LCW UCC (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.

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at LCW UCC (St Charles Centre for Health and Wellbeing) on 19 May 2015. This was to follow up an inspection we carried on 12 March 2014 as part of our new inspection programme to test our approach going forward. We found at that inspection that in relation to premises the provider was not fully meeting the essential standards of quality and safety (since superseded by the fundamental standards of care). Our latest inspection was also to rate the quality and safety of the services under our rating scheme introduced in October 2014. Overall the provider is rated as good.

Specifically, we found the provider to be good for providing safe, effective, caring, responsive and well led services.

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

- The provider had addressed shortcomings identified at our previous inspection.
- Patients were protected from risk of harm because systems and processes were in place to keep them safe.
- Staff were clear about reporting incidents, near misses and concerns and there was evidence of communication of lessons learned with staff.
- The provider was proactive in developing links with other local providers to share best practice and improve patient outcomes
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- The provider implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients.
- The provider had good facilities and was well equipped to treat patients and meet their needs The premises and services had been adapted to meet the needs of people with disabilities.
- There was an effective complaints system, and information about the complaints procedure was made readily available to patients.

Summary of findings

- The provider had a clear vision to provide quality patient centred services ensuring care in a timely, consistent, safe and seamless way.
- There was an open culture and staff felt supported in their roles.

The areas where the provider should make improvement are:

- Ensure the programme of training in safeguarding of vulnerable adults is completed for all GPs.

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?

Good

The provider is rated as good for providing safe services. Staff at all levels understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were appropriate systems for managing and disseminating patient safety alerts and guidance issued by the National Institute for Health and Care Excellence (NICE). The provider had appropriate policies and procedures in place for safeguarding children and vulnerable adults and training was provided in accordance with national guidance. There was a programme in place to fully embed GP training in safeguarding of vulnerable adults and about half of GPs had now been trained in this area. Arrangements were in place to ensure medicines were safely managed. There were effective infection control policies and procedures. There were appropriate processes for recruiting staff and robust systems to ensure there were enough staff to keep patients safe.

Are services effective?

Good

The provider is rated as good for providing effective services. Patients' needs were assessed and care was planned and delivered in line with current legislation. Data showed that the provider was performing well with national quality requirements (NQRs). Staff were supported with a comprehensive programme of training and systems were in place to ensure training needs were identified and planned for. Staff undertook annual appraisals and at the time of the inspection about half of staff who were due an appraisal had received one, with the remainder due to be completed by the end of May 2015. The provider was proactive in developing links with other local providers to share best practice and improve patient outcomes. There were appropriate processes in place to secure patient consent during treatment. The provider promoted good health and prevention.

Are services caring?

Good

The provider is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with

Summary of findings

kindness and respect, and maintained confidentiality. Patients confirmed they were treated in privacy and we observed that consultation doors were always closed when patients were being seen, and conversations could not be overheard. Staff provided appropriate support to help patients cope emotionally with care and treatment. Patient feedback to ongoing satisfaction surveys consistently indicated high levels of satisfaction with the service.

Are services responsive to people's needs?

Good

The provider is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with stakeholders to secure improvements to services where these were identified. Patients we spoke with felt the provider met their healthcare needs, and they were happy with the care provided. When offered an appointment they were seen promptly. The provider had good facilities and was well equipped to treat patients and meet their needs The premises and services had been adapted to meet the needs of people with disabilities. There was an effective complaints system, and information about the complaints procedure was made readily available to patients. Lessons learned were acted upon and communicated to staff when individual complaints were concluded.

Are services well-led?

Good

The provider is rated as good for being well-led. The provider had a clear vision to provide quality, patient-centred services ensuring care in a timely, consistent, safe and seamless way. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. There were robust governance arrangements in place through which risk and performance monitoring took place and service improvements were identified. The provider had a range of policies and procedures to govern activity which were regularly reviewed. There was a clear leadership structure with named members of staff in lead roles. There was an open culture, staff were clear about their own roles and responsibilities and felt supported in their work. There were arrangements for identifying, recording and managing risks. The provider gathered feedback from patients and used it to improve the service.

Summary of findings

What people who use the service say

We received seven completed CQC comment cards and spoke with four patients during the inspection. Generally patients were happy with the service they received. Patients described staff as helpful and caring. They were all complimentary about staff and the care they received. They told us they felt listened to, and that the GP had explained their treatment to them. All the patients we spoke with who attended the service said they had been seen at or before their appointment time. Ongoing patient satisfaction surveys consistently showed a high level of satisfaction with the service.

