Houghton Primary Care Centre

Quality Report

Houghton Primary Care Centre, Brinkburn, Crescent, Houghton Le Spring, Tyne And Wear, DH4 5HB
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Date of inspection visit: 10, 20, 21 and 30 January 2017 and 14 February 2017
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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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Houghton Primary Care Centre on 10, 20, 21 and 30 January 2017 and 14 February 2017. Overall the service is rated as requires improvement.

We previously carried out an unannounced focused inspection at Houghton Primary Care on 24 May 2016. We found breaches of legal requirements relating to medicines and the maintenance of records as necessary to demonstrate effective management of the regulated service and those in relation to staff employed. In line with our policy, as it was a focussed inspection, the service was not rated at the time of the May 2016 inspection. The report on the May 2016 inspection can be found by selecting the 'all reports' link for Houghton Primary Care Centre on our website at www.cqc.org.uk.

The provider, Vocare Limited, provides urgent care for minor injuries and illnesses to residents in the Sunderland area from three centres. This report relates to one of these, Houghton Primary Care Centre. However, some data in the report relates to the overall performance across the three locations, where data was not available at location level. You can find the reports for the provider's other locations by searching for Vocare Limited on our website at www.cqc.org.uk, and selecting the 'all reports' link for each location.

Our key findings were as follows:

- There was an open and transparent approach to safety and an effective system in place for recording, reporting and learning from significant events.
- The most recent results of key performance indicators (October and November 2016) reported to commissioners showed the provider was meeting these requirements.
- Risks to patients were assessed and well managed.
- Patients' care needs were assessed and delivered in a timely way according to need.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had mostly been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment. However, there were gaps in some areas, such as training on the Mental Capacity Act and children's safeguarding to the relevant level.

Summary of findings

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs. Although improvements had been made, we found there were some instances where clinical staffing arrangements were lower than the level assessed as needed by the provider. There were short periods of time where, although other member of non-clinical staff were available, the clinical staffing level was at one member of staff.
- There was a system in place that enabled staff access to patient records, and minor injuries units and out of hours staff provided other services, for example the local GP and hospital, with information following contact with patients as was appropriate.
- The service managed patients' care and treatment in a timely way.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- There was a clear leadership structure in place, but there were mixed views from staff on the culture across all three minor injuries units. Although some staff reported they felt supported by management; others raised concerns with us about their experience of managers listening to, responding and addressing their concerns.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider must make improvements are:

- Ensure all staff receive training appropriate to their role including children's safeguarding and in the Mental Capacity Act. Ensure all staff receive appropriate support, including regular supervision and appraisals.
- Ensure oversight and governance arrangements provide assurance that recruitment processes are safe and that action is taken to address areas of known concern, such as addressing gaps in provision of training requirements for staff, in a timely way.

In addition, the provider should:

- Continue to make improvements in the way the service reviews, monitor and deploys the number and mix of staff needed to meet patients' needs to demonstrate a safe environment is maintained for staff and patients.
- Carry out fire evacuation drills in line with risk management strategies set out in the property fire risk assessments.
- Review how they assess the needs of patients who attend in person to make an appointment to make sure risks to patients are assessed and well managed.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The service is rated as good for providing safe services.

- Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. Risks to patients were assessed and well managed.
- Lessons were shared to make sure action was taken to improve safety in the service. When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, and verbal or written apologies.
- The premises were clean and hygienic and good infection control arrangements were in place. The arrangements for managing medicines, including emergency drugs, kept patients safe.
- Staff recruitment and induction policies were in operation. We reviewed the personnel files of three staff members and found that some recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and the appropriate DBS checks. However, for two of the clinicians and one non-clinical manager, references had not been obtained. Managers told us that a decision had been made by leaders that if a GP's GMC checks are up to date and they are on the national performers list, that references were not needed.
- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs. Although improvements had been made, There were no discernible patterns to the lower levels of clinical staff availability. There was evidence the service had taken action to avert the risks caused by lower staffing levels on other dates, such as the clinical services manager undertaking clinical duties and moving staff from other sites.

Are services effective?

Requires improvement

he service is rated as requires improvement for providing effective services.

- Patients' needs were assessed and care was planned and delivered in line with current legislation.

