or three vehicles (weekends/bank holidays and weekdays respectively) used by the service. These vehicles are based at the Rural Enterprise Centre.

Patients who need to be seen by a clinician are visited at home or are referred by appointment to one of the four primary care centres located in Herefordshire. These are:

- Hereford County Hospital, Stonebow Road, Hereford HR1 2BN (provides OOH services Monday to Friday, 7pm to 8am);
- Leominster Community Hospital, South Street, Leominster HR6 8JH (provides OOH services at weekends and bank holidays, 9am to 1pm);
- Ross-On-Wye Community Hospital, Alton Street, Ross-On-Wye HR9 5AD (provides OOH services at weekends and bank holidays, 9am to 1pm), and;
- Kington Court Community Care Centre, Victoria Road, Kington HR5 3BX (provides OOH services at weekends and bank holidays, 1.30pm to 3pm).

Home visits can take place throughout the out of hours period.

Detailed findings

Staffing at each primary care centre typically consists of two GPs (or one GP plus one Advanced Nurse Practitioner), a receptionist, a shift leader, and a driver. Home visits are carried out by one of the clinicians plus the driver.

There are 40 clinicians who provide the OOH service. These are either employed by Primecare, or contract with Primecare on a sessional basis or through an agency. The majority of these clinicians (35) are GPs, with the remainder being Advanced Nurse Practitioners.

Management, administration, policy and procedure, and governance functions for the organisation are performed by Primecare staff. This includes the Head of Quality and Governance, the Contract Manager, the Head of Governance and Assurance, the Clinical Manager, and the Office Manager.

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.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew. We carried out an announced visit on 24 May 2017 and 27 May 2017. During our visit we:

- Spoke with a range of clinical and non-clinical staff (including GPs, clinical and operational managers, administrative staff, shift leaders, receptionists, and drivers) and spoke with patients who used the service.
- Inspected three of the four out of hours premises, looked at cleanliness and the arrangements to manage the risks associated with healthcare related infections.
- Looked at the vehicles used to take clinicians to consultations in patients' homes.
- 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.

Good

Are services safe?

Our findings

Safe track record and learning

There were systems for reporting and recording incidents, including significant events.

- The service had a comprehensive incident and significant event policy. This included reporting, recording, discussing, sharing and learning from incidents. There was a flowchart included which clearly set out the sequence of events, key responsibilities and governance.
- The service included complaints as incidents and addressed and managed them as part of the incidents and significant events process.
- Staff told us they would inform the shift lead of any incidents, significant events or complaints in the first instance. The shift lead would then report incidents to Primecare management staff. We saw incidences of where this had taken place, for example unexpected deaths in care.
- Staff told us they were encouraged to report incidents, and that they were supported when they did so.
- There was a recording form for incidents, significant events and complaints available on the service's computer system. This form supported the recording of notifiable incidents under 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).We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received support, an explanation based on facts, an apology where appropriate and were told about any actions to improve processes to prevent the same thing happening again.)
- We saw evidence of incidents being discussed and reviewed at service and corporate meetings. This included documentation of learning points and actions. Analysis of themes and trends was carried out at local and corporate level and changes were made. For example the service had identified a number of incidents relating to medicines management, and had made changes to relevant policies, procedures and documentation to support process improvements.
- We saw that findings were shared with all staff. This includes permanent, agency and bank staff. Findings were shared by email, in local and corporate meetings and as part of a Primecare Hereford monthly clinical newsletter. For example information relating to medicines management and medicines prescribing incidents was included as part of the newsletter dated March 2017. Staff told us these newsletters were sent to all clinical and other staff by email.
- The service had recorded 18 incidents (including significant events) during the last 12 months. We saw that these were handled appropriately.

Safety alerts, including those from the Medicines and Healthcare products Regulatory Agency (MHRA), were managed by the Clinical Manager. We saw evidence that alerts were shared with clinicians by email and there was a system to record and monitor actions taken as a result. Clinical staff we spoke with were able to give details of recent alerts shared, including for example an update on sepsis shared during May 2017. (Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs.)

Safety alerts including MHRA alerts were also included in the clinical newsletter, for example alert information relating to injections for patients with heart disease in the March 2017 issue.

