St Ives House (East Lancashire Medical Services)

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	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at East Lancashire Medical Services Limited on 6 March 2017. Overall the service is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for recording, reporting and learning from significant events.
- Risks to patients were assessed and well managed.
- Patients' care requirements were assessed and delivered in a timely way according to needs.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- There was a system in place that enabled staff access to patient records, and the out of hours staff provided other services, for example the local GPs and hospital, with information following contact with patients as was appropriate.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- The service worked proactively with other organisations and providers to develop services that supported alternatives to hospital admission where appropriate and improved the patient experience.
- The service had good facilities and was well resourced to treat patients and meet their needs. The vehicles used for home visits were clean and well equipped.
- There was a clear leadership structure and staff felt supported by management. The service proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider must make improvement are:

Summary of findings

- Ensure that driver safety and fitness checks are in place and drivers who act as chaperones are trained for the role.
- Ensure appropriate recruitment and training checks are undertaken for all staff not directly employed by the service such as ensuring clinical staff have been trained to the appropriate level in safeguarding and resuscitation.

The areas where the provider should make improvement are

- Consider improving privacy in the reception area at the Burnley Urgent Care Centre.
- Consider the ease with which staff can access policies during the evening shifts.
- Consider the mechanisms for ensuring all staff are aware of who the fire marshals on duty are in the out of hours teams.
- Consider site specific patient experience surveys.
- Consider raising incidents from complaints in order to maximise learning opportunities.

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?

Requires improvement

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

- 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. However, incidents were not always discussed and learning identified as part of the complaints process.
- The out-of-hours service had clearly defined and embedded systems and processes in place to keep patients safe and safeguarded from abuse. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out-of-hours. However, we found that the organisation had not received assurance from all GPs employed as to the level of safeguarding training undertaken, and we found evidence that not all staff undertaking the role of chaperone had received appropriate training.
- 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. However the chaperone policy did not include the role of the driver and drivers were not always trained and aware of their role to chaperone patients especially on home visits.
- The service had up to date fire risk assessments and carried out regular fire drills. However, staff we spoke with in the out of hours teams were not aware of who their fire marshal was and none of the staff we spoke with in the evening had received training in this area.

Are services effective?

Good

The service is rated as good for providing effective services.

- The service was consistently meeting National Quality Requirements (performance standards) for GP out-of-hours services to ensure patient needs were met in a timely way.
- 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 care to 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.

- Feedback from the large majority of patients through our comment cards and collected by the provider was very positive.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality. However, the privacy in the reception area at the Burnley Urgent Care Centre was not always well managed during our visit.
- Patients were kept informed with regard to their care and treatment throughout their visit to the out-of-hours service.

Are services responsive to people's needs?

Good

The service is rated as good for providing responsive services.

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

Good

The service is rated as good for being well-led.

Summary of findings

- The service had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The service had a number of policies and procedures to govern activity and held regular governance meetings. However, we found staff working the evening shifts could not always access these with ease.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The provider encouraged a culture of openness and honesty. The service had systems 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 provided to the commissioner of their service.

The Friends and Family Test (FFT) was created to help providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give your views after receiving care or treatment from a service provider. Patients are asked to answer the question: "How likely are you to recommend our service to friends and family if they needed similar care or treatment?" and can rank the answer from "extremely likely" to "extremely unlikely". Between April 2016 and March 2017 the East Lancashire Medical Service (ELMS) treated 59884 patients of whom 3262 responded to this survey. Data from December 2016 showed 95% of patients who used the services were likely or very likely to recommend the services to their friends and family and the results for January 2017 were 97%. Overall from April 2016 to March 2017 the result was 96.5% of patients who used the services were likely or very likely to recommend the services to their friends and family.

The provider had not completed site specific patient experience surveys. They told us they used the monthly Family & Friends based survey to pick up on issues and themes. Feedback for April 2016 to March 2017 showed: (NOTE: these are annulised figures)

Complaints for the year had the following themes (23 complaints):

- 8.7% of the complaints received were in relation to patients who were unhappy with the GP and 4.3% of the complaints were in relation with patients unhappy with the nurse.
- 65.2% of the complaints were about people being unhappy with the clinical treatment they received
- 13% of the complaints were about staff attitude
- 4.3% of the complaints were in relation to safeguarding
- 8.7% of the complaints were in relation to appointments

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our visit. We received 31 comment cards across two sites which were the GP Out of Hours at St Ives House and the GP Out of Hours based at the Urgent Care Centre in Burnley General Hospital. The majority (26) were positive about the standard of care received. Comments included praise for the understanding and the professionalism of the GPs and nursing staff as well as a helpful and polite service from the receptionists. Patients stated they felt the staff were hardworking, determined and wonderful. Patients were satisfied with the availability and timeliness of the appointments and complimented the service from the booking in process through to the information they received after the consultation. Negative comments were based around the lack of communication the patients received from staff when there were delays in being seen.

