St Charles Centre for Health and Wellbeing

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.

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 3

The five questions we ask and what we found 4

What people who use the out-of-hours service say 5

Areas for improvement 5

Good practice 5

Detailed findings from this inspection

Our inspection team 6

Background to St Charles Centre for Health and Wellbeing 6

Why we carried out this inspection 6

How we carried out this inspection 6

Findings by main service 8

Action we have told the provider to take 15

Summary of findings

Overall summary

St Charles Centre for Health & Wellbeing provides telephone advice for home treatment, face-to-face consultations, and home visits to people who need advice or treatment out of normal surgery hours that can't wait until the next available routine GP appointment. The service provides out-of-hours cover for over 800,000 patients registered with GP surgeries in the London boroughs of Hammersmith & Fulham, Kensington & Chelsea, Westminster, and Brent, and for non-registered or temporary residents from the inner north west London boroughs. The service is provided by London Central West Unscheduled Care Collaborative. The premises are shared with other providers and services.

During our inspection, we spoke with people who used the service and their relatives. They were complimentary about their treatment and care. We also used comment cards to ask people for their views, and this feedback was positive too. We observed people being treated respectfully and given information that was clear and concise.

There was effective clinical and operational leadership of the organisation. The focus was on delivering high quality patient care and improving patients' experience of out-of-hours services.

To help to improve its service, St Charles Centre for Health & Wellbeing used the learning from incidents, feedback from patient surveys, compliments and complaints, and information from clinical audit. Clinical leaders took responsibility for checking and ensuring that GPs provided effective treatment and care, in line with recognised best practice standards and guidelines. The Centre recruited GPs with suitable qualifications, skills and experience to meet the needs of people using the service, and provided support for GPs' continuing professional development.

The service was responsive to patients' needs, performing well against national response time targets. There were provisions to enable the diverse population to access the service.

People were protected from the risks associated with medicines and from unsafe and unsuitable medical equipment. Consulting rooms were clean and infection control policies were in place to protect people from the risk of healthcare acquired infection. However, people were not protected from all risks associated with unsafe or unsuitable premises. Most of the waiting area for patients who came in after 9pm to see a GP was out of sight of the staff on reception duty. This increased the risk of a patient's deteriorating condition going unnoticed.

We have asked the service to send us a report by 30 June 2014 setting out the action they will take to meet this safety standard. We will check to make sure that this action is taken.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The provider learned from incidents to improve the safety of the service. Arrangements were in place to protect children and vulnerable adults from the risk of abuse. There were effective systems in place to reduce the risk and spread of healthcare acquired infection.

People were protected from the risks associated with medicines, and from unsafe or unsuitable equipment. However, they were not protected against all risks of unsafe or unsuitable premises.

Contingency plans were in place to avoid disruption in the out-of-hours service in an emergency such as the computer system going down or the premises becoming unusable.

Are services effective?

People's needs were met by suitably qualified and experienced staff working to recognised best practice standards and guidelines. The provider undertook clinical audit to maintain and improve the standard of treatment and care provided. There was support for GPs' continuing professional development.

Are services caring?

People were treated with compassion, respect and dignity. Care was taken to protect people's privacy, and to keep information about them confidential and secure.

Are services responsive to people's needs?

The provider worked continuously to ensure people's individual needs were met appropriately without unavoidable delay. It made provision for the needs of the diverse population it served, and used patient feedback, including complaints, to improve the service.

Are services well-led?

St Charles Centre for Health & Wellbeing was led by GPs with a focus on delivering high quality patient care. The provider, London Central & West Unscheduled Care Collaborative (LCW), worked with other services and commissioners to develop new ways of working to improve patients' experience of out-of-hours services. Governance arrangements and information systems were robust, enabling LCW to monitor, manage, improve and develop the operation of its services in response to opportunities and demands within the wider NHS.

Summary of findings

What people who use the out-of-hours service say

Patients who attended St Charles Centre for Health & Wellbeing to see an out-of-hours GP were highly satisfied with the service. They told us they were happy with how quickly they had been seen, and with the treatment they had received. They told us they felt listened to, and that the GP had explained their treatment to them.

Areas for improvement

Action the out-of-hours service MUST take to improve

- Improve the safety of the waiting area and the disabled toilet. There was a lack of oversight of the out-of hours waiting room after 9pm because staff on reception duty did not have a clear line of sight over the area. This increased the risk of a patient's deteriorating condition going unnoticed. There was no alarm cord in the disabled toilet so that a person could call for help.