Overview of safety systems and processes

Overall the service had clearly defined and embedded systems, processes and services to keep patients safe and safeguarded from abuse. However we identified areas for improvement:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Separate detailed policies for safeguarding adults and children were accessible to all staff and these had been recently updated. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare.
- The service could not provide assurance that all GPs and nurses working at the four OOH sites were trained to an appropriate level in safeguarding children and young people. Records indicated that some GPs and nurses were trained to levels 1 or 2. Staff told us they

were confident that clinical staff were trained to level 3 and that records should support this. There were no records of agency doctor safeguarding children training available.

- There was a lead member of staff for safeguarding. Staff we spoke with demonstrated they understood their safeguarding responsibilities including recording, reporting concerns, information sharing, and escalation.
- Notices in treatment rooms advised patients that chaperones were available if required. Staff told us all patients were informed verbally at the start of their consultation of their right to have a chaperone present. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS
- Drivers acted as chaperones on home visits, and we saw all drivers had been trained to do so. We saw evidence that all drivers (including those employed by an agency) had received a DBS check.
- When patients could not be contacted at the time of their home visit or if they did not attend for their appointment, there were processes in place to follow up patients who were potentially vulnerable.
- The primary care centres where patients were seen were located in shared accommodation (hospitals and health centres). We observed the premises to be visibly clean and tidy at the sites we visited. We saw evidence of appropriate cleaning arrangements for each site. Staff had access to personal protective equipment.
- There was an infection control lead for the service. There was an infection control policy and separate waste, sharps and spillage protocols. All staff had received up to date training. Detailed infection control audits were undertaken by a clinician twice a year. We saw evidence that action was taken to address any improvements identified as a result.
- There was a system to ensure equipment was maintained to an appropriate standard and in line with manufacturers' guidance. We saw evidence that equipment had undergone portable appliance testing and calibration checks where relevant. There was a register to ensure equipment that required checks were not missed. The equipment boxes for home visits were checked by the driver before taking out to the vehicles and there was a checklist for this. Clinical staff told us that they had access to the equipment needed and that this was well maintained.
- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body, appropriate indemnity and the appropriate checks through the Disclosure and Barring Service. Recruitment records were well managed and we saw evidence of appropriate checks for staff. We saw that the provider had processes to obtain assurances for sessional and agency staff.

Medicines Management

- The arrangements for managing medicines at the service, including emergency medicines and vaccines, kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). The service carried out regular medicines audits to ensure prescribing was in accordance with best practice guidelines for safe prescribing.
- We found safe storage of medicines and prescription stationery at the head office and at the three primary care centres we visited.
- All nurses working at the service were independent prescribers; therefore no Patient Group Directions (PGDs) were required.
- The service did not hold stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse). The service could access controlled drugs if needed by using a duty pharmacy system. Staff told us this could take up to two hours to organise due to the geographical location of the sites.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures for monitoring and managing risks to patient and staff safety. The service had a detailed health and safety policy available. 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. The service had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella are bacteria which can contaminate water systems in buildings).

- Reception staff carried out a safety check of the environment as part of the processes for setting up and closing down at the start and end of each shift. There was a checklist for staff to use for this, and completed checklists were stored and the contents logged.
- We looked at two vehicles used for the purposes of home visits. We found these to be visibly clean and tidy. There were systems to ensure the safety of the vehicles. A check sheet was completed at the start and end of shift by the driver to ensure the vehicle was in working order and for reporting any issues. These checks included cleanliness of the vehicles, fuel levels and the lights were working. Vehicles were all within MOT dates and service histories were available. There were breakdown cover arrangements in place. There was a contract for cleaning the vehicles.
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The Office Manager reviewed patient demand data to help identify staffing requirements. There was a shift lead that reviewed staffing levels during each shift and could reallocate calls to clinicians based on waiting time and clinical need.

Arrangements to deal with emergencies and major incidents

The service had adequate arrangements to respond to emergencies and major incidents.