We spoke with five people (including patients and carers) during the inspection. All the people said they were satisfied with the care they had received and thought staff were approachable, committed and caring.

Areas for improvement

Action the service MUST take to improve

- Ensure that driver safety and fitness checks are in place and drivers who act as chaperones are trained for the role.
- Ensure appropriate recruitment and training checks are undertaken for all staff not directly employed by the service such as ensuring clinical staff have been trained to the appropriate level in safeguarding and resuscitation.

Summary of findings

Action the service SHOULD take to improve

- Consider improving privacy in the reception area at the Burnley Urgent Care Centre.
- Consider the ease with which staff can access policies during the evening shifts.
- Consider the mechanisms for ensuring all staff are aware of who the fire marshals on duty are in the out of hours teams.
- Consider site specific patient experience surveys.
- Consider raising incidents from complaints in order to maximise learning opportunities.

St Ives House (East Lancashire Medical Services)

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector and included a GP specialist adviser as well as a second CQC inspector.

Background to St Ives House (East Lancashire Medical Services)

East Lancashire Medical Services (ELMS) is a Social Enterprise organisation delivering Urgent Primary Care Services 365 days a year. The Head Office is at St Ives House and at the time of the inspection there were five satellite centres from which services were provided :

- St Ives House. St Ives Business Park. Accrington Road. Blackburn. BB1 2EG
- Burnley Urgent Care Centre, Casterton Avenue, Burnley. BB10 2PQ
- Clitheroe Community Hospital. Chatburn Road, Clitheroe. BB7 4JX
- Pendle Community Hospital. Leeds Road, Nelson. BB9 9TG
- Rossendale Primary Health Centre. Bacup Road, Rossendale. BB4 7PL.

For the purposes of this inspection we visited the head office and the services based at St Ives House and at Burnley Urgent Care Centre. The service is contracted to provide OOH primary medical services to registered patients and those requiring immediately necessary treatment when GP practices are closed which includes overnight, during weekends, bank holidays and when GP practices are closed for training. Patients may be seen by a clinician, receive a telephone consultation or a home visit, depending on their needs.

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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew. We carried out an announced visit on 06/03/2017. During our visit we:

- Spoke with other organisations such as commissioners to share what they knew about the performance and patient satisfaction of the out-of-hours service.
- Spoke with a range of staff employed including receptionists, drivers, clinical staff, managers and board members. We spoke with GPs and clinical staff.

Detailed findings

- Observed how patients were provided with care and talked with family members.
- Inspected the out of hours premises, looked at cleanliness and the arrangements in place to manage the risks associated with healthcare related infections.
- 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.
- 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.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. Staff told us they would inform the service manager of any incidents.

- The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received support, an explanation based on facts, an apology where appropriate and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared via emails, news bulletins and meetings and action was taken to improve safety in the service.
- The service had recorded 19 significant events between January 2016 and January 2017 and carried out a thorough analysis of the significant events and ensured that learning from them was disseminated to staff and embedded in policy and processes.
- However, we noted that when a complaint was raised, the learning was not always transferred to an incident. For example, we found a compliant had been raised by a patient in relation to medications management, but, this had not been raised as an incident to ensure all the learning and trend analysis was complete.