Areas for improvement

Action the service SHOULD take to improve

- Ensure the programme of training in safeguarding of vulnerable adults is completed for all GPs

LCW UCC (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 Care Quality Commission Lead Inspector. The team included a second CQC Inspector and a GP Specialist advisor. Specialist advisors are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to LCW UCC (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 (LCW UCC). LCW UCC provides a range of unscheduled care, including NHS 111 and urgent care centres. The provider 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 provider provides out-of-hours cover between 6.30pm and 8am Monday to Friday with 24-hour coverage at weekends and Bank holidays for over 991,000 patients registered with GP surgeries in the London boroughs of Hammersmith & Fulham, Kensington & Chelsea, Westminster, and Brent, Ealing and Hounslow, and for non-registered or temporary residents from the inner north west London boroughs.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme for out-of-hours emergency cover for GP services.

How we carried out this inspection

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?

Before visiting, we reviewed a range of information submitted by the provider including information relating to staffing, policies and procedures, complaints and serious incidents. We did not hold any intelligent monitoring information about this provider, at the time of the inspection. The provider did not have a profile on NHS Choices.

We carried out an announced visit on 19 May 2015. As part of the inspection process we spoke with a range of clinical and non-clinical staff including GPs, directors, operational managers, and dispatchers. We also spoke with patients and reviewed information such as policies and procedures and records. We observed how people were being cared for and reviewed patient comment cards.

Good

Are services safe?

Our findings

Safe track record

There were processes in place to ensure safety was monitored over time. There was a process to guide GPs and staff about the action to take following an adverse incident or near miss. The process was set out in the provider's policy for the management of adverse incidents and near misses which was last updated in July 2014. There was a template form for reporting incidents and near misses which was available to all staff online. Incidents could also be raised on paper forms. All incidents were recorded on the provider's risk management system and were presented together with rectification action in the provider's quarterly performance reports. Incidents were reported to and monitored via the provider's senior governance group, serious incident review group, clinical governance committee, and governance team, depending on the nature and severity of the incident. All patient safety incidents were reported to NHS England. Serious incidents were reported to the relevant commissioning CCG and to other external agencies as necessary.

An annual quality report was produced and reviewed by the clinical governance group. Serious incidents were included in this report including outlining the investigation findings, learning points and current status of the incident.

Learning and improvement from safety incidents

The records we looked at showed that the provider 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. For example, in one case the provider provided additional guidance and improved its procedure for the transfer of patients to hospital A&E to ensure all transfers were made by ambulance rather than taxi to mitigate the risk of acute deterioration during transfer. The learning from this incident was published in a staff newsletter.

In another case, we saw the detailed serious incident review report of a patient death which provided an executive summary of the root cause analysis, contributory causes, lessons learned and individual learning. The arrangements for sharing learning included a commitment to participate in and cascade within the service any follow up training recommended by the London Ambulance Service (LAS) regarding 999 response categories and ambulance conveyance to hospital. The provider also undertook to carry out with LAS training for GPs, including clarification of handover arrangements between the provider and LAS when requesting an ambulance for patients.

We saw minutes of the provider's clinical governance group meetings where serious incidents were monitored and reviewed as standing agenda items within the context of the organisation's quarterly performance report. The outcome of incident investigations was reported and learning action identified. For example, in relation to a review of antibiotic dosage in GP bags. GPs were to be reminded of the correct dosage for adults who weighed over 70kg.

There were appropriate systems for managing and disseminating patient safety alerts and guidance issued by the National Institute for Health and Care Excellence (NICE). The provider had a policy and procedure for managing and disseminating safety alerts. This identified roles and responsibilities of those responsible for reviewing and distributing any alerts and guidelines to staff within the service. The clinical governance committee was responsible for monitoring implementation of the process to ensure information was effectively disseminated throughout the organisation. There was also a standard operating procedure with guidance on how to access the provider's safety alert module on the NHS computer-based incident reporting system. We saw an example of a safety alert disseminated to all GPs and pharmacists within the organisation in April 2015 from NHS England regarding skin rashes associated with oak processionary moth caterpillars.

