Leicester City, Leicestershire and Rutland Out of Hours

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Leicester City, Leicestershire and Rutland Out of Hours Service on 17 March 2015 and 18 March 2015. Overall the service is rated as inadequate.

Specifically, we found the Out of Hours Service inadequate for providing safe, effective and responsive services and being well led. It required improvement for providing responsive services.

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

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example emergency and urgent patients were not being seen for face to face consultations in relation to their medical needs and in a timely manner.
- Staff were not clear about reporting incidents, near misses and concerns and there was no evidence of learning and communication with staff.
- There was insufficient assurance to demonstrate people received effective care and treatment. For example we saw evidence of emergency patients waiting far too long to be seen by a clinician. Despite being aware of issues, the provider had not looked at them in detail to identify the root cause.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.
- Essential clinical equipment was found to be out of date in some areas or simply not available. This had caused inappropriate delays when treating some patients.
- Medication management was poor. Medicines were found to be out of date or there were no systems in place to monitor the quantities or expiry dates.
- The provider had no clear leadership structure, insufficient leadership capacity and limited formal governance arrangements.

The areas where the provider must make improvements are:

Summary of findings

- Ensure that National Quality Requirement (NQR) key performance indicators are met each month in respect of definitive clinical assessments, face to face consultations in a primary care centre and face to face consultations for home visits.
- Ensure that the patient queues for definitive clinical assessment, face to face consultations in a primary care centre and face to face consultations for home visits are robustly monitored and managed to ensure patient care does not suffer.
- A supernumerary member of staff must be used on all shifts to monitor patient queues with the authority to intervene and allocate resources to ensure patients are being assessed and receive consultations within NQR timescales.
- Review all incidents to identify serious incidents, then investigate and identify lessons to be learnt. The provider must also implement a new regime regarding serious incidents by communicating to staff and training them on identifying and reporting.
- Staff must be trained appropriately in safeguarding and safeguarding policies must be implemented at all of the sites, rather than just centrally.
- Medicines management policies and procedures need to be implemented across all sites. Responsible staff members must carry out audits of medication stock and whether it is in date.
- Clinical equipment used and required by sites and vehicles must be in place.
- Policies, procedures and checklists must be implemented for clinical equipment to ensure that important equipment is available and working correctly.
- Appropriate and effective clinical audits need to be implemented to ensure that the service can identify areas of development and learning.
- Clinical protocols need to be implemented for clinicians to follow.
- Clinical supervision needs to take place for both doctors and nurses.
- A performance regime for staff must be implemented to identify and investigate poor performance.
- Implement and maintain an intervention type system to monitor waiting times for patients. A person or persons responsible for this must monitor the systems and direct clinicians to ensure patients are being seen appropriately and in line with their needs.
- Information relating to incidents, complaints and lessons learnt must be shared with all staff.
- Procedures relating to walk in patients must be shared with all site staff to ensure patients are not dealt with inappropriately.
- A clear leadership structure must be implemented and staff made aware of their lines of management.
- Communication must take place with all staff regarding changes that are taking place.

On the basis of the ratings given to this service at this inspection, I am placing the provider into special measures. This will be for a period of six months. We will inspect the provider again in six months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC. I have also served a notice on the provider placing conditions on their registration, which they must comply with. The conditions are the first three 'Must Improve' comments listed above.

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 and improvements must be made. Staff felt discouraged from reporting incidents, near misses and concerns due to the lack of response from the provider. They were also unclear about the process for reporting these issues. The provider did not always review when things went wrong, we saw no evidence of lessons learned, lessons identified were not communicated and so safety was not improved. Patients were at risk of harm because systems and processes were either not in place or were weak. We saw issues in relation to medicines management in all sites inspected, serious incident and incidents were not being recorded properly or investigated. There was insufficient information to enable us to understand and be assured about safety because incidents were not being investigated or identifying lessons to be learnt.

Are services effective?

Inadequate

The service is rated as inadequate for providing effective services and improvements must be made. Data showed that care and treatment was not delivered in line with National Quality Requirements. Patient outcomes were hard to identify as little or no reference was made to audits. The service was part of Urgent Health UK and had an audit carried out in January 2015 comparing the service to other similar providers (this information was provided post inspection). There was minimal engagement with other providers of health and social care. There was limited recognition of the benefit of an appraisal process for staff and little support for any additional training that may be required. Basic care and treatment requirements were not met.

Are services caring?

Requires improvement

The service is rated as requires improvement for providing caring services, as there are areas where improvements should be made. All patients said they were treated with compassion, dignity and respect. Patients were asked for their consent before any care or treatment was started. Patients were also kept informed with regard to their care and treatment throughout their visit to the out-of-hours service. Patients' consultations with clinicians were not always private due to environmental factors, such as layout of areas.

Are services responsive to people's needs?