Overview of safety systems and processes

The service had systems, processes and services in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. Staff demonstrated they understood their responsibilities. However, the service had not ensured it had obtained appropriate assurance that all clinical staff had received training on safeguarding children and vulnerable adults relevant to their role. While we saw there was a system in place to request sight of such training certificates from clinicians at the time of recruitment, this was not followed up if the clinician did not provide evidence that training had been completed. We reviewed the personnel and training files of five GPs. Only one of these files contained appropriate evidence of training in safeguarding children or of evidence of competency in safeguarding vulnerable adults.
- A notice in the waiting room advised patients that chaperones were available if required. We found that not all staff, including drivers, who acted as chaperones were trained for the role; we spoke with two drivers and a receptionist who all acted as chaperones. While all were aware of the organisation's chaperone policy, they had not received any formal training for the role. They 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 an infection control lead. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- There was a system in place to ensure equipment was maintained to an appropriate standard and in line with manufacturers' guidance e.g annual servicing of fridges including calibration where relevant.
- We reviewed 10 personnel files, two of which were for staff recruited to the service within the last six months. We examined these two files in detail in relation to the service's recruitment process and found appropriate pre-employment checks had been undertaken prior to the staff commencing work. For example, proof of identification, references, qualifications, registration with the appropriate professional body, appropriate indemnity and the appropriate checks through the Disclosure and Barring Service.

Medicines Management

Requires improvement

Are services safe?

- The arrangements for managing medicines at the service, including emergency medicines, kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). 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.
- Patient Group Directions (PGDs) were used to supply or administer medicines without a prescription and the PGDs in use had been ratified in accordance with the Medicines and Healthcare products Regulatory Agency guidance.
- Processes were in place for checking medicines, including those held at the service and also medicines bags for the out of hours vehicles.
- Arrangements were in place to ensure medicines and medical gas cylinders carried in the out of hours vehicles were stored appropriately.

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. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. Clinical equipment that required calibration was calibrated according to the manufacturer's guidance. The service had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella. (Legionella is a term for a bacterium which can contaminate water systems in buildings).
- The service had up to date fire risk assessments and carried out regular fire drills. However, staff we spoke with in the out of hours teams were not aware of who their fire marshal was and none of the staff we spoke with had received training in this area.
- There were systems in place to ensure the safety of the out of hours vehicles. Checks were undertaken at the beginning and end of each shift by the nominated driver. These checks included checking the cars were mechanically safe and ensuring there was no damage. Staff checked and recorded the mileage, cleanliness and fuel level as well as emergency stocks such as torches and first aid boxes. Records were kept of MOT annual testing and servicing requirements. The provider had vehicles ready for use in the event of another being out of service.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. The inspection team saw evidence that the rota system was effective in ensuring that there were enough staff on duty to meet expected demand. The service planned to implement a system whereby GPs would be required to sign to verify they were not exceeding a set number of working hours in any given week. This was planned to ensure fatigue did not impact on the quality and safety of care and treatment being provided. We saw that the service also already had comprehensive systems in place to proactively monitor the safety and quality of clinical care delivered.
- The provider had reviewed staffing levels during periods of high patient demand as part of the business continuity plan to ensure they met patient need. This was monitored on an ongoing basis and staff skill mix and levels adjusted accordingly.

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.
- Staff received annual basic life support training, including use of an automated external defibrillator. However, the service had not comprehensively sought assurance of the training completed by the GPs employed. Of the five GP files we reviewed, only two contained evidence of basic life support training being completed. The service management team told us they were aware of this issue and had implemented a programme of internal face-to-face training sessions to address possible gaps in clinician's training.

Requires improvement

Are services safe?

- The service had a defibrillator available on all the premises and oxygen with adult and children's masks. A first aid kit and accident book were available at all the sites.
- 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.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The service assessed needs and delivered care in line with relevant and current evidence based 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.

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 these 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 reviewed NQR standards data between April 2016 and December 2016 and found the following:

- NQR12 – Face-to-face consultations (whether in a centre or in the person's place of residence) must be started within 1 hour for an emergency, consulted or visited within 2 hours if urgent and consulted or visited within 6 hours if less urgent. Data showed that:
  - 100% of emergency calls received a face to face consultation within one hour.
  - 100% of urgent calls received a face to face consultation within two hours.
  - 100% of less urgent calls received a face to face consultation within six hours.

Where the service was not performing to the required standard, the provider had assurance process in place to audit why the low performance had occurred.

There was evidence of quality improvement including clinical audit.

- There had been a number of clinical audits completed in the last two years of which four were two-cycle audits where the improvements made were implemented and monitored.
- The service participated in local audits, national benchmarking, accreditation, peer review and research. Findings were used by the service to improve services.
- The service conducted audits of clinical activity and quality benchmarking for all the clinical staff.

