Care UK - North West London

Inspection report

Unit 1, Square One
Navigator Park, Southall Lane
Southall
Middlesex
UB2 5NH
Tel: 020 3402 1300
http://www.careukhealthcare.com/our-services/out-of-hours-services

Date of inspection visit:19/9/2018 & 20/9/2018 19 September 2018 to 20 September 2018
Date of publication: 31/10/2018

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 location	Good
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Overall summary

This service is rated as Good overall.

The key questions are rated as:

Are services safe? - Requires improvement

Are services effective? - Good

Are services caring? - Good

Are services responsive? - Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at Care UK - North West London Out of Hours (OOHs) service on 19 September 2018 & 20 September 2018, as part of our inspection programme. The service operates from a single call centre and administrative base in Southall. Our inspection included a visit to the service's call centre and also to each of its three out of hours primary care centres (OOHs PCCs).

At this inspection we found:

- There was an effective system for reporting and recording significant events. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Risks to patients and staff were assessed and well managed in some areas, with the exception of those relating to calibration of medical equipment, lone worker risk assessment and access to a paediatric pulse oximeter which could be required to enable assessment of a child patient with presumed sepsis.
- The service was unable to demonstrate that they had an effective monitoring system to assure themselves that appropriate health and safety checks had been undertaken regularly to maintain fire safety and legionella at the Hillingdon OOH PCC and the Harrow OOH PCC.
- There were safeguarding systems in place for both children and adults at risk of harm or abuse as well as palliative care (care for the terminally ill and their families) patients who accessed the out of hours to the service.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. The National Quality Requirements (NQRs) standards were monitored and reviewed and improvements implemented.
- The service routinely reviewed the effectiveness and appropriateness of the care it provided.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- The service proactively sought feedback from staff and patients, which it acted on.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- The service worked proactively with other organisations and providers to develop services that supported alternatives to hospital admission where appropriate and improved the patient experience.
- Information about services and how to complain was available.
- There was a clear leadership structure. Communication channels were open and staff felt supported by management.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Ensure care and treatment is provided in a safe way to patients.

The areas where the provider **should** make improvements are:

- Carry out disease specific audits to ensure effective monitoring of antimicrobial prescribing.
- Review feedback on the suitability of the premises at the Harrow OOH PCC and take any necessary action.
- Implement a system to ensure written records are maintained of oxygen cylinder checks at the call centre.
- Improve access to patients with hearing difficulties.
- Ensure all clinical staff have access to a paediatric pulse oximeter which could be required to enable assessment of a child patient with presumed sepsis.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included two GP specialist advisors, a pharmacist specialist advisor, a nurse specialist advisor and a practice manager specialist advisor. A CQC Inspection Manager attended the feedback session.

Background to Care UK - North West London

Care UK is a large UK based independent provider of health and social care.

Care UK-North West London provides out-of-hours (OOHs) primary medical services when GP practices are closed. The out-of-hours service covers a population of approximately 1,038,533 people across outer North West London including Brent, Harrow, Hillingdon, Ealing and Hounslow.

The provider is contracted by the NHS clinical commissioning groups and also has 162 Service Level Agreements (SLA's) for individual practices.

Most patients access the out of hour's service via the NHS 111 telephone service. Patients may be seen by a clinician, receive a telephone consultation or a home visit, depending on their needs. Rarely patients access services as a walk-in patient.

The administrative base and call centre for Care UK-North West London is located in Southall. We visited the Care UK- North West London administrative base and call centre to review policies and procedures relevant to the service and meet with the service managers. The full address for call centre and headquarters is:

- Care UK- North West London, Unit 1, Square One, Navigator Park, Southall Lane, Southall, UB2 5NH. We visited the Care UK- North West London administrative base and call centre to review policies and procedures relevant to the service and meet with the service managers.

Out-of-hours (OOHs) services are provided from three primary care centres. They are:

- Hillingdon OOHs PCC: Hillingdon Hospital opened from 7.30pm to midnight Monday to Friday, from 8am to 11pm on a Saturday and from 9am to 11pm on a Sunday. We visited this base.
- Harrow OOHs PCC: Northwick Park Hospital opened from 8pm to 11pm Monday to Friday, from 9am to 11pm on a Saturday and from 9am to 10pm on a Sunday. We visited this base.
- Hounslow OOHs PCC: Skyways Medical Centre opened from 8pm to 10pm Monday to Friday, from 10am to 1pm and 3pm to 7pm on a Saturday and Sunday. We visited this base.