Inadequate

The service is rated as inadequate for providing responsive services. Although the provider had reviewed the needs of its local population, it had not put in place a plan to secure improvements

Summary of findings

for all of the areas identified. The provider was equipped to treat patients and meet their needs however did not do so in a timely manner. Patients could get information about how to complain in a format they could understand. However, there was no evidence that learning from complaints had been shared with staff.

Are services well-led?

Inadequate 

The service is rated as inadequate for being well-led. It did not have a clear vision and strategy. Staff we spoke with were not clear about their responsibilities in relation to the vision or strategy. There was no clear leadership structure and staff did not feel supported by management. The service had a number of policies and procedures to govern activity, but a number of these were out of date or different policies and procedures were available in different locations. The service did not hold regular governance meetings and issues were discussed at ad hoc meetings. Staff told us they had not received regular performance reviews and did not have clear objectives.

Summary of findings

What people who use the service say

We spoke with nine patients during the inspection, received two comment cards from patients and spoke with managers of 11 care homes across Leicestershire.

The feedback from all was very similar. Patients described obtaining an appointment as a long winded process, where they had to speak with people several times on the telephone before being able to see a clinician face to face. Patients told us that once they had an appointment the GPs they saw were very good, attentive and felt their needs had been met.

Areas for improvement

Action the service MUST take to improve

- Ensure that National Quality Requirement (NQR) key performance indicators are met each month in respect of definitive clinical assessments, face to face consultations in a primary care centre and face to face consultations for home visits.
- Ensure that the patient queues for definitive clinical assessment, face to face consultations in a primary care centre and face to face consultations for home visits are robustly monitored and managed to ensure patient care does not suffer.
- A supernumerary member of staff must be used on all shifts to monitor patient queues with the authority to intervene and allocate resources to ensure patients are being assessed and receive consultations within NQR timescales.
- Review all incidents to identify serious incidents, then investigate and identify lessons to be learnt. The provider must also implement a new regime regarding serious incidents by communicating to staff and training them on identifying and reporting.
- Staff must be trained appropriately in safeguarding and safeguarding policies must be implemented at all of the sites, rather than just centrally.
- Medicines management policies and procedures need to be implemented across all sites. Responsible staff members must carry out audits of medication stock and whether it is in date.
- Clinical equipment used and required by sites and vehicles must be in place.
- Policies, procedures and checklists must be implemented for clinical equipment to ensure that important equipment is available and working correctly.
- Appropriate and effective clinical audits need to be implemented to ensure that the service can identify areas of development and learning.
- Clinical protocols need to be implemented for clinicians to follow.
- Clinical supervision needs to take place for both doctors and nurses.
- A performance regime for staff must be implemented to identify and investigate poor performance.
- Implement and maintain an intervention type system to monitor waiting times for patients. A person or persons responsible for this must monitor the systems and direct clinicians to ensure patients are being seen appropriately and in line with their needs.
- Information relating to incidents, complaints and lessons learnt must be shared with all staff.
- Procedures relating to walk in patients must be shared with all site staff to ensure patients are not dealt with inappropriately.
- A clear leadership structure must be implemented and staff made aware of their lines of management.
- Communication must take place with all staff regarding changes that are taking place.

Leicester City, Leicestershire and Rutland Out of Hours

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, three CQC inspectors and two advanced nurse practitioners.

Background to Leicester City, Leicestershire and Rutland Out of Hours

The GP out-of-hours service for Leicester City, Leicestershire and Rutland is provided by Central Nottinghamshire Clinical Services Ltd. The service is commissioned by the four Leicestershire Clinical Commissioning Groups (CCG's), with the lead for out-of-hours services being East Leicestershire and Rutland CCG.

The out-of-hours service provides care to patients who require urgent medical care from GPs and nurses outside of normal GP hours. The provider employs the services of 254 GPs, nurses, health care assistants and support staff who are engaged on a sessional basis to deliver care to patients. The service operates county wide from 6.30pm until 8am Monday to Thursday, and 6.30pm Friday until 8am Monday, and all public holidays.

Initial telephone contact with the out-of-hours service is through the NHS 111 number, a service provided by another healthcare provider.

The service provides care to a population of approximately 996,000 residing in the area and operates from five primary care centres geographically spread across the county. The five locations are;

- Hinckley & Bosworth Community Hospital, Hinckley
- Leicester Royal Infirmary, Leicester
- Loughborough Community Hospital, Loughborough
- Lutterworth Hospital, Lutterworth
- Rutland Memorial Hospital, Oakham

At the time of this inspection, CQC's systems showed that there was a registered manager in place for the service. We identified that the registered manager had actually left the service in the summer of 2014 and no application to change this had been made by the provider.

Why we carried out this inspection

We carried out the inspection as part of our new inspection programme. It took place with a team that consisted of CQC inspectors, a GP Advisor and Advanced Nurse Practitioners. We spoke with patients and members of the public who used the service to help us capture their experience.