Action the out-of-hours service COULD take to improve

- Improve arrangements for GPs to sign medicines boxes and equipment in and out, so that medicines and equipment are accounted for at all times.
- Improve systems to ensure that that all policies and service level agreements are current. A number of documents were out of date. For example, the Adverse Incidents and Near Misses Management policy was due for review in September 2013.
- Improve information for patients about the service's chaperone arrangements.

Good practice

- Analysing significant events and making changes to the service to improve care.
- Action taken to improve access for out-of- hours GPs to Co-ordinate my Care patient notes.
- The education programme was being developed further to support GPs' continuing professional development, appraisal and revalidation.
- High levels of performance against national response time targets were maintained. Additional performance targets had been agreed locally with commissioners to enhance the service further.
- Cooperation with other unscheduled care providers to improve patients' experience of out-of-hours services.

St Charles Centre for Health and Wellbeing

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. It included a GP and two specialist advisors.

Background to St Charles Centre for Health and Wellbeing

The out-of-hours service operating out of St Charles Centre for Health & Wellbeing is provided by London Central West Unscheduled Care Collaborative (LCWUCC). LCWUCC provides a range of unscheduled care, including NHS 111 and urgent care centres.

The service provides GP telephone advice, GP surgery consultations and GP home visits to people who need advice or treatment that can't wait until the next available routine GP appointment. The service provides out-of-hours cover between 6.30pm and 8am Monday to Friday with 24-hour coverage at weekends and Bank holidays for over 800,000 patients registered with GP surgeries in the London boroughs of Hammersmith & Fulham, Kensington & Chelsea, Westminster, and Brent, and for non-registered or temporary residents from the inner north west London boroughs.

Why we carried out this inspection

We inspected this out-of-hours service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

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 our visit, we reviewed a range of information we held about the out-of-hours service and asked other organisations to share what they knew about the service.

We carried out an announced visit on 12 March 2014. During our visit we spoke with a range of staff including GPs, despatchers, drivers, and members of the service's management team. We spoke with stakeholders, including local NHS 111 staff, adult community health services, GPs whose patients used the out-of-hours service, and commissioners.

Detailed findings

We spoke with patients. We observed how people were treated and cared for when they were talking to the GP on the phone, or arriving at the service to see a GP. We also provided comment cards to enable people to share their views about the service.

Are services safe?

Summary of findings

The provider learned from incidents to improve the safety of the service. Arrangements were in place to protect children and vulnerable adults from the risk of abuse. There were effective systems in place to reduce the risk and spread of healthcare acquired infection.

People were protected from the risks associated with medicines, and from unsafe or unsuitable equipment. However, they were not protected against all risks of unsafe or unsuitable premises.

Contingency plans were in place to avoid disruption in the out-of-hours service in an emergency such as the computer system going down or the premises becoming unusable.

Our findings

Learning from incidents

There was a procedure to guide GPs and staff about the action to take following an adverse incident or near miss. All GPs and staff had access to the provider's online incident reporting form, and those we spoke with correctly described the incident reporting procedure. The Adverse Incidents and Near Misses Management Policy was due for review in September 2013 and the service told us the document was still valid. The document nevertheless appeared to be out of date, and we highlighted this as an area where the service could make improvements.

The records we looked at showed that the service investigated incidents, and collated and analysed information from them to identify where lessons could be learned. Systems were in place to share learning through clinical newsletters, staff bulletins, education, and training.

We saw examples of improvements to the service following incidents. In one example, the service had strengthened safety arrangements for home visits so that GPs could have an escort. In another example, the service had changed its transport arrangements for patients who needed to be transferred to the local A&E department so that any deterioration in their condition could be dealt with effectively.

Medicines

Medicines were stored securely in a locked cupboard, and access to the key was controlled to prevent unauthorised access to medicines. The out-of-hours service did not stock any controlled drugs or medicines that required cold storage.

The provider had a service level agreement with the pharmacy of a local NHS hospital trust to manage its medicines.

Adequate stocks of medicines were maintained to meet patients' needs for medicines out of hours. The pharmacy regularly checked and replenished the service's medicines, including those for medical emergencies. The pharmacy supplied medicines to the service in sealed boxes to keep them safe.