Reliable safety systems and processes including safeguarding

The provider had systems to manage and review risks to vulnerable children, young people and adults. The provider had up to date policies and procedures for protecting both children and adults from harm. There were separate designated lead GPs for safeguarding both vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the service if they had a safeguarding concern.

Good

Are services safe?

Child protection and safeguarding adults was part of mandatory training for all staff. All the GPs employed by the provider and sessional GPs who were used, had completed level three child protection training. When we inspected the provider in March 2014 we found safeguarding adults training was less well embedded. However, at our latest inspection we saw from the provider's training policy that this training was now incorporated in mandatory induction and refresher on-line training modules. We noted also from a training audit report that 50% of GPs had now completed the training in this area. We were told that quarterly evening GP education club sessions would be covering this training. We saw that the clinical governance group regularly reviewed the rates of completed safeguarding adults training. Non-clinical staff had completed safeguarding adults training and level one child protection. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children and were able to describe the organisation's procedures for reporting safeguarding issues. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details of external agencies were easily accessible.

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 provider'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. We were shown the monthly data for this. The provider also maintained quarterly data on adult safeguarding referrals and 30 random cases were run each month to assure potential safeguarding cases were not being missed. Safeguarding was a standing agenda item at clinical governance group meetings and we saw evidence of this in the minutes of meetings we were shown.

The provider had addressed the findings at our inspection in March 2014 that it could improve information for patients about the provider's chaperone arrangements. There was a chaperone policy and we found at our latest inspection there were posters on display offering patients the option of having chaperone if they needed an examination during a consultation. We saw from the Spring 2015 clinical newsletter that the chaperone policy had been reviewed as a result of a patient incident and guidance was being sought from the GMC about intimate examinations during home visits. The clinical staff we spoke with were aware of the importance of offering a chaperone and were able to describe when they would offer a chaperone. (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). Some non-clinical staff we spoke with told us they were used to chaperone and whilst they had not had received formal chaperone training they had been provided with appropriate briefing and instruction. They told us that the GPs always explained their role and made sure they were comfortable being present during the examination. Disclosure and Barring Services checks were in place for all non-clinical staff.

Medicines management

We checked medicines storage and found they were stored securely in a locked cupboard and were only accessible to authorised staff. There were no stocks of medicines requiring cold storage. The out of hours provider had a service level agreement with the pharmacy of a local NHS hospital trust to manage its medicines. The pharmacy regularly checked and replenished medicines including those for medical emergencies. The pharmacy supplied medicines safely in sealed boxes for use in the consultation rooms and for home visits. Processes were in place to record when a box was opened and which medicines had been used so the pharmacy could replenish the stock of medicines. The pharmacy carried out regular checks to ensure medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. Prescription pads were kept securely. There were systems in place for routine audit, reviews of accidents, errors and patient complaints relating to the handling of medicines.

The out of hours provider did not hold stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). Controlled drugs were accessible if necessary via on-call pharmacist or community pharmacists who were

commissioned to supply them out of hours. The provider did hold stocks of Midazolam, however this was a schedule 3 controlled drug and required no special storage arrangements.

At our inspection in March 2014 we identified the need to improve recording of medicines boxes as the system in place was not being followed and medicines could not therefore be accounted for at all times. At our latest inspection we found the provider had addressed this issue and the system for signing medicines boxes in and out was now being adhered to and robust checks were in place to ensure this.

Cleanliness and infection control

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 premises clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the provider's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the provider's infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. Infection control audits were carried out annually and any improvements identified for action were completed on time. Minutes of provider meetings showed that the findings of the audits were discussed.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

A risk assessment for legionella (a bacteria that contaminates water systems) had been undertaken by a professional company in November 2012 and control measures put in place where necessary. NHS Property Services was now the responsible body for legionella risk assessment as the landlord of the premises from which the out of hours service was provided. As part of its ongoing monitoring of infection control the provider had sought assurances from the landlord that the premises remained free from legionella since the previous assessment. NHS Property Services had provided such assurance. A professional company monitored water temperatures monthly and reported any non-conformance, advising of remedial action. Because there had been no non-conformance there had been no need for a further legionella risk assessment in accordance with recent legislative changes. However, a full site compliance inspection was scheduled for later in 2015.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was within the last twelve months. A schedule of testing was in place. We saw evidence of calibration of relevant equipment which was completed in March 2015; for example the defibrillator, thermometers and blood pressure measuring devices. Fire alarms and smoke detectors were tested regularly.