OOHs Primary Care Centers are situated in rented spaces and the facilities are managed by the respective organisations.

The provider is registered to provide two regulated activities:

- Treatment of disease, disorder or injury;
- Transport services, triage and medical advice provided remotely.

Requires improvement

Are services safe?

We rated the service as requires improvement for providing safe services.

Safety systems and processes

The service had systems to keep people safe and safeguarded from abuse. However, some improvements were required.

- The provider conducted some safety risk assessments. It had safety policies, including Control of Substances Hazardous to Health (COSHH) and Health & Safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction and refresher training. The provider had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The service worked with other agencies to support patients and protect them from neglect and abuse. For example, the service worked closely with local safeguarding adults and children teams. The provider had made 88 safeguarding referrals in the last 12 months. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check. Safeguarding leads had received safeguarding children level four training.
- There was an effective system to manage infection prevention and control. There were systems for safely managing healthcare waste.
- The provider had not always ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. For example, some self employed GPs were using their own clinical equipment and the provider was unable to provide the evidence that self employed GPs clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The provider had a lone worker policy in place. However, they had not carried out site specific lone worker risk assessments at the out of hours primary care centres (OOHs PCCs). On the day of the inspection, staff we spoke with and written feedback we received, raised concerns regarding inappropriate safety and security arrangements at the Harrow OOH PCC and the Hounslow OOH PCC. In addition, we observed one patient who complained of the reception area being too hot at the Harrow OOH PCC and the reception staff directed the patient to go outside the waiting area to cool down.
- The provider had comprehensive business continuity plans for major incidents such as power failure, telephony outage including serious malfunction or failure of the telephone system. There were plans to move services to other provider primary care centres or a local GP practice in the event of being unable to access the centre. Services could, therefore, be maintained if one of the bases was unable to be accessed. The plan included emergency contact numbers for staff.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety. However, some improvements were required.

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective system in place for dealing with surges in demand. The provider informed us they had plans in place to meet predictable fluctuations in demand for their contracted service, especially at periods of peak demand, such as a Bank Holiday weekend.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis. However, one of the GPs we spoke with at one of the out of hours primary care centres (OOHs PCCs) informed us they did not have access to a paediatric

pulse oximeter which could be required to enable assessment of a child patient with presumed sepsis. The provider informed us they had a paediatric pulse oximeter available at all sites, which was kept securely and the GP was required to request it from the receptionist when needed. The GP we spoke with was not aware of this arrangement. We saw the paediatric pulse oximeters were carried in vehicles. On the day of the inspection, the provider informed us they had ordered additional new paediatric pulse oximeters.

- On the day of the inspection, we noted a defibrillator was not carried in vehicles and there was no formal documented risk assessment as to why they were not required. However, on the day of the inspection, the provider had documented a formal risk assessment. We saw the provider had purchased a number of new defibrillators and was in the process of developing a protocol to ensure their safe use.
- In line with available guidance, patients were prioritised appropriately for care and treatment, in accordance with their clinical need. Systems were in place to manage people who experienced long waits.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.
- When there were changes to services or staff the service assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The provider informed us they had relocated to Hounslow OOH PCC at four weeks notice on 3 July 2018. Due to the delay in setting up the information technology system, the service had invoked their business continuity plan and was relying on manual processes and individual care records were maintained in the paper format. The provider had created a risk register and implemented a protocol to manage the risks associated with this transition period. The provider informed us that the reminder emails were sent on the daily basis to the staff on duty, paper notes were collected daily and shared with the individual's GPs by fax. Consultation notes were reviewed and medicines information was transferred manually to the spreadsheet to ensure effective monitoring. The provider informed us that the information technology system was planned to be activated on 26 September 2018.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- The provider used an electronic patient record system called Adastra. Information provided from local GP practices was entered onto the system and these records could be accessed and updated by clinicians and staff, emergency department staff, district nurses, palliative care nurses and other health professionals about patients, with the consent of the individual concerned. The system was also used to document, record and manage care patients received.
- Staff had access to information such as do not attempt resuscitation (DNR) orders through special patient notes (SPNs) so that they could take it into account when providing care and treatment. The provider advised all clinicians to register with Co-ordinate My Care (CMC) prior to working independent sessions, so they could access relevant information such as advanced directives and in some cases preferred a place of death.
- Staff we spoke with found the systems for recording information easy to use and had received training. Clinical staff undertaking home visits also had access to IT equipment so relevant information could be shared with them while working remotely. Staff told us they felt that the equipment they used was both effective and friendly to use.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Appropriate and safe use of medicines

The service had reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, including medical gases, emergency medicines and equipment, minimised risks. However, some improvements were required. Arrangements were also in place to ensure medicines and medical gas cylinders carried in vehicles were stored appropriately.

