Barndoc Healthcare Limited OOH - Churchwood House

Quality Report

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Date of inspection visit: 16 and 20 February 2017
Date of publication: 30/06/2017

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?	Inadequate
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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Barndoc Healthcare Limited Out of Hours Service (Barndoc OOH) on 16 and 20 February 2017. Overall the service is rated as requires improvement.

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

- Although overall, governance arrangements focused on the delivery of good quality care, we also noted that governance arrangements regarding infection prevention control (IPC) and medicines management did not always operate effectively.
- Risks to patients were generally assessed and well managed, although we noted that the absence of a proactive approach to managing infection prevention and control risks; and risks associated with medicines management.
- During our inspection we identified concerns regarding safeguarding training in that only 76% of GPs had up to date child safeguarding training to the appropriate level. Shortly after our inspection we were sent evidence confirming that that this had increased to 98%.
- There was an open and transparent approach to safety and an effective system in place for recording, reporting and learning from significant events.
- Clinical audits demonstrated quality improvement.
- Patients' care needs were assessed and delivered in a timely way according to need. The service consistently met the National Quality Requirements and exceeded 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 they were treated with compassion, dignity and respect; and that they were involved in their care and decisions about their treatment.

Summary of findings

- 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 regularly audited its performance to ensure that any hospital referrals it made were appropriate. It also actively supported alternatives to hospital admission.
- 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, well equipped and well maintained.
- 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. For example, we saw that things went wrong, the Chief Operating Officer was proactive in making contact with patients to apologise, offer reasonable support and outline the actions taken to minimise the chance of reoccurrence.

The areas where the provider must make improvement are:

- Ensure that regular IPC audits are taking place so as to identify, capture and manage infection risks.
- 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 as necessary, staff medicines management refresher training.

In addition the provider should:

- Ensure that safeguarding policies are regularly reviewed and kept up to date.
- Consider working with its patient group to see how it can increase the number of patients participating in its patient survey; and consider broadening the survey to seek patients' views on the timeliness of being seen.
- Continue to liaise with the landlord of its Chase Farm Hospital Primary Care Centre to see how signage can be improved.
- Update its Medicines Policy to ensure that it reflects the provider's current practice regarding emergency medicines held at primacy care base locations.

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?

Inadequate

The service is rated as inadequate 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 infection prevention and control risks; and risks associated with medicines management.
- We identified concerns regarding safeguarding training in that only 76% of GPs had up to date child safeguarding training to the appropriate level. Shortly after our inspection we were sent evidence confirming that that this had increased to 98%.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- There was an effective system in place for recording, reporting and learning from 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.
- 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.
- There were systems in place to support staff undertaking home visits.

Are services effective?

Requires improvement

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

- We were advised that since the October 2016 amalgamation of the service into the North London Integrated Urgent Care service, National Quality Requirements (performance standards) data was not being collected.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.

Summary of findings

- 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.
- Clinicians provided urgent care to walk-in patients based on current evidence based guidance.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The service is rated as good for providing caring services.

- Most 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. This was confirmed through comment card feedback and also aligned with the results of surveys undertaken by the provider.
- 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.

Are services responsive to people's needs?

Good

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 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, from October 2016 the provider has worked in partnership with London Central and West Unscheduled Care Collaborative (LCW) (lead contractor) to provide the North Central London Integrated Urgent Care (NCLIUC) Service. As part of this contract, Barndoc provide some of the out of hours (OOH) primary care services in North Central London, comprising the London boroughs of Barnet, Enfield, Haringey, Camden and Islington.
- The service had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- 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.

Are services well-led?

Requires improvement

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

- Although overall, governance arrangements focused on the delivery of good quality care, we also noted that governance arrangements regarding infection prevention control (IPC), medicines management and staff training did not always operate effectively.
- 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 and patients, which it acted on.
- There was a strong focus on continuous learning and improvement at all levels.

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. Patient feedback was obtained by the provider on an ongoing basis and included in their contract monitoring reports.