Summary of findings

- There were systems in place to support multi-disciplinary working with other health and social care professionals in the local area. Staff had access to the information and equipment they needed to deliver effective care and treatment.
- The most recent results of key performance indicators (October and November 2016) reported to commissioners showed the provider was meeting these requirements.
- There was evidence of quality improvement activity through clinical audit and improvements made to patient care and patient outcomes as a result of this.
- Some staff had not received appropriate training to enable them to carry out their duties in relation to the Mental Capacity Act and children's safeguarding.
- The majority of non-clinical staff had not received a recent appraisal to identify any learning or development needs.

Are services caring?

Good

The service is rated as good for providing caring services.

- Feedback from patients was positive. Results from the provider's own survey about the service overall, carried out in October 2016, showed the majority of patients were satisfied with the service; 56 out of 68 respondents (82%) said the service was either good, very good or excellent.
- Staff treated patients with kindness and respect, and maintained confidentiality.
- The National GP Patient Survey, published in July 2016 showed scores were above average. For example, 90% of respondents said they had confidence and trust in out of hours staff, compared to 86% nationally.

Are services responsive to people's needs?

Good

The service is rated as good for providing responsive services.

- Feedback received from patients and from management information provided to the local clinical commissioning group indicated that patients were seen in a timely way.
- The National GP Patient Survey, published in July 2016, showed that patients' impressions of how quickly care or advice was received was better than the national average; 66% of respondents felt the timing was about right, compared to the national average of 62%.
- The service had systems in place to ensure patients received care and treatment in a timely way and according to the urgency of need.

Summary of findings

- The service had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed that the service responded quickly to issues raised. Learning from complaints was shared with staff.
- Where patients attended any of the three minor injuries units in person, there was no clinical triage of their needs undertaken prior to booking an appointment. There was no clear information available to patients setting out the parameters of or what type of medical needs could be met by the service. There was a risk of delay in meeting the needs of a patient, where they attended in person and were booked an appointment for needs that could not be met by the service.

Are services well-led?

Requires improvement

The service is rated as requires improvement for providing well-led services.

- The leadership, management and governance of the service assured the delivery of person-centred care which met patients' needs. Staff understood their responsibilities in relation to the service's aims and objectives.
- There was not effective leadership for ensuring safe arrangements for recruitment and training of staff.
- There was a clear leadership structure in place and staff mostly felt supported by management.
- The provider was aware of and complied with the requirements of the duty of candour. There was a clear leadership structure in place, but there were mixed views from staff on the culture within the service. Although some staff reported they felt supported by management; others raised concerns with us about the openness of the service and their experience of managers listening to, responding and addressing their concerns.
- The leadership team drove continuous improvement. There was a clear and proactive approach to seeking out and embedding new ways of providing care and treatment, and we saw several examples of this during the inspection. This included working with accident and emergency clinicians to reduce demand on secondary care services.

Summary of findings

What people who use the service say

We looked at various sources of feedback from patients about the out-of-hours service they received. Patient feedback was obtained by the provider on an ongoing basis and included in their contract monitoring reports. Results from the provider's own survey about the service overall, carried out in October 2016, showed the majority of patients were satisfied with the service; 42 out of 46 respondents (91%) said the service was either good, very good or excellent.

The National GP Patient Survey does not include specific reference to urgent care centres or minor injuries units, however, patients are asked about their satisfaction with out-of-hours services in the locality. The latest results, published in July 2016 showed scores were above average. For example, 90% of respondents said they had confidence and trust in out of hours staff, compared to 86% nationally.

Results from the Friends and Family Test (FFT), carried out for the period October to December 2016 showed the majority of patients were satisfied with the service, with 82.6% of patients who responded for Houghton Primary Care Centre were either extremely likely or likely to recommend the service to their friends and family. (The FFT is a tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience that can be used to improve services. It is a continuous feedback loop between patients and practices).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. There were no completed comment cards from Houghton Primary Care Centre.

We spoke with four patients at Houghton Primary Care Centre. The majority of patients said they were happy with the care they received and thought staff were approachable, committed and caring. One patient raised concerns of a historical nature with us, which did not relate to the provider currently operating this service.

All four patients had attended the service direct to make an appointment. Two of these patients commented they had attended the service as it was either more convenient than their own GP or they had not been able to get an appointment with their own GP.

Areas for improvement

Action the service MUST take to improve

- Ensure all staff receive training appropriate to their role including children's safeguarding and in the Mental Capacity Act. Ensure all staff receive appropriate support, including regular supervision and appraisals.
- Ensure oversight and governance arrangements provide assurance that recruitment processes are safe and that action is taken to address areas of known concern, such as addressing gaps in provision of training requirements for staff, in a timely way.