Prior to the inspection we had been contacted by East Leicestershire and Rutland Clinical Commissioning Group (CCG). The CCG are the contract commissioners for the out of hours service and monitor contract compliance. The CCG raised a number of concerns relating to the poor performance of the out of hours service over the financial year 2014/15 and supplied the CQC with the supporting information. The CCG informed us it had served 15 contract

query notices (these are served when performance is not meeting targets) in the financial year 2014/15 and that these were still outstanding and had not yet been addressed by the provider. Following the inspection, we were provided with up to date information by both the provider and the CCG which showed that there had actually been 12 contract query notices. Four of these notices had been closed by the CCG following improvement and eight were still open.

How we carried out this inspection

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

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

Before we visited, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. The lead inspector and a GP advisor carried out an announced visit to the providers headquarters on 17 March 2015. At this visit we reviewed the provider's policies and procedures and looked at other information with regard to how the service was run and how it was performing.

On 17 March 2015 we also carried out an announced inspection at the out-of-hours service locations at the Hinckley & Bosworth Community Hospital site, Leicester Royal Infirmary site and Loughborough Hospital site. We spoke with patients who used the service. Prior to the inspection we left comment cards to allow patients to provide feedback. We received two comment cards from patients who had used the service.

We also spoke with nine members of staff employed by the out-of-hours service and with three GPs who were on duty. In addition we spoke with nine patients to gain their views of the out-of-hours service.

We inspected the out of hours premises, looked at cleanliness and the arrangements in place to manage the risks associated with healthcare related infections.

We looked at the 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.

Inadequate

Are services safe?

Our findings

Safe track record

The service had a range of information available to them to identify risks and improve patient safety but did not use this effectively. Staff we spoke with were aware of their responsibilities to raise concerns but were unsure how best to raise concerns. Staff we spoke with told us they would ring the shift supervisor to report issues or send an email to the shift supervisor. Staff we spoke with were unaware of any document or system available to report concerns. Staff at one of the locations told us that when they had raised concerns they did not receive a response or issues were not addressed for several weeks, if at all. For example we saw documented concerns from a GP regarding the lack of response to incidents reported. In May 2014, a GP had reported a number of incidents that presented clinical risks. No response had been received and the risks were still present so the GP had requested to be removed from all future booked shifts with the out of hours service. This incident was recorded as "an investigation is underway" however there was no information available to show what had happened or any learning identified.

The service compiled concerns, never events, complaints and compliments in a monthly newsletter to share with all staff. We showed both clinical and non-clinical staff copies of the newsletter and they informed us they had not seen the newsletter before. We spoke with the member of staff who created the newsletter and they expressed their disappointment that staff had not seen the document. Although there was a system in place to communicate with staff, it either was not being used effectively or at all.

Learning and improvement from safety incidents

The service had a system in place for reporting, recording and monitoring serious incidents, however this was not effectively used and serious incidents were not being recorded or investigated. There were records of two serious incidents that had occurred during the last two years and we were able to review these. Of the two serious incidents there was evidence that the service had identified learning from one of them, however the findings were not shared with relevant staff. The inspection identified 12 possible serious incidents which were not recorded as such. Following the inspection, the Clinical Commissioning Group met with the service to review their incidents. Three of the identified 12 incidents were recorded as serious incidents. Although the service did have a system in place, it was not being used.

We reviewed incident reports from April 2014. We saw 133 documented incidents which ranged in variety from vehicle keys missing to serious medical incidents in reception areas of an out of hours location. 22 incidents between April 2014 and August 2014 were recorded as 'investigation underway'. However there was no further information available as to what had happened or if any learning had been identified. The service had not managed these incidents consistently over time and could not show evidence of a safe track record over the long term. The provider was not learning from incidents that had taken place, potentially putting patients at risk.

National patient safety alerts and other clinical alerts were brought to the attention of clinical staff within the service by a monthly newsletter. The Local Medical Director produced a detailed and informative monthly newsletter that was sent to all clinical staff. Clinical staff we spoke with confirmed that they did receive this newsletter.

Reliable safety systems and processes including safeguarding

The service had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that staff had received role specific training on safeguarding. However, none of the 22 staff files we looked at showed staff with up to date safeguarding training. We asked clinical and non-clinical staff about their most recent safeguarding training. A number of clinicians informed us that they received training as part of their substantive roles in practice and not through the out of hours service. Some informed us that they had sent copies of their safeguarding certificates to the service. Other staff we spoke with such as receptionists or drivers gave us a mixed response regarding safeguarding training. Most informed us that they had not received any safeguarding training for a lengthy period of time. One member of staff told us that they had carried out online safeguarding training a week before the inspection. Staff did know how to recognise signs of abuse in older people, vulnerable adults and children. Documentation and protocols differed significantly depending on the site. There was a comprehensive safeguarding protocol held centrally by the service. The versions available at two of the sites

differed significantly and were very much out of date. This meant that the correct information, including contact details, was not available in its current form in any of the sites we inspected.