Are services safe?

Staff we spoke with informed us that oxygen cylinders carried in vehicles were checked on a regular basis. However, written records of these checks were not maintained at the call centre.

- The service did not store controlled drugs (medicines that require extra checks and special storage because of their potential for misuse) and vaccines.
- The service carried out regular medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing. For example, the pharmacy lead carried out prescribing audits on all clinicians and produced quarterly individual reports which were shared with each clinician.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The service had audited antimicrobial prescribing but they did not carry out disease specific audits to assure prescriptions were given appropriately.
- The service had compared their internal data and demonstrated a reduction in the prescribing of high risk medicines.
- Processes were in place for checking medicines and staff kept accurate records of medicines. The service kept prescription stationery securely and monitored its use. The provider had excellent processes in place to assure the safety and security of medicines and prescription stationery.
- Arrangements for dispensing medicines kept patients safe. The provider informed us that medicines were dispensed as a last resort and clinicians were encouraged to prescribe medicines by using FP10 prescribing form. The provider had an effective monitoring system to manage the medicines cassettes supplied and managed by the external pharmacy supplier. The provider was in the process of updating the contents of the medicines cassettes. For example, they had decided 18 months ago to add Nitrofurantoin (a medicine used to treat urinary tract infections) to the medicines cassettes, however, it had taken longer than expected to implement this change. The provider informed us they had developed an action plan to upgrade the contents of all 24 outstanding medicines cassettes within one to two weeks after the inspection. The provider had assured us that appropriate medicines were prescribed in line with current national guidance to treat urinary tract infections which could be evidenced by their prescribing audits.
- Palliative care patients were able to receive prompt access to pain relief and other medication required to control their symptoms.

Track record on safety

Safety issues were well managed in some areas. However, improvements were required at the Hillingdon OOH PCC and the Harrow OOH PCC.

- There were up-to-date fire risk assessments at the call centre and the Hounslow OOH PCC. However, the provider was unable to provide the evidence of up-to-date fire risk assessments and safety checks at the Hillingdon OOH PCC and the Harrow OOH PCC.
- Legionella (a bacterium which can contaminate water systems in buildings) risk assessments were carried out at the call centre and the Hounslow OOH PCC. However, the provider was unable to provide the evidence of up-to-date legionella risk assessments at the Hillingdon OOH PCC and the Harrow OOH PCC. The provider was unable to provide records to demonstrate that regular water temperature checks had been carried out at the Hillingdon OOH PCC and the Harrow OOH PCC.
- The provider informed us they had requested to access the fire safety and the management of legionella records at the Hillingdon OOH PCC and the Harrow OOH PCC, but they were still waiting for the response from the hosts responsible for managing the premises. Both OOH PCCs were located at another NHS property and the provider had limited control over their environment. However, on the day of the inspection, the provider was unable to demonstrate that they had an effective monitoring system to ensure that risk assessments had been carried out and regular checks had been undertaken by the hosts who were responsible for managing the premises.
- There were systems in place to ensure the safety of the out of hours vehicles. Checks were undertaken at the beginning of each shift. Vehicle checks and maintenance were effective to ensure the cars were mechanically safe. The provider had systems in place to ensure regular servicing, emergency vehicle maintenance and tyre changes would not impact on the level of service. The provider had a spare car ready for use in the event of another being out of service. There were procedures for checking the driving licences of driving staff, to ensure they had not been removed or had had endorsements relevant to their duties. These