- There were effective systems at each site to alert staff to any emergency. Staff could demonstrate their responsibilities in the event of an emergency, for example response, escalation and information recording.
- Staff received annual basic life support training. Training data from the provider showed all clinical staff were up to date with their basic life support training. This included directly employed and agency staff.
- The service had a defibrillator and oxygen available in the vehicles and at the primary care centres. Staff told us that they checked the defibrillator and oxygen and we saw records which demonstrated this was done consistently.
- Emergency medicines were available to clinical staff working remotely and staff knew of their location. All the medicines we checked were in date.
- The service had a comprehensive business continuity plan for major incidents such as power failure, IT failure, telephone failure, or building damage. There were plans for each of the sites. There were shared agreements with Primecare's other OOH services to support and cover calls in the event of systems or telephone failure. Staff provided examples of where they had effectively used the business continuity plan. The plan also included emergency contact numbers for relevant staff.

Good

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 standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The service had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE which was shared by email and used this information to deliver care and treatment that met patients' needs.
- Summaries of NICE and other guidance were shared as part of the clinical newsletter.
- Clinicians were able to access various guidance such as NICE, British National Formulary (BNF) guidance, and local antibiotic guidance. Copies of the British National Formulary were kept in the vehicles and we saw that these were up to date.
- Clinical staff told us that they kept up to date with best practice and latest guidelines in their role as a GP and that they received emails from the out of hours provider.

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 (NQRs) for out of hours providers. The NQRs are used to show the service is safe, clinically effective and responsive. Providers are required to report monthly to the Clinical Commissioning Group (CCG) on their performance against standards which includes for example audits, response times to phone calls, whether telephone and face-to-face assessments happened within the required timescales, seeking patient feedback, and actions taken to improve quality.

The provider's reported performance against some of the NQRs were as follows:

NQR 4: Auditing patient contacts

Providers must regularly audit a random sample of patient contacts and appropriate action will be taken on the results of those audits. Regular reports of these audits will be made available to the contracting CCG.

The provider undertook a programme of consultation audits. Clinical staff had a minimum of 1% of their consultations audited annually. The audits looked at areas such as history taking, assessments taken and prescribing. Clinicians were graded red, amber or green according to audit findings. Where scores showed underperformance, clinicians received more frequent audits and further training where identified. Those of particular concern were included on the corporate risk register and discussed at board level. We saw evidence of this in board reports. New starters also had cases reviewed from their first session with the provider.

NQR 9: Identification of immediate life threatening conditions

Providers must have a robust system for identifying all immediate life threatening conditions and, once identified, those calls must be passed to the ambulance service within 3 minutes.

Definitive Clinical Assessment: Providers that can demonstrate that they have a clinically safe and effective system for prioritising calls, must meet the following standards:

- Start definitive clinical assessment for urgent calls within 20 minutes of the call being answered by a person.
- Start definitive clinical assessment for all other calls within 60 minutes of the call being answered by a person.
- Providers that do not have such a system, must start definitive clinical assessment for all calls within 20 minutes of the call being answered by a person.

Outcome: At the end of the assessment, the patient must be clear of the outcome, including (where appropriate) the timescale within which further action will be taken and the location of any face-to-face consultation.

Data from the contract monitoring reports for Herefordshire CCG from June 2016 to March 2017 showed between 98% and 100% compliance (urgent calls) and between 97% and 100% (other calls) with this indicator, against a CCG target of 95%.

NQR 10: Face-to-Face Clinical Assessment

Identification of immediate life threatening conditions:

Good

Are services effective?

(for example, treatment is effective)

Providers must have a robust system for identifying all immediate life threatening conditions and, once identified, those patients must be passed to the most appropriate acute response (including the ambulance service) within 3 minutes.

Definitive Clinical Assessment: Providers that can demonstrate that they have a clinically safe and effective system for prioritising patients, must meet the following standards:

- Start definitive clinical assessment for patients with urgent needs within 20 minutes of the patient arriving in the centre.
- Start definitive clinical assessment for all other patients within 60 minutes of the patient arriving in the centre.
- Providers that do not have such a system, must start definitive clinical assessment for all patients within 20 minutes of the patients arriving in the centre.

Data from the contract monitoring reports for Herefordshire CCG from June 2016 to March 2017 showed 100% compliance (urgent needs) and between 99% and 100% (other patients) with this indicator, against CCG targets of 100% and 98% respectively.

NQR 11: Meeting patient need

Providers must ensure that patients are treated by the clinician best equipped to meet their needs, (especially at periods of peak demand such as Saturday mornings), in the most appropriate location. Where it is clinically appropriate, patients must be able to have a face-to-face consultation with a GP, including where necessary, at the patient's place of residence.