We looked at the provider's latest patient survey data undertaken during January – March 2016. During that period, the provider despatched 2000 postal surveys directly to patients based upon 16,415 patient contacts for the period. To ensure a cross section of patients across all elements of the service, the patient addresses were selected at random from the patient system. Survey forms were also available at primary care centres and via the provider's website.

A total of 147 surveys were returned which represented a response rate of 0.9%. The response target set by commissioners was 1% which we noted had been met in the previous two quarters. We noted that all responses of "not applicable" and "did not answer question" had been removed from the sample of 147 respondents.Key findings were as follows:

- 93% (127/136) of respondents were satisfied are with the overall care and treatment received.
- 97% (109/112) found receptionists "helpful" or "very helpful".
- 92%(126/137) felt that doctors or nurses explained their care and treatment either "well" or "very well".
- 91% (124/136) felt that the doctor/nurse explained what would happen next either "well" or "very well".
- 91% (122/134) felt that the doctor/nurse listened; and showed empathy and understanding.
- 87% (116/134) felt that the doctor/nurse clearly explained what the patient should do if they did not get better or started to feel worse.
- 63% (80/128) of respondents were offered some choice in relation to care and treatment or where they could attend for an appointment.
- 87% (94/108) of those experiencing pain or discomfort felt that care was either "very good" or "good" regarding making their pain or discomfort better.
- 93% (127/137) were confident in the doctor's/nurse's ability and felt they could trust the doctor/nurse to put their best interests first.
- 96%(127/132) felt that their privacy and dignity were respected at all times.
- 92% (126/137) were either "likely" or "extremely" to recommend the service to friends and family if they needed similar care or treatment.

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 three 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 61% to 64% for the three CCG areas where Barndoc OOH's bases were located (compared with the 69% England CCG average).
- The level of confidence and trust in the last person spoken to ranged from 89% to 90% (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 45 comment cards and, with the exception of two negative comments regarding signage and waiting times, feedback was 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. We also spoke with two patients during the inspection who were both highly satisfied with the care they received and thought staff were approachable, committed and caring.

Summary of findings

Areas for improvement

Action the service MUST take to improve

- Ensure that regular IPC audits are taking place so as to identify, capture and manage infection risks.
- 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 as necessary, staff medicines management refresher training.

Action the service SHOULD take to improve

- Ensure that safeguarding policies are regularly reviewed and kept up to date.
- Consider working with its patient group to see how it can increase the number of patients participating in its patient survey; and consider broadening the survey to seek patients' views on the timeliness of being seen.
- Continue to liaise with the landlord of its Chase Farm Hospital Primary Care Centre to see how signage can be improved.
- Update its Medicines Policy to ensure that it reflects the provider's current practice regarding emergency medicines held at primacy care base locations.

Barndoc Healthcare Limited OOH - Churchwood House

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 member of the CQC medicines team, a service nurse specialist adviser and a service manager specialist adviser.

Background to Barndoc Healthcare Limited OOH - Churchwood House

Barndoc Healthcare Limited Out of Hours Service (Barndoc OOH Service) provides urgent medical care and advice out-of-hours (OOH) for over one million residents of Barnet, Enfield and Haringey who are registered at general practices within these London Boroughs. Barndoc OOH Service sees an average of 500 patients per week.

On 4 October 2016, the five north central London CCGs of North Central London: Barnet, Camden, Enfield, Haringey and Islington launched an integrated NHS 111 out of hours service. The contract to provide the service is held by London Central and West Unscheduled Care Collaborative (LCWUCC).

Barndoc OOH Service is subcontracted by LCWUCC to provide the GP out of hours element of the service for Barnet, Enfield and Haringey CCG areas. The service includes telephone clinical assessments with GPs and nurses, GP home visits and face to face consultations at primary care base locations in Barnet, Enfield and Haringey. The service is provided for registered patients and those requiring immediately necessary care when GP practices are closed; namely overnight, during weekends, bank holidays and when GP practices are closed for training.