staff had been assessed to ensure that they were skilled to drive at the level that might be required of them. All drivers and vehicles had full insurance cover and this covered the transfer of patients, if required.
- Joint reviews of incidents were carried out with partner organisations, including the local A&E department, GP out-of-hours, NHS 111 service and urgent care services.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- Staff told us they would inform the care coordinator or on-call duty medical lead of any incidents and there was a recording form available on the service's computer system. The policy and the reporting forms known as 'Datix incident reporting forms' were available and staff we spoke with knew how to access them. The incident recording form supported the recording of notifiable incidents including complying with the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care or treatment). We saw evidence that when things went wrong with care or treatment, patients of families were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to help to prevent the same thing happening again.
- We noted 50 incidents had been reported in Out of Hours (OOH) service during August 2017 and July 2018, out of which three were declared as serious incidents. The service carried out a thorough analysis of the incidents and ensured that learning from them was disseminated to staff and embedded in policy and processes.
- The provider also had a regular newsletter called 'Reflect'. This provided a summary of the serious incidents and complaints across services to enable staff to learn from all areas in primary care. Each case was looked at in detail and analysed to ensure themes were identified.
- We saw evidence that lessons were learnt from incidents and communicated widely to support improvement. For example, we noted the incidents were fully reported and investigated. We saw that following the incident the provider had reviewed and updated home visiting protocol. The provider had updated the local coroner contact details and shared communication with all clinicians which included advice for families on religious burial when certifying death.
- The service learned from external safety events and patient safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including GPs and other prescribers.

Good

Are services effective?

We rated the service as good for providing effective services.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed.
- Telephone assessments were carried out using a defined operating model. Staff were aware of the operating model which included the transfer of calls from call handler to clinician and use of a structured assessment tool.
- Access to the Out of Hours (OOH) service was via the national NHS 111 service. In North West London this service was provided by the Care UK from the same base (first floor) at Southall. Following a telephone assessment completed by the national NHS 111 service, patients may be referred to the OOH GP service, or they could directly access and book appointments in the OOH service database. Occasionally, some patients accessed the service as a 'walk-in' patient.
- Referred patients received a telephone call from one of the OOH clinicians who undertook a further assessment of their needs. From this assessment, the GP would make a decision for the patient to receive telephone advice with no onward referral, a visit to one of the primary care centre, visited at their place of residence or a referral to an alternative provider (e.g. the emergency services or Emergency Department).
- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- Care and treatment was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable, such as homeless people and patients with a learning disability.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients. There was a system in place to identify frequent callers and patients with particular needs, for example palliative care patients, and protocols were in place to provide the appropriate support.
- When staff were not able to make a direct appointment on behalf of the patient clear referral processes were in place. These were agreed with senior staff and clear explanation was given to the patient or person calling on their behalf.
- Technology and equipment were used to improve treatment and to support patients' independence.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service had a comprehensive programme of quality improvement activity and routinely received the effectiveness and appropriateness of the care provided.

- From 1 January 2005, all providers of out-of-hours services were required to comply with the National Quality Requirements (NQRs) for out-of-hours providers. The NQRs were used to show the service was safe, clinically effective and responsive. Providers were required to report monthly to the Clinical Commissioning Groups (CCGs) on their performance against standards 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 found evidence that the provider had:

- Clearly identified the staffing requirements needed to meet the NQR's and provide safe and effective services.
- Reviewed the use of the service to identify peaks and troughs in demand to plan the numbers of staff required for each shift operated.
- Reviewed the types of care and treatment required by patients to match the skills of staff to the treatments required.

The provider's performance against national quality requirements (NQRs) included:

NQR 4 - A random sample audit of patient contacts:

Good

Are services effective?

- This audit process was led by a clinician, appropriate action was taken on the results of those audits and we saw evidence that regular reports of these audits were made available to the Clinical Commissioning Groups (CCGs).
- We found the provider was monthly auditing contacts by completing call listening audit. We saw evidence that the provider was sharing written feedback with clinicians.
- There was a system in place to monitor the performance of GPs and ANPs (Advance Nurse Practitioners) working in the out of hours service in a comprehensive and systematic manner. We saw the provider was monthly auditing a random sample of 'patients contacts' by completing 1% clinical audit (minimum one case for every clinician) and call listening audit (minimum one case for every clinician). The provider carried out this audit to review clinical performance and ensure consultations to be of the highest quality and where clinicians fell below this standard the provider demonstrated that action was taken to support the clinician to improve their performance.
- One of the audit team who we spoke with described how results were shared with the clinicians and additional training and support was offered where required. They also advised clinical effectiveness was monitored by individual clinician audit. We were told that all consultations ended with 'safety netting' or 'worsening advice' which aimed to ensure that the patient knew what signs to look out for that would indicate that the problem was not improving and that they should seek further help.