The provider reported that the skill mix of clinicians was audited and that NHS 111 telephone service was able to directly book patients for face-to-face consultations.

NQR 12: Face-to-face consultations

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 contract monitoring reports for Herefordshire CCG from June 2016 to March 2017 showed 99% compliance (emergency), 85% compliance (urgent), and 95% compliance (less urgent) with this indicator. This was against CCG targets of 95% for all criteria. Where the targets were not met the service investigated the circumstances, and documented any reasons and lessons learned. This information was reported to the CCG.

The service showed us where analysis had been carried out and actions taken in response to any breaches of NQRs. This included information relating to each individual shortfall, for example travel to remote locations, and difficulties contacting patients. We saw evidence of where meetings had taken place internally and with the CCG (including as part of monthly meetings) to discuss NQR performance, including trends, outcomes and suggested actions. Staff told us they had a transparent relationship with the CCG and would discuss all concerns openly, and we saw minutes of meetings to support this. Staff told us they had two dedicated CCG contacts with who they discussed performance and contract monitoring on an ongoing basis.

All staff were able to access NQR performance using a database which was updated daily. Staff could consider data by area on a daily, weekly or monthly basis.

We saw some evidence of quality improvement, including some clinical audit. All clinicians' consultations were audited individually at least yearly and there was a clinical audit policy to support this. The service was in the process of formalising a monthly programme of dedicated clinical governance meetings. Primecare management staff were responsible for overseeing this and the related governance.

None of the audits we saw were two-cycle audits where improvements were implemented and monitored. We saw no evidence of audits of nurse prescribing. Staff told us they had plans to develop and maintain a consistent programme of two-cycle and nurse prescribing audits, and we saw evidence of documents relating to these.

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 locums. This covered such topics as safeguarding, infection prevention and control,

Good

Are services effective?

(for example, treatment is effective)

health and safety and information governance. Staff (including clinical staff) told us they received an induction when commencing in their role. This included policies, procedures, systems, and their responsibilities. An induction manual was provided to those commencing with the service.

- Staff directly employed received annual appraisals and we saw evidence of this. Clinical staff received appraisals as part of their revalidation process. Revalidation is the process by which doctors are required to demonstrate they are up to date and fit to practice. The quality of clinical consultations was monitored and overseen by the Head of Governance and Assurance, and findings were fed back to individual clinicians.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.
- Staff involved in handling medicines received training appropriate to their role.
- There were systems for monitoring staff adherence to the provider's mandatory training. This flagged up when training was due and allowed administrative staff to follow up staff when training was due for renewal.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was gained from the patients through the NHS 111 service and by speaking with the patient.

As part of the NQRs providers must send details of all out of hours consultations (including appropriate clinical information) to the practice where the patient is registered by 8am the next working day (NQR 2). Data from the contract monitoring report for Herefordshire CCG covering March 2017 showed the service achieved 99.9% compliance with this requirement for the preceding 12 months.

The provider had systems in line with NQRs for supporting the exchange of patient information between those who may be involved in providing care to patients with predefined needs (NQR 3). Any information received from GP practices or other services for example relating to patients with palliative care needs or patients who were at risk of harm were recorded in special notes which clinicians could access during consultations. The provider also had access to summary care records. Summary care records are a system for sharing important information about a patient between healthcare professionals such as details about medicines they are taking. Clinical staff confirmed they had access to this information.

There were systems for sharing relevant information with other services in a timely way, for example when referring patients to other services during out of hours period.

Consent to care and treatment

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

- Staff we spoke with demonstrated they understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and those relating to children and young people.
- Staff carried out assessments of capacity to consent in line with relevant guidance when providing care and treatment for children and young people.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and helpful to patients and treated them with dignity and respect when visiting the primary care centres.

- 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 considered various sources of where feedback could be obtained from patients about the out of hours service they received. Patient feedback was not routinely obtained, recorded and reported by the provider on an ongoing basis. At the time of the inspection patient experiences of the service were not included in the provider's contract monitoring reports.

There was no GP patient survey data available for the provider, and the provider did not participate in the friends and family test.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our visit. The comments box was sent to Hereford County Hospital. We received three comment cards which were all positive about the standard of care received.