The service had a dedicated lead for safeguarding, although staff were not aware of this and we were only informed of this after the inspection. All staff we spoke with said they would raise any safeguarding matters with the shift supervisor.

There was a chaperone policy. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). We could not identify which staff had received training as chaperones as the staff files we checked did not have any information relating to this. Some non clinical members of staff did say they had received local informal training. At the Loughborough site, nurses from the Urgent Care Centre would be asked to chaperone if required. At the Leicester Royal Infirmary site, nurses were used to chaperone if required.

Medicines management

We checked medicines stored in the treatment rooms at all sites and found they were stored securely and were only accessible to authorised staff.

There were not robust processes in place to check medicines were within their expiry date and suitable for use. Not all of the medicines we checked were within their expiry dates. Staff at two of the sites we visited told us that a local contracted pharmacy were responsible for checking the medication, both in the cupboards and also medication bags for the out of hours vehicles. Staff at the third site, Leicester Royal Infirmary, checked the medication themselves. The provider did not have any system for monitoring the quality of the checks provided by the pharmacy.

At the Hinckley & Bosworth Community Hospital site, we looked at the medicines cupboard and medicines bags used when home visits were carried out. We found four different types of out of date medication in the medicine cupboard, including antibiotics. We were informed by staff that the pharmacy would carry out the checks and the GP informed us that medicines from the cupboard were rarely used. The last time medication had been prescribed from the cupboard was November 2014. There was no stock control or balance sheet available for either the cupboard or the bags used, so staff were unaware of what they had or what they should have. We also found a number of loose leaf prescriptions in the cupboard. Neither the GP nor the other member of staff we spoke with were aware of the prescription pads and stationary security policy. We could not see any documentation relating to the monitoring of the prescription sheets. Due to the loose leaf prescriptions and lack of records relating to them, prescriptions could go missing (either lost or stolen) with no method of tracking them.

At the Leicester Royal Infirmary site, all of the medication checked in the cupboards and bags were in date. Again we found that there were no stock control or balance sheets available to check which drugs should be or were available. Staff told us that they "used their eyes" to visually check what should be there. Although staff at this site could find a copy of the Prescription Pads and Stationary Security Policy, they had not read it before.

We also found medication loose in two of the vehicles at Leicester Royal Infirmary site. We found a box of diazepam (Diazepam is used to treat anxiety disorders, alcohol withdrawal symptoms or muscle spasms and is sometimes used with other medications to treat seizures) in the boot of one vehicle and an inhaler in another.

At Loughborough Hospital site, we were given a different response from different people as to who was responsible for checking medication. The GP thought the pharmacy was responsible whereas an operations manager thought the nurses from the adjacent Urgent Care Centre did it. Again, we found there was no stock control or balance sheet in place for the vehicle bags. We did see there was a stock control sheet for the medication stored within the cupboard; however we found that the balance of stock within the cupboard did not match the documentation.

All prescriptions were reviewed and signed by a GP before they were given to the patient. We saw this taking place. The prescriptions would be printed and then checked and signed by a GP prior to being given to a patient.

The lack of proper medicines management by the out of hours service was fragmented and sporadic. The provider did not have proper systems in place to ensure that patients are protected from the risks of inadequate medicines management.

Cleanliness and infection control

Inadequate

Are services safe?

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. However, we found that the vehicles at Leicester Royal Infirmary site were dirty inside and an old water bottle was found inside one. There were daily checklists relating to the cleanliness of the vehicles for driver's to complete, however we did not see copies that had been filled in. It was also the driver's responsibility to leave the vehicles in a clean state for the following shift. This was not being monitored by anybody. Although patients being treated within primary care centres were treated within a clean environment, patients treated by home visits were placed at risk of infection due to the uncleanliness of the vehicles used.

There was a lead for infection control, although staff were not aware of who this was. We were informed of the infection control lead after the inspection had taken place. Staff received induction training about infection control specific to their role and should receive updates. Staff we spoke with told us that they had access to online infection control training. However, information from the CCG prior to the inspection informed us that 74% of staff had received updated training.

An infection control policy and supporting procedures were still being developed between the provider and the CCG. The provider had ratified the infection control protocol in December 2014 although the CCG had requested more work on the protocol to ensure it was robust.

Equipment

We found that there was a lack of equipment required within the out of hours service and found a number of missing pieces of equipment or out of date equipment.

At the Hinckley site, we found that there were out of date syringes, out of date glucose testing strips and out of date water for injection ampoules stored within the vehicles.

At the Leicester Royal Infirmary site we found that emergency vehicles were missing a significant amount of equipment. There were no aprons in one vehicle. None of the vehicles here had thermometers, blood pressure machines, pulse oximeters, auroscopes or otoscopes. There were working automated external defibrillators (AEDs) in all vehicles as well as the oxygen and Entonox being available. We saw documentation that showed equipment had been found missing the week before the inspection (10 March 2015) and reported, although no replacement equipment had been obtained.