NQR 11 - match the skills of clinicians available with peaks of demand in the service:

- The service had plans in place to ensure staffing levels were sufficient to meet the anticipated demand for the service.
- We saw evidence that the provider was carrying out regular audits to monitor coordinators performance. These audits were carried out twice yearly to ensure that staff were fully trained for the job role they employed to do and demonstrate that they were able to manage capacity and demand of the service at periods of busy times during the shift. We saw evidence that the provider was sharing written feedback with the staff.
- We noted the provider had additional clinical staff on duty to meet the increasing demand when some local GPs were closed during the afternoon every Wednesday and Thursday (the provider had Service Level Agreements (SLA's) with individual practices to provide OOH services during this time). During this time, following a telephone assessment completed by the OOH GP, the GP would make a decision for the patient to receive telephone advice with no onward referral, offered a visit (after 7.30pm) to one of the primary care centre, visited at their place of residence or a referral to an alternative provider (e.g. the Urgent Care Centre or Emergency Department).

NQR 12 - Face to face consultations:

- After the definitive clinical assessment had been completed and it was required to attend face to face consultation, the provider had a system in place to prioritise which patient was seen based on their clinical needs.
- Data from May 2018 to July 2018 showed that the provider had achieved 95% (on average) face to face consultations at an out of hours base within two hours of assessment for those patients classified as 'urgent'. The provider had met the 95% target.
- Data from May 2018 to July 2018 showed that the provider had achieved 99% (on average) face to face consultations at an out of hours base within six hours of assessment for those patients classified as 'routine'. The provider had met the 95% target.
- Data from May 2018 to July 2018 showed that the provider had achieved 96% (on average) face to face consultations at the patient's place of residence within two hours of assessment for those patients classified as 'urgent'. The provider had met the 95% target.
- Data from May 2018 to July 2018 showed that the provider had achieved 98% (on average) face to face consultations at the patient's place of residence within six hours of assessment for those patients classified as 'routine'. The provider had met the 95% target.
- The service made improvements through the use of completed audits. For example, the provider carried out a voice recording audit and found the GP had carried out good triage but the recording of consultation notes was not appropriate. The clinical lead had a discussion with the GP and advised to improve record keeping of consultation notes. The provider carried out a follow up audit which demonstrated improvement.

Good

Are services effective?

- The service was actively involved in quality improvement activity, however, they did not carry out disease specific audits to assure prescriptions were given appropriately.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. Staff had access to an online learning tool Learning Management System (LMS) which was featuring various training programs tailored for each staff role.
- The service employed 78 permanent staff who had the appropriate skills and training to perform their required duties. This included medical, nursing, managerial and administrative staff. In addition, the service employed 67 locum/ self-employed GPs and five ANPs (Advance Nurse Practitioners). We reviewed staff training records and saw that staff were up to date with attending courses such as annual basic life support, fire safety awareness, information governance and safeguarding. Staff had access to and made use of e-learning training modules and in-house training. Staff told us that they received regular communication informing them of any outstanding training.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. We saw out of 78 staff, 68 (87%) had an appraisal within the previous 12 months. For the remaining 10 members of staff whose appraisal was due, the service was able to describe why staff had not received the appraisal. Some of the appraisals had been missed following an internal restructure.
- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required.
- The provider could demonstrate how it ensured the competence of staff employed in advanced roles by the audit of their clinical decision making.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together, and worked well with other organisations to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services or when they were referred. Staff also referred patients back to their own GP to ensure continuity of care, where necessary. There were established pathways for staff to follow to ensure callers were referred to other services for support as required. For example, if patients needed specialist care, the out-of-hours service, could refer to specialities within the hospital. Staff also described a positive relationship with the mental health and district nursing team if they needed support during the out-of-hours period.
- The service ensured that care was delivered in a coordinated way and took into account the needs of different patients, including those who may be vulnerable because of their circumstances. For example, the service prioritised palliative care calls to ensure they received timely care and treatment. The clinical staff could give a direct telephone number to the carers of palliative care patients. Those carers no longer had to go through the NHS 111 service so saving valuable time, stress and the repetition of the details of their very distressing circumstances. Information relating to the needs of patients receiving palliative care was shared promptly between the patient's registered GP and the service.