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. This covered such topics as safeguarding, fire safety, manual handling, 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 had nominated trainers to support newly recruited non-clinical staff through their induction.
- The service could demonstrate how they ensured role-specific training and updating for relevant staff. For example, training for Advanced Nurse Practitioners (ANP) included a specific induction pack and staff who undertook this role were signed off as competent when they had received appropriate training in the areas such as conducting triage and clinical assessments. However, the drivers we spoke with had not received any specific training nor had they been monitored to ensure they were driving to a safe standard. There was a system in place to check the driving licences annually to ensure there were no driving convictions. Health checks, such as regular eyesight tests, were not in place.
- Clinical staff were given a staff handbook which was signed out to them and recorded which included access to polices and guidance that helped to equip them with the skills and knowledge for their role.
- 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. All staff had received an appraisal within the last 12 months.

Good

Are services effective?

(for example, treatment is effective)

- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.
- Staff involved in handling medicines received training appropriate to their role.

Coordinating patient care and information sharing

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 and summary care record which detailed information provided by the patient's own GP. This helped the staff in understanding the patient's needs. Staff we spoke with found the systems for recording information easy to use and had received appropriate training. Clinical staff undertaking home visits also had access to mobile information technology equipment so relevant information could be shared with them whilst working remotely. Staff told us they felt that the equipment they used was effective.
- The service shared relevant information with other services in a timely way, for example when referring patients to other services.
- Patients who could be more appropriately seen by their own registered GP or an emergency department were referred on. If patients needed specialist care, the out-of-hours service could refer to specialties within the hospital. Staff also described a positive relationship with the mental health and district nursing team if they needed support during the out-of-hours period.

The service worked with other service providers to meet patients' needs and manage patients with complex needs. It sent out-of-hours notes to the registered GP services electronically by 8am in line with the performance monitoring tool, National Quality Requirements (NQR) for GP out-of-hours Services. Staff told us systems ensured this was done automatically and any failed transfers of information were the responsibility of the duty manager to follow up to ensure GPs received information about their patients.

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. However, we noted that the reception area at the Burnley Urgent Care Centre was shared with staff from the hospital. This was an open area which meant that staff from outside of the organisation could hear and see patient information.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 31 comment cards across two sites which were the GP Out of Hours at St Ives House and the GP Out of Hours based at the Urgent Care Centre in Burnley General Hospital. The majority (26) were positive about the standard of care received. Comments included praise for the understanding and the professionalism of the GPs and nursing staff as well as a helpful and polite service from the receptionists. Patients stated they felt the staff were hardworking, determined and wonderful. Patients were satisfied with the availability and timeliness of the appointments and complimented the service from the booking in process through to the information they received after the consultation. Negative comments were based around the lack of communication the patients received from staff when there were delays in being seen.

We spoke with five people (including patients and carers) during the inspection. All the people said they were satisfied with the care they had received and thought staff were approachable, committed and caring.

Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

The Friends and Family Test (FFT) was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give your views after receiving care or treatment from a service provider. Patients are asked to answer the question: "How likely are you to recommend our service to friends and family if they needed similar care or treatment?" and can rank the answer from "extremely likely" to "extremely unlikely". Between April 2016 and March 2017 the East Lancashire Medical Service treated 59884 patients of whom 3262 responded to this survey. Data from December 2016 showed 95% of patients who used the services were likely or very likely to recommend the services to their friends and family and the results for January 2017 were 97%. Overall from April 2016 to March 2017 the result was 96.5% of patients who used the services were likely or very likely to recommend the services to their friends and family.

The provider had not completed site specific patient experience surveys. They told us they used the monthly Family & Friends based survey to pick up on issues and themes. Feedback for April 2016 to March 2017 showed: (NOTE: these are annualised figures)

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.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.
- Facilities were available for people with hearing impairment e.g. hearing aid loop.
- A system of 'comfort calling' patients was in place to ensure patient welfare if the GP was going to be delayed for a home visit.

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. The provider engaged with the NHS England Area Team and the local Clinical Commissioning Groups (CCG) to provide services that met the identified needs of the local population.

- Patients could access the GP OOH service via the 111 free telephone number, where they were triaged before being offered an appointment as appropriate.
- Home visits were available for patients whose clinical needs resulted in difficulty attending the service.
- The provider supported other services at times of increased pressure to ensure that patients were cared for in their own home as appropriate for example, providing end of life care and supporting those in mental health crises.
- There were accessible facilities, a hearing loop and interpretation services available.