At the Loughborough Hospital site there was a checklist for what equipment should be in the vehicles. There should have been 20 oxygen masks in total in the vehicle, including both adult and child masks. We found that there were more than 50 adult masks in the vehicle and it took more than five minutes to find a child's mask. In addition there were no child nebuliser masks available.

There was no proper checking taking place across all sites and this could have caused potential risks to adults and children that were being treated by the out of hours team.

We found two examples where there was a lack of appropriate equipment or resources available to clinicians during February 2015: -

- A patient with diabetes was unable to have their blood glucose measured as there were no testing strips or glucometers (a machine to test blood sugar levels).
- A patient was unable to have a serious wound examined because there was a lack of dressings and bandages to redress the wound.

The lack of equipment and systems to ensure the appropriate equipment was available and within date was putting at risk patients using the out of hours service. There was no management oversight of equipment checks taking place.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The service had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

We saw that the provider had arrangements in place to check the annual registration of GPs with the General Medical Council (GMC). The provider did not, however, have arrangements in place to check the registration status of nurses working in out of hours. Nurses were provided from an agency. They did obtain evidence of their registration when they were first recruited however they did not check

annually, instead relying on the agency to inform them. Without any systems in place to check the registration, the provider is putting patients at potential risk of being treated by unregistered nurses.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The staffing needs analysis that had been carried out by the out of hours service was extremely detailed and comprehensive. A lot of time and effort had been invested in the staffing needs analysis. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. However, we found that staffing the rota provided more challenges. For example, at the time of the inspection the Easter Bank Holiday weekend still had 150 clinical hours to be filled. As the majority of GPs were sessional rather than working on fixed term contracts, filling clinical hours relied on staff volunteering for additional shifts.

Arrangements to deal with emergencies and major incidents

There were no records to show that all staff had received training in basic life support were not available, particularly for clinicians. Two GPs we spoke with told us that they sent up to date copies of the basic life support to the provider's HQ. However, nine staff files relating to GPs we checked did not contain evidence of up to date basic life support. Basic life support is mandatory training that should be carried out by GPs and should be evidenced by the provider, which it was not. We could not be assured that all staff had up to date basic life support training because the information was not available.

Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area which were accessible by out of hours staff. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. All the emergency medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included IT failure, telephone failure, unplanned sickness or absence and vehicle breakdown.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Calls dealt with by the out of hours service were initially triaged by NHS 111. These calls were then referred to the out of hours service to set up appointments.

Patients using the out of hours service were not having their needs assessed within a timely manner, impacting upon the clinical care and treatment they receive. There were two performance targets that the out of hours service had in relation to calls and the carrying out of definitive clinical assessments. (Definitive clinical assessments are assessments carried out by a GP regarding the patient's medical needs).

Urgent calls should have definitive clinical assessments within 20 minutes. The service's target was 95% of urgent calls will be assessed within 20 minutes. The service's performance in the year to date was 89%. Anything less than 95% is classed as amber and anything less than 90% is red using a traffic light system. The statistics we obtained during the inspection showed that the provider had never met this target between April 2014 and February 2015.

All other calls should receive a definitive clinical assessment within 60 minutes. The service's target was 95% and the service's performance in the year to date was 82%. Anything less than 95% is classed as amber and anything less than 90% classed as red using a traffic light system. The statistics we obtained during the inspection showed that the provider had never met this target between April 2014 and February 2015, only moving from red to amber in one of those months.

At the Hinckley Community Hospital site we saw a patient attend for an appointment. They were asked if they had contacted NHS 111, which they replied they had not. The HCA/receptionist told them they needed to ring NHS 111 for an appointment. They did not ask what the symptoms were or offer for the patient to ring from reception. The staff member explained to us that since NHS 111 had been introduced that was what they had to do. The GP at this time did not have a patient. The patient returned approximately one hour later, the GP had seen no other patients in the meantime. The service's policy for walk in patients is that a clinician should immediately assess them and they are booked in for an appointment without contacting NHS 111. This did not happen and the patient did not receive a timely assessment and treatment.

Emergency face to face consultations in primary care centres were not being carried out in a timely manner. Emergency patients should be seen within 60 minutes of a definitive clinical assessment, to have a proper clinical consultation with a GP. Anything less than 95% is classed as amber and less than 90% classed as red using a traffic light system. The service's performance in the year to date was 77%. The statistics we obtained during the inspection showed that the provider has met the 95% target twice between April 2014 and February 2015. The figures for January 2015 and February 2015 were 40% in each month. We saw that in the months December 2014, January 2015 and February 2015, eight out of 23 patients classed as an emergency were not seen within 60 minutes. The provider has been served notices in February 2015 by the CCG stating that they must improve their performance and meet their targets. These notices were in addition to others served earlier in the year.