Action the service SHOULD take to improve

- Continue to make improvements in the way the service reviews, monitor and deploys the number and mix of staff needed to meet patients' needs to demonstrate a safe environment is maintained for staff and patients.
- Carry out fire evacuation drills in line with risk management strategies set out in the property fire risk assessments.
- Review how they assess the needs of patients who attend in person to make an appointment to make sure risks to patients are assessed and well managed.

Houghton Primary Care Centre

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector. The team included a GP specialist advisor, a nurse practitioner specialist advisor, and an additional CQC inspector.

Background to Houghton Primary Care Centre

Vocare Limited provides urgent care for minor injuries and illnesses to residents in the Sunderland area from three centres: These are the minor injuries units at:

- Houghton Primary Care Centre, Brinkburn, Crescent, Houghton Le Spring, Tyne and Wear, DH4 5HB.
- Minor Injuries Unit, Bunny Hill Centre, Hylton Lane, Sunderland, Tyne And Wear, SR5 4BW
- Minor Injuries Unit, Washington Primary Care Centre, Parkway, Washington, Tyne And Wear, NE38 7QZ

We inspected all three locations during January and February 2017, as well as visiting the headquarters for Vocare Ltd, which is Vocare House, Balliol Business Park, Benton Lane, Newcastle upon Tyne, NE12 8EW. There are separate reports for each of these locations. You can find the reports for the provider's other locations by searching for Vocare Limited on our website at www.cqc.org.uk, and selecting the 'all reports' link for each location.

These services in the Sunderland area are commissioned by Sunderland Clinical Commissioning Group (CCG). They are managed and operated by the registered provider Vocare Limited, which is also known locally as Northern Doctors Urgent Care Limited.

Vocare employs a clinical services manager and an operational manager who oversee the day to day running of the three urgent care and minor injuries units. They employ a number of GPs, advanced nurse practitioners, nurse practitioners and junior nurse practitioners. There is also an operational team in place to support delivery of the service during opening hours.

There are approximately 277,000 people in Sunderland area. Sunderland is one of the 20% most deprived districts/ unitary authorities in England. A higher percentage of children in Sunderland live in low income families, at 23.6% or approximately 11,500 children, when compared to the England average of 18.6%. Life expectancy for both men and women is lower than the England average. Male life expectancy is 77.0, compared to the England average of 79.5. Female life expectancy is 80.09, compared to the England average of 83.1. Life expectancy is 9.9 years lower for men and 7.6 years lower for women in the most deprived areas of Sunderland than in the least deprived areas. 178,000 people (64.3% of the population) are aged between 16 and 64 years. The population of people from black and minority ethnic (BME) groups is 4.1% of the population, which is less than the England average of 14.6%.

On average, 1460 patients use the service each week. Approximately 35% of appointments are at the Minor Injuries Unit at Washington; 35% are at the Minor Injuries Unit at Bunnyhill; and 30% are at Houghton Primary Care

Detailed findings

Centre. From data collected by the provider for January 2017 approximately 70% of these patients attend direct, 3% are referred through NHS 111 and 27% are referred through the out of hours service.

Patients can access the service from 10am to 10pm Monday to Friday and 8am to 10pm Saturdays, Sundays and Bank Holidays. Calls to the service are handled by North East Ambulance Service (NEAS) via the NHS 111 telephone number. The three minor injuries units operate a triage model where all patients receive telephone assessments by a clinician. This prevents unnecessary journeys for patients and enables appropriate coordination of appointments according to clinical urgency and demand. Patients can also book an appointment time by attending the service in person. There is no clinical triage prior to making an appointment through this method, but reception staff do have a generic assessment to help them identify those patients whose needs may be more urgent or those patients presenting with a medical emergency. The reception staff are provided by NHS Property Services as part of the contractual arrangements for the premises.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

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

Please note that when referring to information throughout this report, for example any reference to the National Quality Requirements data, this relates to the most recent information available to the CQC at that time.

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew.