Good

Are services effective?

- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that require them. Staff were empowered to make direct referrals and/or appointments for patients with other services.
- The service had formalised systems with the NHS 111 service with specific referral protocols for patients referred to the service. An electronic record of all consultations was sent to patients' own GPs.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- Information relating to patient consultations carried out during the out of hour's period was transferred electronically to a patient's GP by 8am the next day (NQR 2) in line with the performance monitoring tool. Data showed the service was consistently meeting this requirement and between May 2018 to July 2018, 100% of patient records with details of consultations were sent to the patients GP practice before 8am (NQR 2).
- Issues with the Directory of Services were resolved in a timely manner. For example, the service had reviewed the arrangements with NHS England regarding the pilot project which involved direct booking at hub locations.

Helping patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.

- The service identified patients who may be in need of extra support such as those for whom English was not their first language.
- Where appropriate, staff gave people advice so they could self-care. Systems were available to facilitate this.
- Risk factors, where identified, were highlighted to patients and their normal care providers so additional support could be given.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The provider monitored the process for seeking consent appropriately.

Good

Are services caring?

We rated the service as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information. Call handlers gave people who phoned into the service clear information. There were arrangements and systems in place to support staff to respond to people with specific health care needs such as end of life care and those who had mental health needs.
- We obtained the views of patients who used the Out of Hours (OOH) service via Care Quality Commission comment cards that patients had completed. All of the 43 patient Care Quality Commission comment cards we received were positive about the service experienced. This was is in line with the results of the NHS Friends and Family Test and other feedback received by the service.
- All written and verbal feedback received indicated patients were satisfied with the service they had received. Patients said they felt the service provided was excellent and staff were helpful, caring and treated them with dignity and respect. All five patients we spoke with recommended the out of hour's service provided. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available. Patients were also told about the multi-lingual staff who might be able to support them.
- Patients told us that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Staff respected confidentiality at all times.
- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The service monitored the process for seeking consent appropriately.

Good

Are services responsive to people's needs?

We rated the service as good for providing responsive services.

Responding to and meeting people's needs

The provider organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The provider understood the needs of its population and tailored services in response to those needs. For example, the provider had negotiated flexible working patterns with the clinicians to manage the local capacity effectively to accommodate religious and cultural commitments such as Ramadan, Diwali and Christmas.
- The provider engaged with commissioners to secure improvements to services where these were identified. For example, the provider was in discussion with the NHS England to implement the Electronic Prescription Service (EPS), which would enable them to send a prescription electronically to the closest open pharmacy, allowing patients to quickly receive the medication they need.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service, such as alerts about a person being on the end of life pathway. Care pathways were appropriate for patients with specific needs, for example those at the end of their life, babies, children and young people.
- The facilities and premises were appropriate for the services delivered. For example, accessible facilities and baby changing equipment. All base locations offered step free access and were accessible to patients with reduced mobility. However, a hearing induction loop was not available at the Hillingdon OOH PCC and the Harrow OOH PCC.
- The service made reasonable adjustments when people found it hard to access the service. For example, the provider had access to a translation service for those patients who had difficulty communicating in English.
- The service was responsive to the needs of people in vulnerable circumstances. For example, home visits were available for patients whose clinical needs resulted in difficulty attending the service.
- The provider had a contract with some GP practices to provide message handling service between 8am and 9am, and for few hours in the afternoons as required to ensure that services were covered during local GP practices monthly training or staff meeting time.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients were able to access care and treatment at a time to suit them. The service operated from 6.30pm to 8.00am Monday to Thursday and from 6.30pm on Friday until 8am on Monday inclusive. The service also operated on all bank holidays.