We looked at the patients who had not been seen within an appropriate timescale and the GP Advisor inspected the patient consultation notes. The consultation notes and patient history showed that the systems for the monitoring of emergency patients were not in place. Checks were not carried out to ensure that patient lists were being effectively managed and that patients were being seen in a timely way. The provider explained that the shift leader was responsible for monitoring the order in which patients see a GP, making sure that those presenting as an emergency were seen as a priority.

In one particular case, we saw patient notes relating to a six week old baby that was very unwell and was classed as an emergency case. The baby's parents spoke with the out of hours service at approximately 7.30pm and were given an appointment at 10.30pm (despite emergency patients needing to be seen within 60 minutes). The parents arrived at the Leicester Royal Infirmary site with the baby shortly before 10.10pm. The baby was seen at approximately 12.50am the following morning, when the baby was admitted to the paediatric unit in Leicester Royal Infirmary. We looked at demand and resource availability on the night in question. We saw that there were two GPs on shift between 10pm and 11pm, one GP on shift between 11pm

Inadequate

Are services effective?

(for example, treatment is effective)

and midnight and then one GP from midnight onwards. Six patients (who were less of an emergency) were seen by GPs between the time the baby arrived at the Leicester Royal Infirmary OOH site and being seen.

There was no rationale as to why this emergency patient had waited over five hours to be seen. The provider had not identified the risk or carried out any investigations to establish the cause. This was after the CCG had raised concerns about the performance of the provider. Emergency patients were therefore at risk of harm when using the out of hours service as they are not always seen in a timely way.

Urgent face to face consultations were also not being carried out in a timely manner. Urgent patients should be seen within two hours of their definitive clinical assessment. Anything less than 95% is classed as amber and anything less than 90% red using a traffic light system. The service's performance in the year to date was 86%. The statistics we obtained during the inspection showed that the provider has met this target once between April 2014 and February 2015. We looked at specific numbers for urgent patients using the service between December 2014 and February 2015, 605 patients out of 2437 patients classed as urgent were not seen within two hours. The queues were not being effectively monitored or managed and no intervention was taking place when targets were not being met.

Patients using the service were at risk of harm by not receiving timely care in relation to their assessed needs.

Management, monitoring and improving outcomes for people

The provider did not have robust clinical audit systems, nor had they identified any learning for the service to benefit from. The provider showed us two clinical audits that had been undertaken in the last year. Neither of these were completed audits and the provider could not demonstrate that the audits had resulted in any change for the service.

The audits related to GP triage in quarter two of 2014/15 and GP face to face consultations in quarter two of 2014/15. The audits were difficult to understand. The introductions did not explain why the audits had been carried out and what was expected. A number of figures used were classed as "not applicable" yet there was no explanation of why, nor how it might impact on the audit. The data used was hard to understand, there was nothing to show learning outcomes, there was no benchmarking, no date of review and no mention of communication with staff. Staff we spoke with were unaware of clinical audits being carried out. In addition, despite one of the audits being in relation to face to face consultations it used information from telephone consultations as well without any clarification.

The clinical audits were discussed with the Clinical Director, who had only been in post 3 weeks. They accepted that the clinical audits were not fit for purpose and a number of audits had not been carried out. Clinical Auditors were being recruited by the provider to ensure audits were being carried out appropriately and effectively.

Effective staffing

We reviewed staff training records but could not identify if staff were up to date with attending mandatory courses such as annual basic life support. Managers did not know where the training records were held and were unable to provide assurance that staff had received appropriate training for their role.

GPs were up to date with their yearly continuing professional development requirements or revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). As the GPs working in the OOH service had substantive posts working for other providers, such as GP practices, this information was held there. The out of hours service did not have any information to show that the GPs had been revalidated.

In addition, we did not see any up to date training information on the nurses used through agencies. We were told that training information was checked annually by the agency and the service would dip sample this training by telephoning the agency. No copies of updating training records was placed on nurse's staff files.

We did not see any evidence of clinical supervision taking place with either the GPs or the nurses.

We did not see that poor performance had been identified and appropriate action had been taken to manage this. There was no evidence of this in files we looked at. The clinical director informed us that historically poor

Inadequate

Are services effective?

(for example, treatment is effective)

performance of clinicians had not been identified or managed. A system was being implemented which would assist with performance managing staff, although this would be a number of months before it was implemented.