Staffing and recruitment

The provider had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. 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 the appropriate checks through the Disclosure and Barring Service (These 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).

At our inspection of 12 March 2014 we found incomplete personnel records for non-clinical staff. However, at our latest inspection we saw evidence from staff records that this had been addressed.

Good

Are services safe?

There were sufficient numbers of suitably qualified, skilled and experienced GPs and staff employed to provide the out-of-hours service. The provider used locum GPs and drivers and there were appropriate arrangements in place to ensure these staff were properly checked prior to their employment. The provider 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 provider were suitable for the role. The provider had drawn up a GP recruitment and compliance action plan for 2015/16 to ensure a sufficient supply of GPs to meet existing contracts and prepare for any increase in contracts. This included recruitment targets and a pre-winter recruitment drive to meet winter pressures.

The provider used a rostering tool to forecast and schedule GPs to predicted demand for the service. The provider 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.

Monitoring safety and responding to risk

The provider had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the service. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The provider also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. There was a health and safety committee which met on a quarterly basis to discuss updates relating to health and safety including risk assessments.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the log. We saw an example of this and the mitigating actions that had been put in place. The meeting minutes we reviewed showed risks were discussed at governance meetings and within team meetings. For example the results of an infection control audit had been discussed in a senior management meeting.

At our inspection of 12 March 2014 we judged that the provider must take action to improve the safety of the waiting area and the disabled toilet. At our latest inspection we saw evidence to confirm this had been addressed. There was now full oversight of the out-of hours waiting room after 9pm and staff on reception duty had a clear line of sight over the area. Closed-circuit television in the waiting area was being used to assist with this. There was now an alarm cord in the disabled toilet so that a person could call for help.

Arrangements to deal with emergencies and major incidents

The provider had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Clinical staff had received training in the previous twelve months and non-clinical staff in the previous three years. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff in a secure area and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the 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 service. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included building loss, utility failure, IT and data communications failure, building access restrictions and staff shortages. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The plan was last reviewed in 2014.

The provider had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. There was a clear and transparent pathway of how new guidelines were managed by the organisation. We saw minutes of meetings where new guidelines were disseminated, the implications for the provider's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. 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.

The provider used special patient notes, uploaded from all the GP practices serviced so that they could identify patients with complex needs who had multidisciplinary care plans documented in their local GP case notes.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the provider's culture was that patients were cared for and treated based on need and the provider took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The provider reported monthly to the Clinical Commissioning Groups on their performance against National Quality Requirements (NQRs) which included 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 the 2014/15 annual reports. We saw that the provider was generally meeting its targets. However, there were some breaches over the twelve month period. For example, the report for one service contract showed that the provider did not meet the NQR target for '% walk-ins triage completed within 20 minutes for three months May-July 2014 (target of 100% but 60%, 75% and 80% achieved respectively). 100% was achieved for all other months of the year. The results of NQRs were reviewed at clinical governance meetings. We saw that exception reports for these breaches were reviewed to identify why the breaches occurred and set learning actions which led to improving outcomes for people. For example, the learning actions included refresher training for reception/ despatcher staff, a review of the walk in policy and changes in procedure in assessing patients for life threatening conditions.

The provider undertook regular clinical audits of GP staff and there was a clinical audit work plan in place to audit their work in the first three months of their employment. This had been reviewed and updated in April 2015. The audit showed if any concerns were identified the auditor (an external assessor) followed this up with the GP performance lead to review and agree action. The performance lead then communicated the outcome to the GP and invited them to reflect on their practice and address any concerns identified. We saw examples of such audits.

We saw from the Winter 2014 newsletter the provider had completed a review with external pharmacist support of compliance with the new West London formulary (a list of medicines for adult patients for use in North West London. The service was compliant with the exception of one antibiotic which should no longer be prescribed and had been removed from the provider's standard medicines stock boxes. Two new antibiotics were added to replace it.

The provider also participated in external quality reviews conducted within the CCG areas served, for example, the Hammersmith and Fulham and West London care homes review project. In March 2015 the provider reviewed the impact on out of hours services in the provision of primary care to a range of care home service providers. The review looked at 111 calls and GP visits data and analysed when visits occurred, the medical reason for the call or visit, for example medication, falls, wound care etc. The findings highlighted that in more than half the calls related to medication, homes were without medicines, very little

Good

Are services effective?