We carried out announced visits as follows:

- 10 and 30 January 2017 at Vocare House
- 20 and 21 January 2017 and 14 February 2017 at Houghton Primary Care Centre

During our visit we:

- Spoke with a range of staff (the head of governance, a clinical manager, three GPs, five nurse practitioners, an advanced nurse practitioner, a health care assistant, an operations manager, an operations team leader, a dispatcher and a clinical services manager). We spoke with personnel who managed the maintenance and cleaning of the premises, who were not employed by, but worked closely with the service.
- Looked at the policies and procedures used to govern activity at the service.
- Looked at information the practice used to deliver care and treatment plans.
- Observed how staff interacted with patients in the reception and waiting areas, and talked with patients, carers and/or family members.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events and staff were well aware of their roles and responsibilities in relation to this.

- Staff told us they would inform the service manager of any incidents and there was a recording form available on the service's computer system. All staff could access the system and input data.
- The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received support, an explanation based on facts, an apology where appropriate and were told about any actions to improve processes to prevent the same thing happening again.
- Significant events were discussed at dedicated monthly and quarterly meetings.
- The service carried out a thorough analysis of such events and ensured that learning from them was disseminated to staff and embedded in policy and processes.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the service. For example, following an incident of missed diagnosis of severe epiglottitis the service provided additional information to staff to highlight the seriousness and indications of this condition to all staff in the monthly bulletin. (Epiglottitis is inflammation of an area of soft tissue in the throat, and the swelling associated with this can interfere with breathing.)

Overview of safety systems and processes

The practice had systems, processes and practices in place to keep people safe, although improvements could be made:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. Staff demonstrated they understood their responsibilities. However, not all staff knew who the safeguarding lead was for the service. The provider sent us a new policy following the inspection to show how they planned to revise the leadership arrangements for safeguarding to give greater accountability and support to staff at a local level. Staff we spoke with told us they had received training on safeguarding children and vulnerable adults relevant to their role. However, nurse practitioners had not received training to level three in the safeguarding of children. The expectation for GPs was that training requirements for safeguarding were checked through the national appraisal process for GPs, but no separate assurance processes were in place to confirm this. We looked at a sample of records and these did not include any reference to whether or not appropriate training on safeguarding had been completed by clinicians.
- All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- We reviewed the personnel files of six staff members and found that some recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and the appropriate DBS checks. However, for two of the clinicians and one non-clinical manager, references had not been obtained. Managers told us that a decision had been made by leaders that if a GP's GMC checks are up to date and they are on the national performers list, that references were not needed.

Medicines management

We carried out a responsive focused inspection of Houghton Primary Care Centre on 24 May 2016. During this inspection we found there were risks in the way the service managed medicines as the process for checking expiry dates of medicines available to treat patients in a medical emergency was not effective.

Requires improvement

Are services safe?

In January 2017, we found the service had made improvements to the process for checking the expiry dates of medicines. A more rigorous checking process was in place. A daily emergency trolley checklist was implemented and this included a list of all emergency equipment and medicines to remind staff to check availability and also whether the items were in date. This included an action plan section to record any actions needed and confirm follow up completed. We saw this was in place across each of the three registered minor injuries units. However, we found out of date (as of October 2016) medicine used to treat severe hypoglycaemic reactions in the refrigerator, although there was also a supply of this medicine, which was in date.

Overall, the arrangements for managing medicines, including emergency drugs, in the service minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- Regular medication audits were carried out to ensure the service was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use.
- The service held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had standard operating procedures in place that set out how controlled drugs were managed in accordance with the law and NHS England regulations. These included auditing and monitoring arrangements, and mechanisms for reporting and investigating discrepancies. We reviewed the controlled drugs registers maintained by the service registers and found adequate arrangements. The provider held a Home Office licence to permit the possession of controlled drugs within the service. There were also appropriate arrangements in place for the destruction of controlled drugs.
- Advanced nurse practitioners had qualified as Independent Prescribers and could therefore prescribe medicines for clinical conditions within their expertise. They received mentorship and support from the medical staff for this extended role

Monitoring risks to patients

Risks to patients were assessed and well managed.

- The service had well established risk management systems in place and had been accredited with the International Standard ISO 31000 (Risk Management). A number of risk assessments had been developed and undertaken; including a fire and a health and safety risk assessment. As part of the ISO 31000, regular external audits were carried out before the service could be reaccredited with the Standard.
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the office. The service had up to date fire risk assessment, but there was no evidence of recent fire evacuation drills.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The service also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (legionella is a type of bacteria found in the environment which can contaminate water systems in buildings and can be potentially fatal).