Information sharing

Staff used an electronic patient record computer system, Adastra, to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We received two completed comment cards and they were positive about the service experienced. Patients said they felt the out of hours service provided very good care, once they had got further than the telephone system (this being NHS 111). We also spoke with nine patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We also spoke with the managers of 11 care homes across Leicestershire. All of the care homes provided us with similar feedback. The process of obtaining an out of hours GP was convoluted. They had to telephone NHS 111. They would then receive a call back from the out of hours service when they would have to repeat the same issues as they had told NHS 111. On some occasions they described receiving a third call from a GP to discuss the same issues again. Once a home visit was carried out, they told us that GPs were professional and provided appropriate clinical care.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard in two of the sites. At the Leicester Royal Infirmary site we were informed by staff that consultations could be overheard if the waiting room was quiet. Staff had requested a TV or radio to mask the noise from the provider but said that they had not received any response or acknowledgement for several weeks.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the shift leader. The incidents would be recorded and then investigated. However, we found that a number of incidents reported were not being investigated or responded to. We saw and spoke with staff regarding five incidents relating to privacy and dignity, none of which had either been investigated or staff raising concerns being responded to. One of the issues was where a patient suffering a miscarriage being placed in a waiting room with a receptionist for comfort.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

There was no signage in any of the sites identifying the out of hours service. We spoke with one patient who asked us for directions to the out of hours service as they did not know where to go. If patients had not used the service before they may be unsure where to go.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and 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 they wished to receive. Patient feedback on the two comment cards we received was also positive and aligned with these views.

One patient we spoke with specifically requested to speak to the inspection team after their consultation. They told us that they had spent 30 minutes with the GP discussing their health concerns and that a referral had been made to attend hospital the following day. They compared the service to their own GP practice and said that they would never have received such a timely hospital appointment if they had gone to their practice.

Staff told us that translation services were available for patients who did not have English as a first language. There were no notices in the reception areas informing patents this service was available.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the service was not always responsive to patient's needs. Although they had systems in place to maintain the level of service provided, these systems were not utilised effectively. Identified patient needs were not being met in a timely manner.

The Clinical Commissioning Group (CCG) told us that they regularly communicated with the provider as they were currently monitoring performance. The CCG has currently served 15 contract quality notices on the provider in the financial year 2014/15. This is when the provider is not meeting their contracted performance targets and formally notified to improve. The CCG had also served two withholding notices, where funding is held back due to inadequate performance.

Tackling inequity and promoting equality

The provider had access to online and telephone translation services. A number of GPs who worked for the OOH service spoke different languages.

The service provided equality and diversity training through e-learning. Some staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months.

The premises and services had been adapted to meet the needs of patient with disabilities such as automatic doors.

Access to the service

The service operated from 6.30 pm to 8.00am Monday to Thursday and from 6.30pm until 8am Friday to Monday inclusive. The service also operated on all bank holidays.

Comprehensive information was available to patients about appointments on the services website, NHS's website and other practice's websites. This included how to arrange appointments and home visits and how to book appointments.

Appointments did not have a set time, although there was a goal of four patients per hour to be seen. Patients were given as much time as they needed with clinicians for their needs to be met.

Patients were not satisfied with the appointments system. They told us that there were several telephone discussions taking place before any appointment was given. They would speak with NHS 111 and then later receive a call from the out of hours service to discuss the same thing again. With some patients we spoke with, they had received another call to speak with a doctor before they were given an appointment.

We were informed by the CCG that there was no communication between NHS 111 and the out of hours service. We were provided with no information to counter this during the inspection despite requests. Following the inspection we were provided with information that showed there was communication taking place between the two services

Listening and learning from concerns and complaints

The provider had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints.

We visited the provider's headquarters in October 2014 and found that the systems for handling complaints required improvement. We advised the provider of our concerns at that inspection. This report was published in November 2014. However, at our inspection on 17 and 18 March we saw that the provider had begun to take action although this had progressed slowly.

There was no information in any of the locations for patients on how to make a complaint. Patients we spoke with were not aware of the process to follow if they wished to make a complaint, nor were they aware of who to contact. Some patients thought they should complain to the hospital they visited, whereas others told us they would contact NHS 111 to complain. None of the patients we spoke with had ever needed to make a complaint about the out of hours provider.

The provider had recently reviewed their complaints to detect themes or trends. We looked at the report for the last review and several themes had been identified. However, lessons learned from individual complaints had not been acted on as the newsletter produced to discuss learning had not been seen by staff.

Are services well-led?

Inadequate

(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 vision to deliver high quality care and promote good outcomes for patients at the executive level but not at a front line level. There had been significant recent change at executive level which was part of the business plan's first year. These changes had not been communicated effectively with staff as staff were not always aware of these changes, although some staff who were aware welcomed the changes.

Governance arrangements

The provider had a number of policies and procedures in place to govern activity; 100 had been identified by the provider's Head of Quality. These had been identified as part of a review looking at policies and procedures that were in place. In addition the review was looking at the appropriateness of the policies. This process had just begun. We looked at 13 of these policies and procedures and found no staff had completed a cover sheet to confirm that they had read the policy and when, nor was there any evidence to show it had been sent to all staff. In addition staff at different sites had access to out dated and different policies than those available centrally. Some policies and procedures were not up to date. The Head of Quality explained that a process was taking place, identifying all of the policies available and then reviewing their validity before updating and sharing with staff. We saw this process was taking place and on the day of the inspection staff were emailed with the updated complaints, media and whistleblowing policy.