Barndoc's managerial and administrative staff are based at its operational headquarters in Cockfosters, Barnet. The service's three primary care base locations located at:

Enfield

Chase Farm Hospital

The Ridgeway

London

EN2 8JL

Barnet

Finchley Memorial Hospital

Granville Road

London

N12 0JE

Haringey

The Laurels

256 St Ann's Road

London

N15 5AZ

Detailed findings

Barndoc OOH service's staff team includes a chief operating officer, a medical director, a head of governance, call handling staff, drivers, nurses and GPs. The service employs sessional (self-employed contractor) GPs directly and occasionally through agencies.

The opening hours are seven days a week from 6:30pm to 8am and 24 hours at weekends and bank holidays.

Patients access Barndoc OOH Service via the NHS 111 telephone service. Depending on their needs, patients may be seen by a GP at one of the service's three base locations, receive a telephone consultation or a home visit. The service does not normally accommodate walk in patients.

Barndoc Healthcare Limited (Out Of Hours Service) is registered for the Regulated Activities of Transport services, triage and medical advice provided remotely; and Treatment of disease, disorder or injury. The service has been registered since January 2012.

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 2013 using our old inspection methodology and at which time, the provider was judged to be compliant.

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. We carried out an announced visit on 16 and 20 February 2017 to the provider's headquarters and three primary care base locations. During our visit we:

- Spoke with a range of staff including Chief Operating Officer, Deputy Chief Operating Officer, Head of Medicines Management, Medical Director, Head of Governance, Head of Customer Services, clinicians and base receptionists.
- Inspected the three 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.

Inadequate

Are services safe?

Our findings

Safe track record and learning

We noted an open culture in which safety concerns raised by staff and people who used services were highly valued as integral to learning and improvement.

- The service carried out thorough analyses of significant events and ensured that learning from them was disseminated to staff and embedded in policy and processes. For example, the provider produced a quarterly bulletin which The bulletin highlighted learning from recent incidents and near misses such as the need to verify a patient's identify by using their name and date of birth and also reiterating that it was appropriate for GPs to decline a telephone triage request for oral contraception without first seeing the patient to undertake an examination to include the patient's blood pressure. We were told that the bulletin was available on the extranet: allowing sessional GPs (also known as agency GPs) to access this information from base locations and also remotely.
- Base staff told us they would inform the Head of Governance of any incidents and there was a recording form available on the service's computer system which we were shown at primary 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. We noted that this routinely involved a face to face meeting with the Chief Operating Officer where an apology and an explanation were offered based on facts in addition to details of any actions to improve processes and prevent the same thing happening again.
- We also noted that reporting incidents and near misses was actively encouraged. For example, the reverse side of staff members' ID badges contained a summary of how to report incidents and near misses.

We reviewed audits, safety records, incident reports, patient safety alerts and minutes of 2015 and 2016 quarterly Clinical Governance Meetings where these were discussed. We saw evidence that lessons were routinely shared and actions taken to improve or maintain safety in the service. For example, records showed that in September 2016, in the course of auditing call recordings associated with complaint cases, staff noted that the content of voicemail messages were incomplete and did not give patients information about how to recontact the provider. In order to enhance patient "safety netting", the provider therefore agreed a script for leaving up to three phone messages for patients within two hours. This was also aligned with the provider's protocol for Failed Patient Contacts.

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 child protection and vulnerable adults safeguarding policies were accessible to all staff. However, we noted that the vulnerable adult's policy did not reflect new definitions of abuse contained in the 2014 Care Act and changes in how vulnerable adults are protected from the risk of abuse and neglect. Records indicated that this had also recently been highlighted by the provider's commissioners and that the provider was shortly convening a meeting to further discuss this matter.
- We also noted that some staff had not received safeguarding training relevant to their role. For example, records showed that only 76% of GPs had in date level 3 child safeguarding training. Records also showed that only 78% of non clinical staff had received level 1 child safeguarding training.
- Records showed that the provider was aware of its low safeguarding training uptake and planned to take action to improve its performance.
- Shortly after our inspection we were sent evidence which confirmed that the GP level 3 child safeguarding training completion rate had increased to 98%.
- We noted a proactive approach to identifying and reporting safeguarding concerns. For example, the provider routinely undertook audits of cases to identify missed opportunities to make notifications of contacts for patients on the safeguarding registers to local authorities. Safeguarding reporting was actively encouraged (for example, the reverse side of staff members' ID badges contained a summary of how to report safeguarding concerns).