Access to the service

Patients could access the service by calling the NHS 111 telephone number. The service did not see 'walk in' patients. Those that came in were told to ring and make an appointment, unless they needed urgent care in which case they would be stabilised before being referred to the most appropriate service such as the accident and emergency department. There were arrangements in place for people at the end of their life so they could contact the service directly.

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

The service had a system in place to assess whether a home visit was clinically necessary and the urgency of the need for medical attention. This was based on a telephone triage with the patient or carer in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical need.

Listening and learning from concerns and complaints

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

- Its complaints policy and procedures were in line with the NHS England guidance and their contractual obligations for GPs in England and the NQR standard.
- There was a designated responsible person who co-ordinated the handling of all complaints in the service. Where required, there was always input from a clinical representative.
- We saw that information was available to help patients understand the complaints system. During the inspection we saw a specific complaints information form on display in the centre. Staff we spoke with were fully aware of the complaints process and how to explain this to patients. Information about how to make a complaint was detailed in full on the services website.

The provider had received 45 complaints between January 2016 and January 2017 of which 10 were still open at the time of inspection. Fourteen of these were not upheld and four were partially upheld at the time of inspection. We looked in detail at four complaints received in the last 12 months and found they were all handled appropriately, in line with the service complaints procedure and complaints analysed to detect any themes. We noted that the responses offered an apology, were empathetic to the patients and explanations were clear.

The chairman of the service's patient voice group reviewed all the complaints raised and to independently assess them to ensure a fair judgement was made. The complaints were anonymised and reviewed monthly to decide if they should be upheld or not.

Complaints for the year had the following themes (23 complaints):

- 8.7% of the complaints received were in relation to patients who were unhappy with the GP and 4.3% of the complaints were in relation with patients unhappy with the nurse.
- 65.2% of the complaints were about people being unhappy with the clinical treatment they received
- 13% of the complaints were about staff attitude
- 4.3% of the complaints were in relation to safeguarding
- 8.7% of the complaints were in relation to appointments

Are services well-led?

Good

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

Our findings

Vision and strategy

At East Lancashire Medical Services the main aim was "to provide the best possible treatment and patient experience within our allocated budget. Not to compromise on patient care at the expense of the public purse, and we will do this by utilising existing resources to their capacity and working in partnership with other providers to provide a whole systems approach to urgent and unplanned care where appropriate".

The service had a clear vision and the provider, along with their staff, had developed a set of organisational values. The service had a strategy and supporting business plans that reflected the vision and values and both were regularly monitored.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Service specific policies were implemented and were available to all staff via the provider's online portal. However, we found that during the evening shifts, not all staff could access these.
- The provider had a good understanding of their performance against National Quality Requirements. These were discussed at senior management and board level. Performance was shared with staff and the local clinical commissioning group as part of contract monitoring arrangements.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- Arrangements were in place for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

The senior management team told us they prioritised safe, high quality and compassionate care. Staff told us the senior management team were approachable and always took the time to listen to all members of staff. All the staff told us they felt part of a "family" and enjoyed working at the service.

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. The provider 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.
- 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.

- The service had gathered feedback from patients through surveys, complaints and incidents.
- The service had a very active lead in the "patient voices group" who led various initiatives including patient-led assessments of the care environment (PLACE). We saw these were conducted in a number of the locations and

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positive action was taken where issues were identified. There were over 1500 virtual members of the patient voices group who were contacted regularly by email and asked to participate in various surveys and initiatives.

- The provider had gathered feedback from staff through staff meetings, staff surveys, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the service was run.
- The service had a whistleblowing policy which included external contact details and informed staff how to access independent advice. Whistleblowing is the act of reporting concerns about malpractice, wrong doing or fraud. Within the health and social care sector, these issues have the potential to undermine public confidence in these vital services and threaten patient safety.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the service. The service team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area.

- The organisation was looking into 24 hour care over seven days and using new innovative ideas and technology and enhancing the workforce skill mix.
- The service utilised “clinical guardian” software which allowed an ongoing audit of the consultations the GPs undertook. This allowed feedback to be seen by the GPs and also fed into the appraisal process.

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 We found the registered provider was failing to ensure the safety of patients by not appropriately training those who act as chaperones for the role and not conducting appropriate recruitment and training checks for all staff not directly employed by the service. There was failure to ensure all staff had received proper safeguarding & Basic Life Support training. This was in breach of Regulation 12.