The service opening times varied dependent upon the base location. The service opening hours were:

- Hillingdon OOHs PCC: Hillingdon Hospital opened from 7.30pm to midnight Monday to Friday, from 8am to 11pm on a Saturday and from 9am to 11pm on a Sunday.
- Harrow OOHs PCC: Northwick Park Hospital opened from 8pm to 11pm Monday to Friday, from 9am to 11pm on a Saturday and from 9am to 10pm on a Sunday.
- Hounslow OOHs PCC: Skyways Medical Centre opened from 8pm to 10pm Monday to Friday, from 10am to 1pm and 3pm to 7pm on a Saturday and Sunday.
- Patients could access the out of hours service via NHS 111. The service could see walk-in patients (very rare) and a 'walk-in' policy was in place which clearly outlined what approach should be taken when patients arrived without having first made an appointment, for example patients were told to call NHS 111 or referred onwards if they needed urgent care. All staff were aware of the policy and understood their role with regards to it, including ensuring that patient safety was a priority.
- The service had a system in place to facilitate prioritisation according to clinical need where more serious cases or young children could be prioritised as they arrived. The reception staff had a list of emergency criteria they used to alert the clinical staff if a patient had an urgent need. The criteria included guidance on sepsis and the symptoms that would prompt an urgent response. The receptionists informed patients about anticipated waiting times.
- Waiting times, delays and cancellations were minimal and managed appropriately. Where people were waiting a long time for an assessment or treatment there were arrangements in place to manage the waiting list and to support people while they waited. For example, comfort calls had been made by the staff if delayed due to heavy traffic on the roads, while on their way to home visit.

Good

Are services responsive to people's needs?

- The service engaged with people who are in vulnerable circumstances and took actions to remove barriers when people found it hard to access or use services.
- Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs. For example, the patient's own GP or a local pharmacist.

Patients had timely access to initial assessment, test results, diagnosis and treatment. We saw the most recent National Quality Requirements (NQRs) results for the service (May 2018 to July 2018) which showed the provider was meeting the following indicators:

NQR 9b - Telephone clinical assessment within 20 minutes (urgent):

- The provider had met the standard for starting definitive clinical assessment for patients with 'urgent' needs within 20 minutes of the call being answered by a person. Data from May 2018 to July 2018 showed that 97% (on average) of patients defined as in need of 'urgent' assessment had been assessed within 20 minutes.

NQR 9c - Telephone clinical assessment within 60 minutes (all other):

- The provider had met the standard for starting definitive clinical assessment for 'all other' patients within 60 minutes of the call being answered by a person. Data from May 2018 to July 2018 showed that 95% (on average) of 'all other' patients had been assessed within 60 minutes.

In July 2018, the service dealt with 4,519 patient consultations, these consultations consisted of advice calls, primary care centre appointments and home visits.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately. None of the patients we spoke with during the inspection had ever needed to make a complaint about the OOH service.
- The complaint policy and procedures were in line with recognised guidance.
- There was a designated responsible person who co-ordinated the handling of all complaints and feedback received into the service.
- The service reported that there had been 17 complaints received in the last 12 months, the ratio of a number of complaints to patient attendance was 0.05%. We reviewed complaints and found that they were satisfactorily handled in a timely way.
- The service learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, the service had clarified the "booking into hub" protocol and advised all staff to follow the flow chart, record a name of staff in hub accepting the call and kept the case open for the coordinator to carry out the checks.

Good

Are services well-led?

We rated the service as good for leadership.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the service strategy.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- The service was run by a dedicated leadership team and they assured us to implement the changes to address the issues identified during the inspection.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- Senior management was accessible throughout the operational period, with an effective on-call system that staff were able to use.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.
- The new service delivery manager had started two months before the inspection. During the inspection, the previous service delivery manager was also present to support the new service delivery manager.

Vision and strategy

The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The service had a realistic strategy and statement of purpose to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The provider planned the service to meet the needs of the local population.
- The provider monitored progress against delivery of the strategy.
- The provider ensured that staff who worked away from the main base felt engaged in the delivery of the provider's vision and values.

Culture

The service had a culture of high-quality sustainable care.

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed. For example, the service operated an on call manager rota and staff were able to contact a duty manager at any time. This enabled urgent problems to be escalated to management promptly whilst the service was in operation and staff were on site.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. Most staff had received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional time for professional development and evaluation of their clinical work.
- The service aimed to focus on the safety and well-being of all staff. However, some improvements were required. For example, on the day of the inspection, staff we spoke with and written feedback we received, raised concerns regarding inappropriate safety and security arrangements at the Harrow OOH PCC and the Hounslow OOH PCC.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.
- The provider was offering healthcare awards to recognise staff achievements.
- The provider was offering a cycle to work scheme and a car lease scheme.

Governance arrangements

Good

Are services well-led?