Inadequate

Are services safe?

- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had 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.
- The service maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. There was a designated infection control lead who had received IPC training although records showed that only 58% of clinicians had received training and less than 1% of non clinical staff. Shortly after our inspection we were sent confirming evidence that performance had improved respectively to 79% and 69%.
- We noted that an infection control protocol was in place but that an infection control audit had not taken place since November 2015. Senior managers told us that a planned November 2016 audit had not taken place because LCW assumed overall IPC responsibilities when the service was reconfigured in October 2016.
- We were later advised that Barndoc had undertaken a Provider Infection Control Compliance Assessment in September 2016, although we noted that it did not evidence how the effectiveness of base location protocols for hand hygiene, safe handling and disposal of sharps, the cleaning of Visiting Cars and the appropriate use of personal protective equipment had been assessed regarding preventing, detecting and controlling the spread of infections, including those that are health care associated.
- We noted that doctors had access to small sharps bins that they could take out with them when required. When they were used, they were brought back to base for disposal.
- The organisation was able to evidence its response to safety alerts relating to infection prevention and control and incidents as well as cleaning schedules and provision of infection prevention and control equipment.
- There was a system in place to ensure equipment was maintained to an appropriate standard and in line with manufacturers' guidance; for example annual servicing of fridges including calibration where relevant.
- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, clean driving licence, references, qualifications, registration with the appropriate professional body, appropriate indemnity and the appropriate checks through the Disclosure and Barring Service.

Medicines Management

We reviewed the arrangements for managing medicines and how the service ensured that patients were kept safe. We were told that in October 2016 (as part of the service's reconfiguration) an external contractor had been commissioned to provide a pharmacy service. This service entailed the contractor attending the service on a twice weekly basis to supply medicines in tamper evident cassettes (which enabled GPs to easily establish whether a cassette contained the necessary medicines). The responsibility for checking medicines cassettes when they returned to headquarters was retained by the provider's Head of Medicines Management as was management of Controlled Drugs (CDs).These are medicines that require extra checks and special storage because of their potential for misuse.

Records showed that in January 2017, the Head of Medicines Management reduced their hours from 30 hours per week to one hour per week but we did not see evidence from this period that the provider took action to ensure that medicines management was sufficiently resourced to keep patients safe. When we inspected on 16 February 2017 we noted that for the period 1 January 2017 – 15 February 2017, we did not see records confirming that medicines cassettes were being checked upon their return to headquarters. We highlighted our concern and were advised that a protocol would be put in place to ensure that these checks immediately took place.

On Day 1 of our inspection we also saw excess quantities of expired CDs awaiting disposal. The items had been expired for varying lengths of time, the longest being well over 20 months. When we highlighted this to the provider we were told that the drugs had accumulated due to a lack of denaturing kits (which would render the drugs irretrievable and unfit for further use until they were fully destroyed). These kits were immediately ordered and when we returned on Day 2, we were shown confirming evidence that the expired CDs had been denatured.

Are services safe?

We noted that CDs were stored in an appropriate cabinet within a locked clinic room at the provider's headquarters. Access to the CD keys was via a key code which was changed weekly and sent to relevant GPs via text message.

CDs were not routinely taken on home visits by GPs. They were only taken to patients when required (usually for palliative care). There were CD boxes made up for use on home visits. Each lockable CD box had a corresponding CD register which the GPs completed when CDs were administered.

We were told that all new GPs staff received a medicines management induction session and were required to attend a refresher session after 24 months. However, records showed that only 44% of GPs had completed their refresher training.

The service held a comprehensive range of emergency medicines at each base location and we noted that these were in date. However, they were not stored in a manner which facilitated immediate access in an emergency. For example at one base location, the emergency oxygen cylinders and airways were stored in different locations.

We also noted that at each primary care centre, expiry dates for each item were listed on the front of each box. However we found an item that had an earlier expiry date than that listed on the front of the emergency box.