Despatchers and drivers checked that sealed boxes of medicines were supplied to the consultation rooms and to GPs' cars for home visits. A system was in place to record when a box had been opened and which medicines had been used so that the pharmacy could replenish the stock of medicines. However, the system for GPs to record when they signed out a medicines box and then signed it back into the St Charles Centre for Health & Wellbeing was not being followed. This was a weakness in the Centre's arrangements for reducing the risk of drugs being misappropriated, and we highlighted this as an area where the service could make improvements.

Prescription forms were kept securely to prevent them being stolen and misused.

The medicines we looked at were within their expiry date, and were packaged so that GPs could supply a complete course of necessary emergency medicine to a patient when their local pharmacy was closed.

The pharmacy monitored trends in GPs' prescribing practice to ensure they followed good practice. The pharmacy was represented on the service's clinical governance group which made decisions about ways to improve the service. GPs received medicines and prescribing updates in the clinical newsletter.

Medical equipment

A contract was in place for the maintenance and repair of equipment provided by the out-of-hours service to ensure equipment was fit for use. Despatchers and drivers checked the equipment was fit for use each time it was issued to a

Are services safe?

GP. However, the system for GPs to sign out and then sign equipment back into the equipment store was not being followed, and we highlighted this as an area where the service could make improvements.

Infection control and hygiene

The consulting rooms were visibly clean and there were appropriate facilities for hand-washing and for dealing with clinical waste. Personal protective equipment, for example disposable gloves, and adequate supplies of single use items were available.

Premises

Most of the waiting area for patients coming in after 9pm to see a GP was out of sight from the staff on reception duty. There was a notice advising patients to tell staff if they felt unwell and patients did not usually have to wait long to be seen. However the lack of oversight of the waiting room increased the risk of a patient's deteriorating condition going unnoticed. There was closed-circuit television in the waiting area, which the service was not using. There was no alarm cord in the disabled toilet to enable a person to call for help. The service must improve the safety of the waiting area and the disabled toilet.

Safeguarding

There were procedures to guide GPs in their role in child protection. Designated lead GPs for child safeguarding were responsible for implementing the procedures. GPs had completed child protection training to an appropriate level and were required to keep up to date with child protection practice. Procedures and training requirements for safeguarding vulnerable adults were less well embedded. However, the service had improved the electronic patient management system to enable GPs to record action taken to safeguard vulnerable adults to ensure they were kept safe. There was a designated lead GP for adult safeguarding.

There was a system in place for receiving information from other organisations for adults who were at risk, or children for whom a protection plan was in place. This information was recorded securely on the out-of-hours computer system as a Special Patient Note (SPN), and was available to the GP during an assessment or consultation to enable them to help keep the vulnerable adult or child safe.

The service's clinical audit programme regularly assessed how well GPs addressed any potential safeguarding issues, to maintain and improve their ability to respond effectively to possible abuse and neglect.

Dealing with foreseeable emergencies

The business continuity plan set out alternative arrangements to be put in place, for example in the event of the computer system going down or the premises becoming unusable, so that there would be no disruption to the service for patients.

Are services effective?

(for example, treatment is effective)

Summary of findings

People's needs were met by suitably qualified and experienced staff working to recognised best practice standards and guidelines. The provider undertook clinical audit to maintain and improve the standard of treatment and care provided. There was support for GPs' continuing professional development.

Our findings

Promoting best practice

The out-of-hours GPs worked to guidelines from the National Institute for Health and Care Excellence (NICE). They were subject to regular clinical audit to ensure patients received effective care as set out by the guidelines. Samples of electronic patient records and recordings of telephone consultations were checked using the urgent and emergency care clinical audit toolkit from the Royal College of General Practitioners.

Clinical audit results were reviewed by the clinical governance group. Areas of good practice were highlighted and most GPs performed well. There was a system in place for dealing with persistent poor performance.

The service undertook additional checks to monitor and improve the treatment and care provided in specific areas, and by the organisation as a whole. Recent examples included the use of Co-ordinate my Care (CMC) patient notes by the out-of-hours GPs. CMC is an end-of-life care service and is a way of storing information about a person's illness and any specific wishes they may have. The service used the checks to identify ways of enabling GPs to view the CMC record for every patient using the service who had one.