There was not a clear leadership structure and a number of required lead roles had not been identified, such as a safeguarding lead or infection control lead. We spoke with ten members of staff and they were all clear about their own roles and responsibilities when it came to dealing with patients, however they were unclear about their roles and responsibilities in relation to issues such as medication management or infection control. Most staff told us they did not really feel valued and some did not know who their line manager was. Staff were not always aware of the executive changes, nor did they know the names of the executives. Staff told us they felt isolated and did not see management regularly. At the Leicester Royal Infirmary site, staff told us during the inspection that was the first time they had seen the clinical manager for three months.

The provider did not have an on-going programme of clinical audits which was used to monitor quality and systems to identify where action should be taken. It had been identified by the provider as an area for improvement. Two clinical audits had been conducted in the years 2014/15 and these audits were unclear, lacked methodology, did not provide any evidenced results or conclusions. The audits had not been reviewed, nor had any learning been identified.

We saw that although there was a system in place for incidents to be reported, these incidents were not being investigated or acted upon by management. Between April 2014 and July 2014 there were 40 recorded incidents. Of these 40 incidents, 22 had still not been acted upon or investigated. One of these incidents was a prescribing error regarding too high a dose of insulin and another related to a suicidal patient who had contacted out of hours, where it was recorded the following morning that the patient had not been dealt with. As these incidents had not yet been investigated, there was no learning identified for the organisation.

The provider did not hold regular staff meetings, other than for supervisors. Governance meetings had only recently started following the recruitment of a clinical director. Staff at the different sites were not being kept up to date on relevant information that was important for them to know.

Leadership, openness and transparency

Staff told us they were concerned that there was no system to ensure there were regular staff meetings; this meant that they were not able to meet colleagues to discuss current issues, learnt from incidents and complaints. Staff did not feel as if the leadership team were engaged with the way they worked.

We reviewed a number of policies, for example, the recruitment policy, whistleblowing policy and sickness policy which were in place to support staff. Staff we spoke with knew where to find these policies if required but commented that they could not always access them

Are services well-led?

Inadequate

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

remotely from their place of work. They could not access them because they did not always have access to the organisation's intranet or electronic files, depending on the site they worked at.

Management lead through learning and improvement

Staff told us that they were not supported to maintain their clinical professional development through training and mentoring. This was usually provided through their substantive employment. We looked at 24 staff files and saw that regular appraisals did not take place. The clinical director accepted that supervision and appraisal had not been taking place. Staff told us that the provider was not very supportive of training. We did not see evidence of continuous professional development or regular access to training. One member of staff even commented that they had received no training since they had been transferred into the out of hours service from the ambulance service two years earlier.

The provider had completed reviews of two significant events and some other incidents. This had not been shared with staff as staff had not received the monthly newsletter. The provider could not evidence they were improving their service from lessons learnt.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We found that the registered person did not take proper steps to ensure that each service user was protected against the risks of receiving care and treatment that was inappropriate or unsafe. This was because the registered person was not carrying out appropriate assessments of the needs of service users and did not plan or deliver care or treatment in such a way to meet the service user's individual needs and did not ensure the welfare and safety of the service user. This was in breach of regulation 9 (1)(a) and (b)(i)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (3)(a)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person was not protecting service users, or others who may be at risk, against the risks of inappropriate or unsafe care and treatment, because they did not have an effective operation of systems designed to enable them to regularly assess and monitor the quality of services provided or identify, assess and manage the risks relating to the health, welfare and safety of service users and others. The registered person did not make changes to the treatment or care provided reflecting information relating to the analysis of incidents that resulted in, or had the potential of resulting in, harm to a person using the service.

This section is primarily information for the provider

Requirement notices

The registered person did not establish mechanisms for ensuring decisions in relation to the provision of appropriate care or treatment was taken at the appropriate level by the appropriate person.

This was in breach of regulation 10 (1)(a)(b), (2)(c)(i) and (d)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment We found that the registered person did not have suitable arrangements to ensure that service users are safeguarded against the risk of abuse. They had not taken reasonable steps to identify the possibility of abuse and could not respond appropriately to allegations of abuse. This was in breach of regulation 11 (1)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment We found that the registered person did not have suitable arrangements to protect service users and others who may be at risk from the use of unsafe equipment as they did not ensure that equipment provided was properly maintained and suitable for purpose. The registered person did not ensure that equipment was available in sufficient quantities in order to ensure the safety of service users and meet their assessed needs.

This section is primarily information for the provider

Requirement notices

This was in breach of regulation 16 (1)(a) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person was not protecting service users against the risks associated with the unsafe use and management of medicines as they did not have in place appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration or disposal of the medicines. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.