(for example, treatment is effective)

referrals to community services, and an element of reassurance or training to care home staff in many of the calls visits. As a result of the review the provider's next steps included sharing the information with the Care Home Board and actioning accordingly; carrying out ongoing monitoring of care home call outs and trends; and discussing with care home managers how to get the best of on call GPs.

Effective staffing

Staffing included medical, managerial, operational and administrative staff. We reviewed staff training records on the 's central training tracker and saw staff were mostly up to date with attending mandatory courses such as annual basic life support, health and safety, safeguarding and infection control. The tracker identified clearly when training had been completed and when updates were due. The service was proactive in encouraging staff to complete mandatory training. The training and development team used the training tracker to prompt line managers to ensure staff attended training due.

The provider had a designated lead GP for education and held quarterly evening Education Clubs. Recent subjects included Level 3 safeguarding of children and the duty of candour statutory regulation. GPs working for the service were required to attend at least one Education Club a year. The Education Club was used to support GPs with annual appraisal and 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). All GPs had either been revalidated or had a date for revalidation.

The service also provided GP staff with annual performance data to enable them to reflect on practice and incorporate the report in the annual external GP appraisal for revalidation. We saw an example of an annual performance report which provided data on outcomes from telephone triage calls and scores for consultations based on recordings of consultations or written medical records for face to face or home visits. It also provided graphical information to allow GPs to see at a glance how their performance compared to their colleagues. GPs were given the opportunity to meet with the service's lead GP for performance and appraisals to review and develop their performance.

All other staff undertook annual appraisals that identified learning needs. Staff records we looked at showed that recent appraisals had taken place. We were told at the time of the inspection that about half of staff who were due an appraisal had received one and the remainder would be completed by May 2015. Our interviews with staff confirmed that the service was proactive in providing training and time off for relevant courses. For example, cover for call handlers was provided during shifts to enable them to complete mandatory training.

Working with colleagues and other service providers

The provider worked with other service providers to meet patients' needs and manage patients with complex needs. It sent out-of-hours notes to the relevant GP services electronically the next morning.

The provider worked in partnership with NHS acute trusts, A&E teams and the local Community Trust. It provided GP support and leadership to five Urgent Care Centres (UCC) located within central London.

The service followed a multi-agency approach to child and adult safeguarding. It worked closely with GP practices, community named doctors or nurses for child protection and local social services in dealing with both adult and child safeguarding concerns and referrals. There were seven multidisciplinary meetings in 2014/15 regarding frequent callers to the service involving safeguarding issues.

The provider was represented at tri-borough Central London, West London, Hammersmith and Fulham, Hounslow and Ealing (CWHHE) Systems Resilience Group – Urgent Care Programme Board meetings. The board met monthly to consider strategic urgent care issues, for example funding and capacity to meet winter pressures on the urgent care services across the three boroughs. We were shown the minutes of the February 2015 meeting which included an action plan covering ongoing issues.

The provider had recently secured a successful tender to work in partnership with an NHS Trust within the Community Independence Service (CIS) to provide a rapid response nursing, reablement and supported discharge service. The provider would be working closely with GP federations to develop clinical pathways and service redesign.

Good

Are services effective?

(for example, treatment is effective)

The provider had also taken a proactive part in developing both planned and reactive models for a tri-borough whole systems integrated care across health, social and third sector (voluntary) care. The aim of this was to shift care from acute to community and primary care, and thereby reduce admissions and improve early discharge.

As part of the 'Winter pressures' initiative the provider had offered support to a 20 bed nurse led 'step up/step down' service run by Central London Community Healthcare. This had proved invaluable in freeing up bed capacity at two local NHS acute hospitals. Designated LCW UCC doctors carried out ward rounds at weekends to support the service and also provide early morning cover.

Information sharing

The provider used several electronic systems to communicate with other providers. For example, there was system with the capability to interface with other providers to enable patient data to be shared in a secure and timely manner.

In line with their reporting requirements the provider had arrangements in place to ensure data about patients they saw was with the patients practice by 8am the following morning. There was a was a web based system and operational process in place to ensure that all patient alerts and updates to existing patient notes were amended upon receipt of updated information.

The provider had systems to provide staff with the information they needed. Staff used an electronic patient record 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. We saw evidence that audits had been carried out using these records to audit the performance of GPs and that action had been taken to address any shortcomings identified.