Staffing

There was a system for completing pre-employment checks before staff were allowed to work for the service. These checks ensured staff were of good character, and were appropriately qualified and fit for the work. There was also a programme of mandatory training to ensure staff kept their skills and knowledge up to date, and an appraisal system to ensure staff performed their role well. Mandatory training included health & safety, manual handling, child protection and safeguarding adults, and patient confidentiality.

However, the personnel records we looked at for despatchers and for drivers were incomplete. We could not be assured that all pre-employment checks had been completed, that all staff were up to date with mandatory training and annual health checks where required, and that all staff were being appraised. These were long-serving members of staff and the service had taken over their employment from a former primary care trust (PCT) in 2012. The service received their personnel records in 2014 and the records were incomplete. The service recognised this was a risk and had put in place a programme of work to update these records, however we were not able to assess the impact of this work at our inspection.

There were sufficient numbers of suitably qualified, skilled and experienced GPs and staff employed to provide the out-of-hours service. The service did not use agency or locum GPs. The service was recruiting more GPs to meet increasing demand on the service. Robust recruitment, selection and vetting processes were in place to ensure GPs working for the service were suitable for the role.

All GPs were required to provide evidence to the service every year that they were members of a professional defence organisation, and included in a NHS medical performers list and therefore may perform primary medical services. They were also required to submit evidence of their Medical Performers list annual appraisal, and that they had completed Child Protection Level 3 and Basic Life Support update training.

The provider used a rostering tool to forecast and schedule GPs to predicted demand for the service. The service also monitored on a daily basis that it was able to meet response time targets. There was an emergency standby doctor procedure in place to deal with unforeseen increased demand for the service. This ensured there were enough GPs to meet demand on the service at all times.

There was clinical support for GP Speciality Registrars, and those we spoke with were positive about the training the service provided them.

GPs and staff felt supported and were positive about working for the service. Morale was high, and there was a culture of openness, candour, and involvement.

GP education

The service had a designated lead GP for education and held Education Clubs four times a year. The focus of the

Are services effective?

(for example, treatment is effective)

Education Club was being redirected to support GPs with annual appraisal and revalidation. Revalidation is the process by which licensed doctors are required to regularly demonstrate that they are up to date and fit to practise.

GPs working for the service were required to attend at least one Education Club a year and the service told us that recent events on child safeguarding and cardiopulmonary resuscitation had been well attended. GPs were also being invited to carry out clinical audits, which would help count towards revalidation and appraisal. Topics had been identified that would help the organisation to review clinical practice in line with best practice guidance, and to understand and improve how it worked with other services, for example care homes.

Each GP was offered an annual report from the service to provide them with feedback on their performance, and the opportunity to meet with the service's lead GP for performance and appraisals to review and develop their performance. This was especially important for portfolio GPs and those who considered the London Central & West Unscheduled Care Collaborative to be their main place of work.

Are services caring?

Summary of findings

People were treated with compassion, respect and dignity. Care was taken to protect people's privacy, and to keep information about them confidential and secure.

Our findings

Involving patients in their treatment

Patients and their families told us they felt they had been listened to, and that their treatment and care met their needs. They told us that they had received the information they needed and that they understood their treatment. We observed GPs and staff to be courteous and approachable in their dealings with patients.

Privacy, dignity and confidentiality

GPs and staff had received training on information governance, and we observed them taking care to protect people's privacy and to keep information about people confidential and secure.

There was a chaperone policy in place. It stated that a chaperone must be available prior to an intimate examination, and that a chaperone must always be used during examinations of patients of the opposite sex. There was a form for patients to sign if they did not want a chaperone. There was however no information available for patients about the chaperone policy, and we highlighted this as an area where the service could make improvements.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The provider worked continuously to ensure people's individual needs were met appropriately without unavoidable delay. It made provision for the needs of the diverse population it served, and used patient feedback, including complaints, to improve the service.

Our findings

Responding to patients' needs

People using the service received a call back from a GP, and were seen by a GP when required, in a timely way. We observed GPs working in a calm and unhurried way to respond to people's needs.

All telephone calls came through to the out-of-hours service via local NHS 111 services. There was a policy in place which provided guidance to GPs about what to do if they were unable to make telephone contact with a patient, and what action to take if a patient is considered to be clinically at risk to ensure these patients received appropriate treatment and care.