Staffing

Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs. Weekly meetings were held for line managers to review staffing levels and identify any gaps. The service had a dedicated 'rota team' and used a computerised system to plan staffing levels. There was a rota system in place for all the different staffing groups to ensure there were enough staff on duty. A forecast model was used to assess the number of staff required, this took into account the number and type of calls made during previous similar time periods.

At the May 2016 inspection of Houghton Primary Care Centre we found there were some occasions when staffing levels were below the provider's assessed requirements. Vocare managers told us improvements had been made to ensure appropriate staffing levels across the service. Their strategy included:

- Several recruitment drives, with further interviews planned as part of the ongoing recruitment activity.
- A review of the skills mix within the service to address recruitment difficulties. The service had started to recruit emergency care practitioners and healthcare assistants as well as GPs and nurse practitioners.

Requires improvement

Are services safe?

- Deploying non-clinical support staff, such as the operations manager, team leaders and dispatchers, on site to provide additional support to clinical staff.

However, we found there were continuing concerns about the clinical staffing levels within the unit. We looked at the actual clinical staffing arrangements across 15 weeks from 12 September to 1 January 2017. We found there were instances where clinical staffing arrangements were lower still lower than the level assessed as needed by the provider. There were short periods of time, where there was one clinical staff member on site (either a GP or a nurse practitioner). There were four one-and-a-half-hour periods (on 18 September 2016, 30 October 2016, 17 November 2016 and 15 December 2016) and two three-hour periods (on 27 September 2016 and 25 October 2016) where there was one clinical member of staff. There were, however, other non-clinical staff members on site, both from the provider and receptionists provided by NHS Property.

There were no discernible patterns to the lower levels of clinical staff availability. There was evidence the service had taken action to avert the risks caused by lower staffing levels on other dates, such as the clinical services manager undertaking clinical duties and moving staff from other sites. Managers also told us, where particular clinical skills were required, but not available at Houghton Primary Care Centre, staff at the other locations would be called upon for support. For example, if a patient needed to speak with a GP a phone call could be arranged (if appropriate) or the patient was offered an appointment at one of the other locations. Staff told us they had observed improvement in staffing levels over the last six months.

Arrangements to deal with emergencies and major incidents

- Emergency equipment was available including access to oxygen and a defibrillator (used to attempt to restart a person's heart in an emergency). At the inspection of Houghton Primary Care Centre in May 2016, we highlighted there were no paediatric pads for use on older children. In January 2017, we found the service had addressed this issue. Paediatric pads were now available
- Emergency medicines were available securely in the centre and all staff knew of their location. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All but one of the medicines we checked were in date and fit for use. We found out of date (as of October 2016) medicine used to treat severe hypoglycaemic reactions in the refrigerator, although there was also a supply of this medicine, which was in date.
- A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the service, such as power cuts and adverse weather conditions. Risks were identified and mitigating actions recorded to reduce and manage the risk. For example, the computer system could be accessed from various sites and appointments could be arranged at the other locations within Sunderland if necessary.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Staff assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The service had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The clinical director published a regular bulletin for staff; this included information about any new or amended guidelines.
- The service monitored that these guidelines were followed.

Management, monitoring and improving outcomes for people

The provider was required to report monthly to the clinical commissioning groups on their performance against standards which includes audits, whether face-to-face assessments happened within the required timescales, seeking patient feedback and actions taken to improve quality.

We saw that the most recent results of key performance indicators (October and November 2016) reported to commissioners. This data was reported at service level, covering all three registered minor injuries units. This showed the provider was meeting most of these requirements.

In October 2016, 99.8% of patients were admitted, transferred or discharged within four hours of their arrival. In November 2016, this was 99.6%. Both months were within the indicator threshold rate of 95%.

In both October and November 2016, the service achieved 100% for notification of attendance at the service in a timely way to other professionals involved in the delivery of health and social care, such as a patient's GP, community nursing or mental health teams, by 8am the next working day.

In October 2016, 46.5% of patients, and in November 2016, 46.1% of patients were discharged from the service are requiring as no further action.

There was evidence of quality improvement activity including clinical audit.