We spoke with seven patients in total during the inspection. This consisted of patients attending Hereford County Hospital (five patients), and Leominster Community Hospital (two patients). All seven patients said they were satisfied with the care they received. Patients who used the service described the staff as helpful and caring and told us that they were seen promptly.

Care planning and involvement in decisions about care and treatment

Feedback received from patients told us that they felt listened to during their consultation. Clinicians made use of special notes to support decisions about care and treatment. (Special notes are a way in which patients' usual GP can raise awareness about their patients who might need to access the out of hours service, such as those nearing end of life or with complex care needs. It may also include details of advance directives in which patients have recorded their wishes in relation to care and treatment).

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

- Staff told us that translation facilities were available for patients who did not have English as a first language. This included multi-lingual staff and Google Translate.
- GPs could access translators using the telephone.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The provider reviewed the needs of its population and engaged with the Herefordshire Clinical Commissioning Group (CCG) to secure improvements to services. The provider sent monthly performance reports to the CCG and met with them on a monthly basis to discuss performance.

- Home visits were available for patients whose clinical needs resulted in difficulty attending one of the primary care centres.
- There were accessible facilities including translation services available.
- At the three primary care centres we visited we saw that they were accessible to patients with mobility difficulties. For those attending with young children baby changing facilities were available.
- There was a failed home visit policy which set out the process to follow if patients could not be contacted by telephone or during a home visit or failed to attend their appointment at a primary care centre. This was included in the driver pack which went out with the vehicle. Staff we spoke with were aware to describe the processes and that the final decision to close a case would be made by the clinician.
- Comfort calls were undertaken on patients awaiting home visits if waiting times reached five hours.

National Quality Requirement (NQR) 13 states that patients unable to communicate effectively in English will be provided with an interpretation service within 15 minutes of initial contact. Data from the contract monitoring reports for Herefordshire CCG from June 2016 to March 2017 showed 100% compliance with this indicator.

Access to the service

Patients who needed to be seen by a clinician were visited at home or were referred by appointment to one of the four primary care centres located in Herefordshire. These were:

- Hereford County Hospital, Stonebow Road, Hereford HR1 2BN (provided OOH services Monday to Friday, 7pm to 8am);
- Leominster Community Hospital, South Street, Leominster HR6 8JH (provided OOH services at weekends and bank holidays, 9am to 1pm);
- Ross-On-Wye Community Hospital, Alton Street, Ross-On-Wye HR9 5AD (provided OOH services at weekends and bank holidays, 9am to 1pm), and;
- Kington Court Community Care Centre, Victoria Road, Kington HR5 3BX (provided OOH services at weekends and bank holidays, 1.30pm to 3pm).

Patients accessed the service via the NHS 111 telephone service. The NHS 111 service would prioritise the call and were able to directly book patients at the primary care centres. The service tried to see 'walk in' patients wherever possible especially if they were vulnerable. Where it was not possible to see these patients they were directed to telephone NHS 111 to book an appointment. Reception staff told us they would assist patients in calling NHS 111 if necessary.

There were arrangements for people at the end of their life so they could contact the service directly.

Feedback from comment cards and patients we spoke with indicated that they were seen in a timely way.

Listening and learning from concerns and complaints

As part of the NQRs (NQR 6) out of hours providers are required to operate a complaints procedure that is consistent with the principles of the NHS complaints procedure and report anonymised details of each complaint, and the manner in which it has been dealt with, to the contracting CCG. All complaints must be audited in relation to individual staff so that, where necessary, appropriate action can be taken. The provider reported compliance in their contract monitoring reports to the commissioning CCGs against this national quality requirement.

The service had an effective system for handling complaints and concerns.

- Complaints policy and procedures were in line with the NHS England guidance and their contractual obligations.
- There was a designated responsible person (the Clinical Manager) who co-ordinated the handling of all complaints in the service. This was overseen by the Head of Quality and Governance.
- We saw that information was available to help patients understand the complaints system. A complaints procedure leaflet was available on display to take away from the primary care centres.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The provider had received 12 complaints in the last 12 months. We looked at two of these complaints and found these had been dealt with appropriately and in a timely way.