Waiting times

National response time targets require the service to respond to 95% patients within the target. The response time target for a patient depended on the assessed urgency of the patient's needs. Activity reports showed that St Charles Centre for Health & Wellbeing had met or exceeded all response time targets for calling people back and for seeing patients face-to-face in the quarter October to December 2013. Nevertheless, the service continued to analyse those few cases when a response time target had been missed to identify learning actions so that high levels of performance were maintained.

Access

The service had made arrangements to enable people with diverse needs to access the service. People who are hard of hearing were able to access the service using typetalk, a service which allows text-based communications over the phone. There was a specialist language translation service available for people who don't speak English as their first language. Wheelchair access was available at the service.

Patient feedback and complaints

The service used information from patient surveys and complaints to help improve the service. Analyses of patient surveys, compliments and complaints were reported every three months to the clinical governance group, the senior governance group and to commissioners.

Patient survey questionnaires (PSQs) showed that almost all respondents rated the service as good or excellent. PSQs providing negative feedback were analysed for any learning points. The service told us that they contacted these respondents for further information, but had never received a response. No further action could be taken if its records showed that the person had received appropriate and timely treatment and care.

Complaints were also analysed for any learning points, and action was taken to improve the service. For example, information about the different appointment systems for Urgent Care Centre and out-of-hours patients was put on display in the waiting area to explain why some patients are prioritised and might see a GP before others who are waiting.

The service had set up a patient experience group which had agreed to do work on the service's communications with patients, and to review the service's policy on capturing and following the wishes of patients who have an end of life care plan. The service's lead for patient and public engagement (PPE) had retired in July 2013 and the service had recently appointed a new PPE lead to continue work with the patient experience group. We were unable to assess the impact of the patient experience group at our inspection.

Are services well-led?

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

Summary of findings

St Charles Centre for Health & Wellbeing was led by GPs with a focus on delivering high quality patient care. The provider, London Central & West Unscheduled Care Collaborative (LCW), worked with other services and commissioners to develop new ways of working to improve patients' experience of out-of-hours services. Governance arrangements and information systems were robust, enabling LCW to monitor, manage, improve and develop the operation of its services in response to opportunities and demands within the wider NHS.

Our findings

Governance arrangements

The clinical governance and senior governance groups were chaired by GPs and met regularly. The groups received reports about clinical and operational performance and effectiveness. They supported the GP-led London Central & West Unscheduled Care Collaborative (LCW) board to grow the organisation and to innovate as a provider of high quality unscheduled care. For example, LCW had recently won the contract to pilot NHS 111 services in Inner North West London.

The service maintained a risk register and reviewed regularly the controls put in place to minimise risks to patient safety, to ensure the controls continued to be effective.

Systems were in place to collect accurate and timely data to support governance and reporting arrangements. In addition to national quality requirements, LCW had agreed a range of commissioner and local quality requirements to enhance the service further. For example, it was analysing the number of calls the service received by ethnicity. This enabled LCW to begin to check that its services were meeting the needs of the diverse population it served.

The service was a member of Urgent Health UK (UHUK), which is the federation of social enterprise unscheduled primary care providers. The service took part in UHUK reviews to benchmark its performance against other members of the federation, and to promote best practice. The UHUK reviews in 2012-13 showed the organisation had well-defined and well-operated governance systems.

Cooperating with other providers

LCW was involved with local A&E departments, urgent care centres, and community health services to improve patients' experience of out-of-hours services. For example, the Community Night Team had been invited to base itself with the GP out-of-hours service in St Charles Centre for Health & Wellbeing, and pathways had been developed so that patients received timely and appropriate treatment and care from these professionals. Collaborative working arrangements were also in place with the Pembridge palliative care unit, so that GPs could obtain advice from a specialist palliative care consultant. The service worked with a Rapid Response Team so that unnecessary admissions to hospital could be avoided.

Putting the patient first

LCW's vision and values were clearly stated. Staff at all levels of the organisation and GPs we spoke with told us they enjoyed working for the out-of-hours service. They demonstrated commitment to providing care that is high quality, and to working in partnerships to improve how care is provided so that patients experience services that are ever more centred on their needs, timely, safe, consistent and seamless.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Safety and Suitability of Premises How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because staff on reception duty after 9pm did not have a clear line of sight over the entire waiting area. This increased the risk of deterioration in a patient's condition going unnoticed. There was no alarm cord in the disabled toilet so that a person could call for help. Regulation 15 (1) (a).