- An assurance framework was in place; annual audits were carried out and there was also a three year rolling audit schedule. Responsive audits were carried out where appropriate and improvements implemented and monitored where necessary. The service had carried out clinical audits for a number of areas of prescribing, including the prescribing of antibiotics.
- The service participated in local audits and national benchmarking.
- The service regularly reviewed national studies and implemented improvements to services. Recent action taken included the development of a sepsis toolkit (sepsis is a life-threatening condition that arises when the body's response to infection injures its own tissues and organs); clinical leaders had worked with specialists from secondary care, including paediatric consultants and intensive care clinicians and had implemented a set of guidelines and information leaflets for staff and patients on how to recognise sepsis and ensure treatment is provided as soon as possible. The toolkit was accessible to all clinicians at the Vocare House site, at all of the hospital and urgent care sites.

Effective staffing

We carried out a responsive focused inspection of Houghton Primary Care Centre on 24 May 2016. During this inspection we found the service did not maintain appropriate records relating to the employed staff. In January 2017, we found improvements had been made. Managers had access to the e-learning system used by staff and could produce reports detailing what training staff they line-managed had undertaken. They also maintained a record of other training for staff.

- The service had an induction programme for all newly appointed staff. New staff were supported to work alongside experienced staff and their performance was regularly reviewed during their induction period.
- Clinical supervision processes were in place for the salaried GPs, which included reflective feedback and a review of their professional standards. A clinical supervision policy had recently been implemented; this set out expectations for clinicians and their supervisors that appraisals would be carried out annually.
- The performance of each clinician was audited regularly. Based on the level of concern identified

through the audit, clinicians were rated on a three point scale - red flag, borderline or proficient. A red flag meant all clinical work was ceased and the clinician was invited in to discuss the results further and reflect on their work; borderline; meant the clinician could continue to work but were invited to reflect on their consultation and were audited again within three months; and proficient. Audits were carried out every three, six or 12 months or more frequently, depending on the clinician's results.

- The learning needs of staff were identified through ongoing assessments. Monthly training sessions were provided for all clinical staff and they were provided with a seasonal clinical bulletin which included several 'learning points'.
- The arrangements for ensuring that all staff received appropriate training were not sufficiently rigorous. The service had a mandatory training programme that covered topics such as information governance, equality and diversity, child protection and infection control. We looked at a sample of staff files. There were some records of on-line training for staff. However, there were gaps in training for child safeguarding and the Mental Capacity Act. Of the six clinical staff training records we looked at none had received training in children's safeguarding to the required level 3 as set out in the providers mandatory training programme. Most staff had received some awareness training, but for the majority this was to level one only. None of these staff had received training in the Mental Capacity Act 2005. The clinical services manager told us they were aware of these gaps and were exploring opportunities to source this training from other local agencies, such as the local clinical commissioning group and the local authority. However, there were no firm plans as to how this training would be delivered.
- Managers did not have a clear overview of whether GPs had completed mandatory training. There were no processes in place to monitor that this training, including children's safeguarding, basic life support and infection control, had been completed by the GPs.
- The arrangements for carrying out staff appraisals for staff were unsatisfactory. Managers told us that department leaders were responsible for arranging appraisals. We looked at a sample of staff files; the majority staff had not received a recent appraisal, where for example, training needs were identified.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the service's patient record system and their intranet system.

- This included access to required 'special notes'/summary care records which detailed information provided by the patient's GP. This helped the out-of-hours staff in understanding a person's need.
- The service shared relevant information with other services in a timely way, for example when referring patients to other services.
- The provider worked collaboratively with other services. Patients who could be more appropriately seen by their registered GP or an emergency department were referred.
- Clinical notes were sent to the patient's registered GP electronically by 8am the following morning. The most recent key performance indicator results (October and November 2016) showed that the service had achieved 100%; all notes were sent to the relevant GP by 8am.
- Clinicians commented that patients often attend the service with chronic health needs or other non-urgent health problems, that would normally be dealt with by the person's GP. However, as a service they were encouraged to not turn any patient away. Managers told us the commissioners of the service wanted to maintain a facility for patients to walk into the service and make an appointment. This led to the service providing routine health appointments as well as minor injuries and urgent care. Many of the patients we spoke with told us they had come into the service to make an appointment, as this was more convenient than or they had been unable to get an appointment with their own GP service.

Consent to care and treatment

Patients' consent to care and treatment was mostly sought in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements.
- When providing care and treatment for children and young people, assessments of capacity to consent were carried out in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP assessed the patient's

Requires improvement

Are services effective?

(for example, treatment is effective)

capacity and recorded the outcome of the assessment. However, some staff were less familiar with the requirements of the Mental Capacity Act 2005. Staff had not received training to support them in this area.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed throughout the inspection that members of staff were courteous and very helpful to patients when interacting with them in reception and waiting areas.