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Service specific policies were implemented and were available to all staff. We asked the number of staff to demonstrate their familiarity with the policies and all were able to do so. Staff were confident that if they did not know about a policy they would be able to find out.
- The service had a medical lead who was responsible for monitoring of NQRs and audits, supported by an audit team centrally. A report for the Care UK - North West London then fed back to the Care UK (Urgent Care) Limited national board.
- Overseen by a regional medical director for London and the head of contracts for London; the service delivery manager, departmental managers, together with a team of GPs, nurses, drivers, call handlers and administration staff undertook the day to day management and running of the service.

Managing risks, issues and performance

There were clear and effective processes for managing performance. However, some improvements were required for managing risks.

- The provider maintained a risk register that was visible to all staff.
- There were procedures in place for monitoring and managing risks to patient and staff safety. However, improvements were required. For example, the service was unable to demonstrate that they had an effective monitoring system to assure themselves that appropriate health and safety checks had been undertaken regularly to assess fire safety and legionella risks at the Hillingdon OOH PCC and the Harrow OOH PCC.
- The provider had not assured that all self-employed GPs clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The provider had processes to manage the current and future performance of the service. Performance of employed clinical staff could be demonstrated through the audit of their consultations, prescribing and referral decisions. For example, the provider was monthly auditing patients contacts by completing clinical audit (minimum one case for every clinician) and call listening audit (minimum one case for every clinician). The provider was preparing quarterly reports for individuals which were shared with every clinician to review clinical performance.
- The provider was auditing performance of co-ordinators, call handlers, receptionists and drivers every six months.
- Leaders had oversight of MHRA alerts, incidents, and complaints. Leaders also had a good understanding of service performance against the national and local key performance indicators. Performance was regularly discussed at senior management and board level. Performance was shared with staff and the local CCG as part of contract monitoring arrangements.
- An audit plan had been introduced listing audits which were relevant to an out of hours service and which had positively impacted on the quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality.
- The providers had plans in place and had trained staff for major incidents.
- The provider implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information which was reported and monitored, and management and staff were held to account.

Good

Are services well-led?

- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service used information technology systems to monitor and improve the quality of care.
- The service submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example, the provider had adapted the NHS Friends and Family Test (FFT). This national test was created to help service providers and commissioners understand whether their patients were happy with the service provided, or where improvements were needed. We saw the friends and family test (FFT) results for the last 12 months (August 2017 to July 2018) and 97% of patients were likely or extremely likely recommending this service. The service had received 1,434 responses across the year.
- Staff who worked remotely were engaged and able to provide feedback through daily shift reports. Staff we spoke with told us despite the role being remote and in unsocial hours, they felt well supported by managers and saw managers regularly.
- Staff were able to describe to us the systems in place to give feedback and they had the opportunity to contribute to the development of the service. There were regular team meetings. Staff at all levels were encouraged to attend. There were consistently high levels of constructive staff engagement which included a staff survey titled as 'Over to You' and the results of these showed high levels of staff commitment within the service. We saw an action plan developed to address the areas identified during the recent staff survey.
- The service was transparent, collaborative and open with stakeholders about performance.
- The service informed us that they were in the process of exploring options to develop a patient participation group (PPG), however, this had not yet been implemented.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the service. For example, the service held clinical meetings every two months to monitor clinical quality and improve performance.
- The service held weekly calls every Tuesday to evaluate weekly performance including any breaches. This meeting was chaired by the regional medical lead.
- The service was in the process of evolving an OOH service model with the aim of moving from traditional OOH service into Integrated Urgent Care.
- Staff knew about improvement methods and had the skills to use them.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- There was a strong culture of innovation evidenced by the number of pilot schemes the provider was involved in. For example, the service was using innovative approaches to accessing relevant patient information in conjunction with other providers, through the use of a system called the Co-ordinate My Care (CMC) which provided wider access to palliative care records such as advanced directives and in some cases preferred a place of death. There were systems to support improvement and innovation work.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:The provider had not assured that all self-employed GPs clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.The service was unable to demonstrate that they had an effective monitoring system to assure themselves that appropriate health and safety checks had been undertaken regularly to maintain fire safety and legionella at the Hillingdon OOH PCC and the Harrow OOH PCC.They provider had not carried out site specific lone worker risk assessments. Staff we spoke with and written feedback we received, raised concerns regarding inappropriate safety and security arrangements at the Harrow OOH PCC and the Hounslow OOH PCC.This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.