We also noted that the provider's medicines policy listed diazepam (a schedule 4 CD used to treat seizures) in the contents of its emergency medicines boxes. However, this medicine was not held and records showed that a decision had been taken in January 2017 to remove diazepam from all primary care base locations. The records further stated that this was due to the provider's schedule 4 CD licence being amended to only cover storage of CDs at its headquarters location.

We did not see any documentation providing assurance that these boxes were routinely checked. Consequently, when we checked one of the two emergency oxygen cylinders at a base location we noted that it was empty. The provider took immediate action to remove the empty oxygen cylinder and ensure that equipment was stored in a manner which enabled immediate access in an emergency. We were also advised that a more robust system of checking medicines and equipment would be introduced.

The service carried out regular medicines audits with the support of the local CCG medicines management team, to ensure prescribing was in accordance with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. 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 it 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 in place 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).
- There were 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 coolant levels, tyre pressure and fire extinguisher checks. Records were kept of MOT and servicing requirements. We checked three vehicles and found that they were clean and well equipped.

Drivers underwent pre-employment checks such as DBS checks and references and a copy of their driving licence and counterpart was taken. An online check was also completed to see if any drivers were disqualified or had points on their driving license. We saw that vehicle checks were completed at the start of each shift by each driver and that each vehicle was cleaned on a weekly basis.

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. We saw evidence that the rota system was effective in ensuring that there were enough staff on duty to meet expected demand.

Inadequate

Are services safe?

For example, the service had systems in place to meet any predictable fluctuations in demand, especially at periods of peak demand such as Saturday and Sunday mornings. An escalation process was in place for unexpected events, that allowed the service to meet patient needs and we saw operate effectively when a GP phoned in unable to work their session. Records also showed that a surge in demand during the Easter 2016 bank Holiday had been discussed by senior managers, individual cases analysed and planning undertaken to ensure that the provider had future capacity to meet demand and ensure that patients had access to the clinician best equipped to meet their particular needs. We also noted that different staffing models were used for two and four day bank holiday weekends, so as to ensure staffing capacity.

Arrangements to deal with emergencies and major incidents

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

- There was an effective system to alert staff to any emergency.
- All staff received annual basic life support training, including use of an automated external defibrillator.
- The service had defibrillators available at all locations; in addition to oxygen with adult and children's masks (although we noted that at one base location, they were not stored in the same room which would delay prompt access in the event of an emergency).
- 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.
- The service had access to a cab service and/or courtesy cars in the event of vehicles breaking down.

Requires improvement

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 telephone and face to face assessments happened within the required timescales, seeking patient feedback and actions taken to improve quality.

We were advised that since the October 2016 amalgamation of the service into the North London Integrated Urgent Care service NQR data was not being collected. We therefore reviewed NQR data for the period October 2015 - September 2016. This data had been submitted to the provider's then commissioners and also used by the provider to manage and improve its own performance.

- For the period October 2015 to September 2016, the provider's performance on starting emergency, urgent, or less urgent consultations respectively within one hour, two hours or six hours ranged between 95% - 100%. The commissioner's performance target was 95%.

We saw extensive evidence of quality improvement activity (including clinical audit) and of how findings were used by the provider to improve services and drive improvements in patient outcomes:

- For example, the provider had an audit policy in place which stipulated auditing 1% of each GP's and nurse's case load every quarter (with a 75% pass mark) to assess the quality of clinical care given. Records showed that quarterly findings had routinely been presented to the provider's Clinical Governance Committee in the previous 24 months, covering clinical performance of starter and established GPs, starter and established nurses and also GPs who had conditions on their medical registration (for whom 100% of case notes were audited). We also saw evidence of action being taken as necessary to improve quality (for example developing action plans to improve performance on how clinician's "safety-netted" patients).
- Accurate and up-to-date information about effectiveness was used to improve care and treatment and this improvement was checked and monitored. For example, the provider regularly audited cases referred to local accident and emergency departments to see whether these were clinically appropriate. We noted that an April–June 2015 audit on the appropriateness of direct referrals to accident and emergency departments highlighted that 69 of 102 referrals (68%) were appropriate. Following interventions such as training sessions on how best to assess an unwell child while performing telephone triage, a July – September reaudit highlighted that 70 out of 81 cases (86%) were correctly referred to the accident and emergency department for assessment and treatment. The audit also looked at why the remaining cases had been referred when these could have been seen at a Barndoc primary care centre or at an appropriate secondary care team in the hospital.
- We saw evidence of participation in monitoring activities, such as reviews of services and benchmarking. For example, the provider was a member of a federation of unscheduled primary and community care providers which were also Social Enterprises. The federation validated the quality of care of each member organisation by requiring it to participate in an annual external audit, the results of which were shared with members to encourage and promote best practice. The provider's 2016 report identified low levels of GP safeguarding children training although when we inspected we saw or were shortly thereafter sent confirming evidence that performance had improved.

Requires improvement

Are services effective?

(for example, treatment is effective)

- Information and analysis were proactively used to identify opportunities to drive Improvements in care. For example, the provider proactively undertook quarterly audits to identify any safeguarding cases where there were missed opportunities to make safeguarding referrals. We noted that the audit findings were presented to the provider's quarterly Clinical Governance Committee and triggered activity such as writing to individual GPs to remind them of their information sharing responsibilities.
- The provider's Medical Director had lead responsibility for audit; including implementation and monitoring of the audit policy and auditor training. He spoke positively about how the provider strove to continuously improve the quality of clinical care. For example, records showed that in January 2017, the provider's Auditors Group had met to review its audit methodology to be assured of its robustness and the reliability of audit findings.

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 complaints management, information governance, 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. However, we also noted that only 44% of staff involved in handling medicines had received refresher training as required.

Coordinating patient care and information sharing

- For the period October 2015 to September 2016, 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 was 100%. The commissioner's performance target was 95%.
- For the period October 2015 to September 2016, the provider's performance on having 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) was 100%. The commissioner's performance target was 95%.

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.
- We saw evidence that the service shared relevant information with other services in a timely way, for example when referring patients to other services and when supporting vulnerable patients.
- The provider worked in partnership with the NHS111 provider in its area, having recently formed part of an integrated NHS111/ out of hours integrated urgent care service.

The provider 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 and routinely undertook audits to ensure that clinicians referred patients appropriately.

Requires improvement

Are services effective?

(for example, treatment is effective)

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.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff 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 42 (95%) of the 44 patient Care Quality Commission comment cards we received were 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 highlighted that reception staff at primary care centres responded compassionately when patients needed help and provided support when required. When we asked a receptionist how they ensured that anxious patients were treated with dignity and respect, they stressed the importance of recognising each patient's individual needs.

We looked at the provider's latest patient survey data undertaken during January – March 2016. During that period, there were 16415 patient contacts and the provider subsequently despatched 2000 postal surveys directly to patients. To ensure a cross section of patients across all elements of the service, the patient addresses were selected at random from the patient system. Surveys were also available at primary care centres and via the provider website.

A total of 147 surveys were returned which represented a response rate of less than 1%. Key findings were as follows:

- 97% of respondents who had attended a base, found reception staff to be either "helpful" or "very helpful".
- 96% of respondents said their privacy and dignity were respected at all times.
- 91% of respondents said that the GP/nurse showed empathy and understanding.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views.

Results from the provider's latest survey carried out in January – March 2016 showed:

- 92% of respondents felt the GP/nurse explained their treatment "very well" or "well".

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

Good

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.

- Home visits were available for patients whose clinical needs resulted in difficulty attending the service.
- There were accessible facilities, a hearing loop and translation services available.
- 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 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 from NQR scores indicated that in 95% or more cases, patients were seen within NQR target timescales.

This was generally in alignment with the patient feedback received via the CQC comment cards.

However, we noted that the provider's patient survey did not seek patients' views on the timeliness of their being seen by a clinician.

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 Barndoc OOH Service 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.