Results from the provider's own survey carried out in October 2016 showed the majority of patients were satisfied with the service:

- 42 out of 46 respondents (91%) said the service was either good, very good or excellent;
- 52 out of 56 respondents (92%) said they would be either extremely likely or likely to recommend the service to their friends and family.

The National GP Patient Survey does not include specific reference to urgent care centres or minor injuries units, however, patients are asked about their satisfaction with out-of-hours services in the locality. The latest results, published in July 2016 showed scores were above average. For example, 90% of respondents said they had confidence and trust in out of hours staff, compared to 86% nationally.

Results from the friends and family test (FFT), carried out for the period October to December 2016 showed the majority of patients were satisfied with the service, with 82.6% of patients who responded for Houghton Primary Care Centre were either extremely likely or likely to recommend the service to their friends and family. (The FFT is a tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience that can be used to improve services. It is a continuous feedback loop between patients and practices).

We did not receive any CQC comment cards from Houghton Primary Care Centre.

Care planning and involvement in decisions about care and treatment

The service provided facilities to help patients be involved in decisions about their care. Staff told us that translation services were available for patients who did not have English as a first language. Sign language interpreters and a braille translation service were also available.

Patients reported they felt involved in decision making about the care and treatment they received. Results from the provider's own survey about the service overall, carried out in October 2016, showed that 62 out of 72 respondents (86%) were satisfied with how the health professional explained things to them.

Clinicians made appropriate use of special notes from patients' own GPs during consultations. Special notes are a way in which the patient's usual GP can share information with out-of-hours clinicians, for example, about patients with complex needs or nearing the end of life and their wishes in relation to care and treatment.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Services were planned and delivered to take account of the needs of different patient groups. For example:

- Translation services were available. Hearing loops were available hearing loop to assist communication with those patients with hearing impairment.
- In response to a high volume of calls to the service from patients with queries about their medication, the provider had employed clinical pharmacists to answer calls and issue prescriptions, where appropriate. This meant if patients accessed the service through the NHS 111 line, they did not have to attend a centre and this freed up time for doctors on shift to continue to triage and treat patients.
- There were systems in place to monitor demand in real time. This meant work could be shared more effectively between clinicians, reducing waiting times for patients.
- There were three centres across Sunderland where patients could attend to see a GP or a nurse practitioner.

Access to the service

The service was open from 10am to 10pm Monday to Friday and between 8am and 10pm on Saturday, Sunday and Bank Holidays.

Patients could access the service via NHS 111. Patients who needed to be seen face to face were allocated an appointment at one of three sites across Sunderland. Patients could also attend in person at any of the three minor injuries units to make an appointment.

Feedback received from patients and performance management information about the overall service indicated that in most cases patients were seen in a timely way. In October 2016, 99.8% of patients were seen, treated and discharged or admitted to hospital or another service within four hours of their arrival. In November 2016, this was 99.6%. Both months were above the indicator threshold rate of 95%.

The National GP Patient Survey, published in July 2016, showed that patients' impressions of how quickly care or advice was received out of hours was better than the national average; 66% of respondents felt the timing was about right, compared to the national average of 62%.

The provider's own survey undertaken in October 2016 showed:

- 45 out of 55 respondents (81%) were satisfied with the time taken to speak to a health professional.

All four patients had attended the service direct to make an appointment. Two of these patients commented they had attended the service as it was either more convenient than their own GP or they had not been able to get an appointment with their own GP.

Where patients contacted the service through the NHS 111 phone line, the service had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

However, where patients attended in person to make an appointment there was no clinical triage prior to making an appointment. Reception staff had a generic assessment to help them identify those patients whose needs may be more urgent or those patients presenting with a medical emergency. If they were concerned or in any doubt, staff told us reception staff would request clinical staff see the patient as a matter of urgency.

There was no clear information available to patients setting out the parameters of or what type of medical needs could be met by the service. Those who contacted the service via the NHS 111 phone line were directed to the most relevant service, such as A&E, their own registered GP or for self-care, where they did not have an urgent care need or minor injuries appropriate to this service. However, those patients who attended in person were booked the next available appointment. Where the patient's needs could not be met by the service, for example, where they had serious eye injuries, the clinician would redirect them when they attended for this appointment. This could lead to a delay in the patient having their needs met.