Consent to care and treatment

There were appropriate processes in place to secure patient consent during treatment. We found that staff were aware of the Mental Capacity Act 2005 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. For some specific scenarios where capacity to make decisions was an issue for a patient, the provider had drawn up a standard operating procedure to help staff with, for example to ensure they identified when a patient had a 'do not attempt resuscitation order'.

Staff we spoke with demonstrated a clear understanding of Gillick competencies and Fraser guidelines. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

We saw patient information leaflets in the waiting and consulting rooms relating to health promotion. GPs we spoke with confirmed they discussed health promotion with patients when relevant and appropriate. However they also advised patients to follow things up with their own GP for further and more detailed information.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the service. We received seven completed cards and spoke with four patients. All were positive about the service experienced. Patients commented that they were offered a good service and staff were friendly, helpful and caring. They said staff treated them with dignity and respect. All told us they were satisfied with the care provided by the provider and confirmed that they were seen promptly with no undue waiting.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff treating patients with dignity and respect and saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. We listened to a GP talking with patients over the telephone. They were respectful and compassionate to the patients they spoke with.

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 one of the managers.

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

Care planning and involvement in decisions about care and treatment

We observed GPs undertaking telephone consultations with patients, during which they checked that the patient understood the treatment they were offering. 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 told us that the GP gave appropriate information and advice about the issue they visited for. They also told us they felt listened to and supported by staff and had sufficient time during consultations and the telephone conversation to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

Supervisor staff told us that often people on calls were anxious and worried about a family member who they were calling on behalf of. They explained how their call handlers provided empathy and care when dealing with patients and relatives. The patients we spoke with on the day of our inspection and the comment cards we received confirmed that staff provided appropriate support to cope emotionally with care and treatment. We noted from feedback from the provider's ongoing patient satisfaction survey that one patient commented that both the person who answered the call initially and the doctor that called back were warm, professional, well informed and reassuring. They felt it was a brilliant service and they couldn't have asked for more.

Notices in the patient waiting room and patient website also told patients how to access support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer.

The provider had information available to patients relating to support services available in the local area. Staff showed us various leaflets, for example information relating to drug and alcohol services, which were given to patients who visited.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the provider was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the provider population were understood and systems were in place to address identified needs in the way services were delivered.

The provider used their National Quality Requirements (NQRs) to monitor how well they responded to patients' needs. We reviewed the quarterly contract report for January to March 2015 and found the provider had scored 100% for a number of quality requirements including the percentage of emergencies consulted and visited within one hour, the percentage of patients with urgent needs consulted and visited within one hour, and the number of routine patients consulted and visited within six hours. The provider had adequate staffing levels to meet patients' needs and had scored 100% in matching staffing levels to demand.

The provider carried out quarterly patient satisfaction questionnaires (PSQs). We reviewed results from July to September 2014 and found 96% of respondents were overall satisfied with the service and would recommend it to others. A link to provide feedback was available on the website.

The provider had an established patient reference group (PRG) which met quarterly to obtain feedback from patient representatives including members of Healthwatch from the CCG areas served. The provider was represented by the public and patient engagement lead and communication lead. We saw examples of meeting minutes which recorded discussion and action agreed, for example on the introduction of a patient privacy, dignity and respect policy and the agreement of changes necessary before implementing the policy, such as addressing issues to make aspects of the policy easier for patients whose first language was not English. We were told the provider was developing a new strategy for patient and public engagement and we saw the notes of the provider's patient and public engagement forum held in October where issues for the development of the forum were discussed including the need to recruit more members, utilising social media to attract younger members, and the promotion of meetings well in advance to maximise attendance.

The provider met monthly with each commissioner to review performance, financial and all clinical governance elements of the service. They have worked closely with commissioners to further develop the joint clinical governance forums as well as joint provider forums to identify opportunities for improved patient pathways across providers.

Tackling inequity and promoting equality

The provider had recognised the needs of different groups in the planning of its services. For example, the provider had access to the language line interpreter service for patients whose first language was not English and a text-based communication telephone service for those patients hard of hearing. Wheelchair access and a hearing loop were available at the service and a home visiting service for those patients who were housebound.

There were male and female GPs who worked at the out of hours service; therefore patients could usually choose to see a male or female doctor if they wished.