Complaints were classified as incidents and as such were subject to the provider's significant event and incident processes. We saw evidence that complaints were discussed at internal meetings and with the CCG. Findings and actions were shared with all staff (including agency and bank staff) by email and as part of the monthly clinical newsletter. We saw examples where the provider had made improvements as a result of complaints, such as providing additional guidance on handling patients in the reception area.

Patient feedback (other than complaints) was not routinely obtained, recorded and reported by the provider on an ongoing basis. At the time of the inspection patient experiences of the service were not included in the provider's contract monitoring reports.

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

The provider had a corporate website which included details of the Hereford out of hours (OOH) provision and set out details of the services provided. Clinical and non-clinical staff told us they believed the values of the organisation was were to promote patient safety, to contribute to and adhere to policies and procedures, and to effectively provide care to patients in a manner you would like to be treated yourself.

Governance arrangements

The service had an overarching governance framework which was part of wider corporate arrangements. This was mostly effective in supporting the delivery of the service but we identified some areas for improvement:

- Performance was reported through the monthly contract monitoring reports and monthly meetings with the Clinical Commissioning Group (CCG).
- A comprehensive range of detailed, service-specific policies were implemented and were available to all staff (including those working remotely) though the provider's intranet and in hard copy form at the sites providing OOH services.
- The provider had arrangements for reviewing, updating and sharing policies which included effective version control and governance.
- The provider had a good understanding overall of their performance against National Quality Requirements (NQRs). These were discussed at local and corporate level. Performance was shared with staff and the CCG as part of contract monitoring arrangements. However the provider did not routinely obtain, record or report patient feedback on an ongoing basis. At the time of the inspection patient experiences of the service were not included in the provider's contract monitoring reports.
- A programme of audit (including some clinical audit) was used to monitor quality and to help drive improvement. None of the audits we saw were two-cycle audits where improvements were implemented and monitored and we saw no evidence of audits of nurse prescribing.
- We saw evidence that complaints were discussed at internal meetings and with the CCG. Findings and actions were shared with staff by email and as part of the monthly clinical newsletter.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- The service could not provide assurance that all GPs and nurses working at the four OOH sites were trained to an appropriate level in safeguarding children and young people.

Leadership and culture

On the day of inspection the provider of the service demonstrated they had the experience, capacity and capability to run the service and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the managers were approachable, shared information and took the time to listen to them.

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 support training for all staff on communicating with patients about notifiable safety incidents. The partners 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 an explanation based on facts and an apology where appropriate, in compliance with the NHS England guidance on handling complaints.
- The service kept written records of verbal interactions as well as written correspondence.

There was a leadership structure in place which was communicated to staff. Staff said they felt supported by management.

- There were arrangements to ensure the staff were kept informed and up-to-date. This included emails, the clinical newsletter and weekly staff meetings.

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

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

National Quality Requirement (NQR) 5 states that providers must regularly audit a random sample of patients' experiences of the service and appropriate action must be taken on the results of those audits. Regular reports of these audits must be made available to the contracting CCG.

Other than complaints, patient feedback was not routinely obtained, recorded and reported by the provider on an ongoing basis. At the time of the inspection patient experiences of the service were not included in the provider's contract monitoring reports.

Staff told us patients were encouraged to give feedback either verbally or using the Primecare 'how did we do' form. We saw copies of these forms at the sites we visited. Managers told us that feedback was discussed at meetings including trends and actions, but we did not see any documentary evidence of this. We did not see any evidence of where changes were made as a result of patient feedback.

Feedback from staff was gathered during monthly staff meetings, supervision sessions, appraisals, and by email. Staff were able to provide examples of where feedback had resulted in improvements, for example developing a handover process for staff to use at shift change. Staff told us Primecare carried out staff surveys and this information was used at corporate and local levels.

Continuous improvement

Staff told us they were working closely with corporate IT staff to develop and improve clinician management software with the aim of improving monitoring. This would help to provide assurance that clinicians were performing to a good standard.

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
Nursing care Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not have effective systems to ensure and record that clinical staff were trained to an appropriate level in safeguarding children and young people.** Regulation 17(2)

Regulated activity	Regulation
Nursing care Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not have effective systems to seek and act on feedback from patients for the purpose of improving services.** Regulation 17(2)