Listening and learning from concerns and complaints

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

- The complaints policy and procedures were in line with recognised guidance and contractual obligations.
- There was a designated responsible person who handled all complaints. Each complaint was then allocated to an independent person or team to investigate.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- We saw that information was available to help patients understand the complaints system. Leaflets detailing the process were available in the waiting rooms and there was information on the service's website.

We looked at three complaints received in the last 12 months across the Vocare Limited service and found these were satisfactorily handled and dealt with in a timely way. The service displayed openness and transparency when dealing with complaints.

Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, following a complaint about the lack of support for a visually impaired patient; an agreement was made with an organisation to provide information in a braille format.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

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

- The provider had a mission statement, this was; "Our mission is to provide clinically-led services and 24/7 urgent care in hospitals, at our centres and at home, as well as leadership around care policy development and service regulation".
- Staff knew and understood the service's values.
- The service had a supporting business plan which reflected the vision and values and was regularly monitored.

Governance arrangements

The service had an overarching governance framework which supported the delivery of the strategy and good quality care.

- There was a clear staffing structure and staff were aware of their own roles and responsibilities.
- Service specific policies were implemented and were available to all staff.
- Managers had a good understanding of their performance against National Quality Requirements and key indicators. These were discussed at senior management and board level. Performance was shared with staff and the local clinical commissioning groups as part of contract monitoring arrangements.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- However, there was not effective leadership for ensuring safe arrangements for recruitment and training of staff.

Leadership, openness and transparency

Staff told us managers were approachable and always took the time to listen.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support and training for all staff on communicating with patients about notifiable safety incidents. Managers encouraged a culture of openness and honesty. Systems were in place to ensure that when things went wrong with care and treatment:

- The service gave affected people reasonable support, truthful information and a verbal and written apology
- The service kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place, but there were mixed views from staff on the culture within the three minor injuries units. Although some staff reported they felt supported by management; others raised concerns with us about their experience of managers listening to, responding to, and addressing their concerns. We asked if any staff surveys had been conducted. The provider told us this was underway but did not provide us with the results of this.

- The staff we spoke with had mixed views as to how open the culture was within the service. Some staff told us they felt discouraged about raising issues and ideas for improvement. Some told us they felt they did not have time to reflect on ways of working and ways in which they could improve. They told us there was an expectation that mandatory training was conducted within their own time and they were not remunerated for this. Other staff told us they were given five days paid study leave per year.
- There were arrangements in place to ensure the staff were kept informed and up-to-date. This included feedback on incidents, complaints or safeguarding that staff had reported.
- Medical indemnity cover was provided for clinical staff. This was an incentive to improve staff well-being and to encourage new staff to join the organisation.
- During operational hours staff had access to team leaders and on-call clinical support at all times.

Seeking and acting on feedback from patients, the public and staff

Challenge from people who used the service, the public and stakeholders was welcomed and seen as a vital way of holding the service to account. The service encouraged and valued feedback from patients, the public and staff.

The service had gathered feedback from staff through meetings and one to one discussions, as well as a staff

Are services well-led?

Requires improvement

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

survey. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the service was run.

Continuous improvement

There was a focus on continuous learning and improvement.

- Two detailed reviews of the service were carried out each year. 'A day in the life of' sessions were attended by various managers and team leaders, including operations staff, clinicians, the head of governance and the local clinical director. All activities (initial telephone calls, triage calls, home visits and centre consultations) from a particular day were reviewed in detail. The team considered whether the advice given and patient pathways were appropriate. Any learning points were disseminated to staff, usually within the seasonal clinical bulletin.
- In response to a perception from secondary care staff that referral rates to hospital were high, some accident and emergency clinicians worked with the service and carried out triaging of patients so they were able to understand the process and provide guidance as to where hospital referrals could be avoided. An initial review of this showed that patients were more appropriately triaged and there was a reduction in the number of inappropriate referrals to accident and emergency.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems and processes established to ensure compliance with regulations did not operate effectively. There was insufficient governance and oversight to provide assurance that; recruitment processes were safe and that action was taken to address areas of known concern, such as addressing gaps in provision of training requirements for staff, in a timely way. This was in breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Some staff had not received appropriate training to enable them to carry out the duties they were employed to do, including children's safeguarding, and Mental Capacity Act 2005. Some staff did not receive appropriate appraisals to support them to carry out the duties they were employed to do. This was in breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.