The provider provided equality and diversity training through e-learning and the training was mandatory for all staff. We saw records to confirm all staff had received this training which also identified when refresher training was due. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months. Following review of the Equality and Diversity policy by the patient reference group, a number of changes were made to the policy. The provider monitored access data regarding patient access to the out of hours service by age, sex and ethnicity and this was provided to commissioners on a quarterly basis.

We saw that call handlers were given additional training to deal with people with communication difficulties to ensure they fully understood their needs in the absence of them being physically present. This included dealing with complex calls and meeting the needs of patients with mental health problems. We noted also there was a policy in place which provided guidance to GPs about what to do

Good

Are services responsive to people's needs?

(for example, to feedback?)

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.

Access to the service

The out of hours service was open from 6.30pm to 8.00am Monday to Friday and 24 hours Saturday, Sunday and bank holidays. Comprehensive information was available to patients about how they could receive care or treatment on the provider's website including instructions for contacting the out-of-hours service through the NHS 111 service. There were also arrangements to ensure patients contacting the service following 111 assessment were prioritised by call handlers who had been given specific training. They were given clear instructions to follow where they could transfer urgent calls to the GP for further triaging and prioritising.

Patients were generally satisfied with the appointments system. Patients we spoke with during the inspection who were attending for an appointment and those who completed CQC comments cards told us they had been given their appointment quickly. One commented that they had been seen before the allotted time.

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. The policy set out duties and responsibilities for complaints. There was a designated person responsible, with the support of the service's complaints team, for the investigation of all complaints and incidents in the service. The complaints lead provided regular reports and quarterly summaries of complaints and incidents to the provider's clinical governance committee.

We saw that information was available to help patients understand the complaints system. Posters were displayed in the waiting area and information was available on the website including a 'Have your say' leaflet and details of the person to write about any complaints or concerns. All staff we spoke with had a good knowledge of the complaints policy. None of the patients we spoke with had ever needed to make a complaint about the service.

We looked at 15 'unsolicited' complaints received in 2014-2015 and found they had been satisfactorily handled and dealt with in a timely manner by the provider.

Complaints were handled with full transparency based on the organisation's 'Being Open' policy which highlighted that communicating honestly and sympathetically with patients and their families when things go wrong. The complaints procedure included fully involving the complainant and the staff member being complained about (if applicable). For example, we reviewed a complaint where a patient's parent was not happy with out of hours GP's treatment of their son regarding the prescribing of antibiotics. The provider fully investigated the incident including interviewing the GP being complained about and meeting with the complainant. The complaint was upheld and led to the provider reviewing with the GP their prescribing practice to ensure the correct dosages were prescribed.

All GPs were audited every month on the number of complaints or feedback received about them. If there had been complaints or feedback, the provider's performance lead or a senior practitioner assigned as a mentor went through them with the GP to identify any lessons learnt or to promote best practice.

The provider reviewed complaints, compliments and professional feedback annually to detect themes or trends. Quarterly and annual reports were completed which included complaints. The reports looked at themes occurring in complaints. The provider explored and acted on themes that occurred. For example, we saw from the 2014-2015 review of lessons from complaints the clinical governance group determined that GPs needed to: write their notes so that they could be fully understood by others; explain to patients that delay in being seen can happen at busy times; to use special patient notes (SPNs), past encounters, and directory enquiries to contact a patient before resorting to the police; and to be thoughtful and listening, remembering that patients were often anxious and some may need extra reassurance that they are being listened to. These outcomes were communicated to all GPs, both individually in person where they were directly involved and collectively by email to remind everyone of good practice. Cases were also discussed at quarterly GP education clubs. We noted also that in the annual review of the 15 'unsolicited' complaints over 2014-15, six were fully or partially upheld, five not upheld and two were still under investigation.

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

The provider had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and provider values were part of the provider's strategy and business plan. The vision and values were communicated on the provider's website through the provider's leaflet and annual report. The provider's vision is to provide patient-centred services ensuring care is timely, consistent, safe and seamless. They aim to remain a high quality unscheduled care provider who leads innovation in service redesign to continually improve access and choice for patients in our community.

We spoke with nine members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We saw from the presentation at a staff workshop in November 2014 that the provider's future out of hours strategy including working models and workforce planning towards achieving the service strategy were discussed.