We noted limited signage at the Chase Farm Hospital base centre location. We were told that the primary care base location was located in the hospital's urgent care centre and that Barndoc had raised the issue of signage with the Hospital NHS Trust.

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 on a quarterly basis by the provider's Clinical Governance Committee. We looked at 34 complaints received between May 2015 and 30 Sept 2016 (after which time the provider formed part of an integrated urgent care service which assumed complaints management responsibility). We found that complaints were satisfactorily handled and dealt with in a prompt, open and transparent manner.

We also saw evidence of a clear protocol in place to ensure that lessons were learnt from individual concerns and trends; and used to drive improvements in the quality of care.

For example, records showed that a complaint was received following a GP advising that an ambulance be called for an unwell patient; despite the patient's Do Not Attempt Resuscitation (DNAR) order and Advance Care Plan (ACP) stipulating that they were not to be hospitalised. Following an investigation, it was determined that the GP did not did not explore the DNAR or ACP in sufficient detail to ascertain if there were any reversible scenarios to hospitalisation. The learning from this incident was discussed with the GP and training was provided for clinicians on how to access and interpret Do Not Attempt Resuscitation orders and Advance Care Plans.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We also noted the reasonable support provided to complainants, with for example, the Chief Operating Officer or Medical Director visiting complainants to discuss the outcome of the investigation and any unresolved issues.

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's mission statement was to provide excellent local primary healthcare that delivered good value and a high quality patient experience. Staff with whom we spoke were aware of this mission statement.

Governance arrangements

We looked at the governance arrangements in place for supporting the delivery of good quality care and noted:

- 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 staff were aware of their own roles and responsibilities.
- Service specific policies were implemented and were available to all staff.
- The provider had a good understanding of their performance against National Quality Requirements.
- Performance was shared with local CCGs as part of contract monitoring arrangements.

However, we also noted that governance arrangements did not always operate effectively. For example:

- We could not be assured that medicines management arrangements kept people safe.
- We noted the absence of a system for checking emergency medicines and equipment which meant that risks associated with expired emergency medicines and equipment were not being proactively identified.
- On the day of our inspection, records highlighted that a high percentage of staff had not received safeguarding or infection prevention control training in accordance with the provider's own protocols (although records showed that senior managers management were aware of performance in this area and planned to take action).
- Risks were not always dealt with appropriately. For example, an infection prevention and control audit had not taken place within the last 12 months.

Leadership and culture

On the day of inspection senior managers told us they prioritised safe, high quality and compassionate care. Staff told us that the Chief Operating Officer and other senior managers were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place 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. For example, we saw evidence that the Chief Operating Office routinely visited patients when things went wrong to apologise and explain what would happen to minimise the chance of reoccurrence. Senior managers encouraged a culture of openness and honesty. The service had systems in place 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 clear leadership structure in place and staff felt supported by management.

- There were arrangements in place to ensure the staff were kept informed and up-to-date. This included a regular newsletter highlighting incident, near misses and the subsequent learning.
- 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, particularly by the providers. Staff had the opportunity to contribute to the development of the service.

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.

Are services well-led?

Requires improvement

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

- The service had gathered feedback from patients through surveys and complaints received. For example, following a patient complaint, the provider had made changes to the way in which home visits to confirm a patient's death were carried out, so as to ensure that the process was conducted in a compassionate manner.
- The service had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example, receptionists spoke positively about how their suggestions to improve base security had been acted upon. Staff told us they felt involved and engaged to improve how the service was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the service.

The provider's Medical Director had lead responsibility for audit; including implementation and monitoring of the audit policy and auditor training. He spoke positively about how the provider strove to continuously improve the quality of clinical care. For example, records showed that in January 2017, the provider's Auditor Group had met to review its audit methodology to ensure its robustness and the subsequent reliability of audit findings.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014** **Safe care and treatment** **How the regulation was not being met:** **The provider did not do all that was reasonably practicable to assess, monitor and improve the quality and safety of the services provided by:** • Failing to assess the risk of (and preventing, detecting and controlling the spread of) infections, including those that are health care associated. • **Failing to ensure that there were adequate arrangements in place to safely manage medicines.** **This was in breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**