Governance arrangements

The provider had a number of policies and procedures in place to govern activity and these were available to staff on the provider's computer system. We looked at a wide range of these policies and procedures and they had all been reviewed at appropriate intervals and were up to date. Each policy and procedure was subject to a document control process which identified the author, date, status and reasons for review or change.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a medical director (who was also the lead for complaints), a chief operations officer, and head of operations. There were also designated leads for patient and public engagement, infection control and safeguarding. There was an in-house lead pharmacist who was responsible for medicines policy and management. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the service with any concerns.

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

The provider had arrangements for identifying, recording and managing risks. There was a risk register for the whole organisation which was reviewed regularly to ensure controls put in place to minimise risks to patient safety were appropriate and continued to be effective. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. There was a named person accountable for each risk identified.

The clinical governance and senior governance groups were chaired by GPs and met quarterly. The groups received reports about clinical and operational performance and effectiveness and we saw a sample of meeting minutes which confirmed this. 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, in partnership with Hammersmith & Fulham (H&F) GP Federation, the provider had tendered successfully to provide the new weekend appointment and walk-In service for residents of Hammersmith & Fulham. This was a nine month pilot to provide increased access to GP services and to relieve pressure from emergency departments across the borough.

The provider was a member of Urgent Health UK (UHUK), which is the federation of social enterprise unscheduled primary care providers. The provider 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. We noted in addition, as part of the provider's membership UHUK, NHS Auditors undertook an information governance, risk management and performance and patient safety audit which started in February and was due to end in June 2015. The initial feedback had been positive and the provider awaited the final reports so they could address any learning or actions.

Leadership, openness and transparency

Are services well-led?

Good

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

There were clear leadership structures in the organisation. There were experienced GPs on the board with management experience.

We saw from minutes that team meetings were held regularly. Staff told us that there was an open culture within the service and they had the opportunity and were happy to raise issues at team meetings. Staff told us that managers were approachable and they were constantly updated on how the provider was performing. We spoke with staff at all levels within the organisation and found that everyone demonstrated an awareness of how the provider was performing, indicating that leaders were open and transparent with staff.

We also noted that the provider held a number of board and executive strategic 'away days' to determine the provider's aims and objectives for the coming year and next three years. We also saw evidence of periodic workshops to engage staff in discussions about the strategic direction of the service.

The Chief Operating Officer was responsible for human resource (HR) policies and procedures with the support of the HR team. We reviewed a number of policies (for example whistleblowing policy, induction and mandatory training policy, disciplinary and capability procedures) which were in place to support staff. Staff we spoke with knew where to find these policies if required.

Provider seeks and acts on feedback from its patients, the public and staff

The provider gathered feedback from patients through unsolicited complaints and compliments sent by patients, feedback from professionals, questionnaires sent to 4% of all callers and external audit of 6.5% of written notes or telephone consultation. Lessons learned from these sources were analysed and reviewed by the provider's clinical governance group. Appropriate action was taken and communicated to staff to reflect on practice. We saw that the results of patient questionnaires were shared with staff and the public. For example results were published in the quarterly staff newsletter which appeared on the provider's website.

The provider had an established patient reference group (PRG) which met quarterly to obtain feedback from patient representatives including a member of Healthwatch from the CCG areas served. The provider was also developing a new strategy for patient and public engagement and patient and public engagement forum meetings had been held to discuss issues for the development of the forum.

The provider had gathered feedback from staff through staff away days, workshops and generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

The practice had a whistleblowing policy which was available to all staff. Staff we spoke with were aware of the policy and knew who to go to if they wished to report any concerns.

Management lead through learning and improvement

Staff told us that the provider supported them to maintain their clinical professional development through training. We looked at staff records and saw that they received regular appraisals and learning and development needs were linked to the appraisal process. Staff told us that the provider was very supportive of training and that they kept their skills and knowledge relevant to their work up to date.

The provider was continually monitoring activity and quality at all levels including committee level.

This was to ensure the right learning and development opportunities were available to staff.

The provider had completed reviews of significant events and other incidents and shared these with staff at meetings and through appraisals, newsletters and email communications to ensure the provider improved outcomes for patients. For example, we saw that learning from a significant event disseminated to staff in the Spring 2015 newsletter following an incident where one of the provider's cars was flagged down by a member of the public seeking help for a patient who had collapsed,. The provider reviewed its policy for dealing with such events and updated in the manual used by GPs to clarify their responsibilities. This included reference to GMC guidance that they must offer help if emergencies arise in clinical settings or in the community, taking account of their own safety, competence and the availability of other options for care.