Herschel Medical Centre Primary Care Centre

Quality Report

Herschel Medical Centre Primary Care Centre
Osborne Street
Slough
Berkshire
SL11TT
Tel: 03000 243 333
Website: http://ebpcooh.org.uk

Date of inspection visit: 4 October 2016
Date of publication: 12/01/2017

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?	Good
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 East Berkshire Primary Care Out of Hours Services Limited – Herschel Medical Centre Primary Care Centre on 4 October 2016. Overall the service is rated as requires improvement.

Specifically, we found the service to require improvement for the provision of safe and well led services. The service is rated good for providing effective, caring and responsive services.

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

- There was an effective system for reporting and recording significant events. A wide range of events was reported. They were systematically assessed and dealt with.
- Risks to patients were assessed and well managed. However, some systems to address these risks were not implemented well enough to ensure patients were kept safe. For example, the service had not always taken appropriate action in relation to recent alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA). We found vehicle equipment checks were not completed in line with the service policy and regular infection control checks were not completed on-site. Unlogged prescriptions were found in the Out of Hours (OOH) vehicles.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- There 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.
- Verbal and written patient feedback said they were treated with compassion, dignity and respect and despite that the service provided single episodes of care, patients were involved in their care and decisions about their treatment. Comment cards that patients completed confirmed this finding.
- The premises were well equipped to treat patients and meet their needs, with the exception of some items of

Summary of findings

equipment, such as blood glucose testing strips and needles, which were out of date. The out of date equipment was found in the vehicle and the services' on site stock.
- There was limited information on display about how to complain and no complaint information was available in the mobile vehicles for patients receiving care and treatment in their place of residence. The complaints we reviewed were fully investigated by a senior member of staff and patients were responded to with an apology and full explanation.
- Patients said they found it easy to make an appointment and data showed most patients were seen or contacted in a timely manner.
- There was a clear leadership structure. Staff felt supported by the management team.
- The service was aware of and complied with the requirements of the duty of candour.
- The provider had a clear vision and strategy promoting positive outcomes for patients in Berkshire and Richmond.
- The provider has been working with the local Clinical Commissioning Groups to discuss how to improve and maintain response times for patients accessing the service.

However, there were also areas of practice where the service needs to make improvements. The areas where the service must make improvements are:

- Ensure the governance framework and processes are improved. Including a review of the systems and processes to ensure that the service actions patient safety alerts and MHRA (Medicines and Healthcare Products Regulatory Agency) alerts; undertaking site specific quality improvement activity and a review of the governance arrangements and operating procedures for the services use of Controlled Drugs, including an application for a Controlled Drugs Home Office license.
- Ensure all equipment both in vehicles and on-site is within date and regularly tested in accordance with the manufacturing guidelines; infection control audits are completed regularly; and medical equipment checking identifies and removes items passed the expiry date.

The areas where the service should make improvements are:

- Review signage ensuring the correct telephone number is displayed at Herschel Medical Centre Primary Care Centre.
- Ensure that staff undertaking chaperoning duties have received the appropriate training, including the drivers of the OOH vehicles.
- Information to patients about the complaints procedure should be on display and carried in vehicles to be made available to patients receiving care and treatment in their place of residence.
- Ensure prescription stationary is stored securely at all times, specifically in the OOH vehicles.

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 provider is rated as requires improvement for providing safe services as there are areas where improvements should be made.

- There was an effective system for reporting and recording significant events. A wide range of events was reported. They were systematically assessed and dealt with.
- Lessons were shared to make sure action was taken to improve safety. There was evidence of collaboration with other healthcare services in implementing systems to avoid the recurrence of certain events.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- Vehicle checks were not carried out in accordance with the provider's policy, which resulted in equipment not being appropriately checked and fit for purpose.
- There was out of date equipment also found on-site at Herschel Medical Centre.
- Risks to patients were assessed and well managed. However, some systems to address these risks were not implemented well enough to ensure patients were kept safe. For example, the service had not always taken action appropriate action in relation to recent alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA). They had not ensured all equipment both in vehicles and on-site was within date and regularly tested in accordance with the manufacturing guidelines; and infection control audits were not completed regularly and some medical equipment had passed the expiry date.
- The service had clearly defined processes and practices in place to keep people safe and safeguarded from abuse. However, these were not always followed for example staff training in chaperoning was not up to date.
- Aspects associated to medicines management was well managed. However controlled drugs records were not always accurate.

Are services effective?

Good

The provider is rated as good for providing effective services.

Summary of findings

- Data showed the provider had consistently high performance against the National Quality Requirements (the minimum standards for all out-of-hours GP services) to help ensure patient needs were met in a timely way. For example, in August 2016, 100% of urgent cases had a face-to-face consultation within 120 minutes and 100% of less urgent cases had a face-to-face consultation within 360 minutes.
- Staff assessed needs and delivered care in line with current evidence based guidance. A range of methods were used to help ensure that clinicians kept up to date.
- Clinical audits demonstrated quality improvement and as well organisational performance also focussed on individual clinician's decisions. However, these were at a provider level and not always site specific.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. There was a consistent focus on ensuring staff had completed mandatory training. There were appraisals and personal development plans for staff.

Are services caring?

Good

The provider is rated as good for providing caring services.

- Feedback from patients about their care and treatment was consistently and strongly positive. Patients, their relatives and carers were all positive about their experience and said they found the staff friendly, caring and responded to their needs.
- We observed and heard a kind compassionate culture.
- There was good evidence that the provider took positive steps to promote the service and informed patients of what they could expect from the service.
- Although uptake was low, patient experience surveys conducted by the provider indicated a high degree of satisfaction with the service provided and a high number of patients who had used the service would recommend it. For example, the patient satisfaction survey (January 2016 - March 2016) indicated all of the patients said they were treated politely and with respect by the healthcare professional they saw.
- The provider was mindful and respectful of the needs of patients, and their carers, receiving end of life care and, where necessary, provided them with a direct telephone number so that they were able to access clinician's out-of-hours directly.

Are services responsive to people's needs?

Good

The provider is rated as good for providing responsive services.

Summary of findings

- The service engaged with the NHS England Area Team and local clinical commissioning groups to secure improvements to services where these were identified.
- Patients said access was good and National Quality Requirements data showed patients were consistently seen or contacted in a timely manner.
- The provider had good facilities and mobile vehicles were well equipped to treat patients and meet their needs. However, signage for patients visiting Herschel medical centre displayed the incorrect telephone number. Patients we spoke with and comment cards we received showed that patients were satisfied with the service provided.
- Information about how to complain was available but not clearly displayed or carried in mobile vehicles. Complaints we reviewed showed that the service responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Requires improvement

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

- The service had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision, it was well understood and staff were committed to it.
- Governance and performance management arrangements helped to support high quality responsive care. However, the management team were not sighted on matters contributing to patient safety such as the process for ensuring staff had acted upon patient safety and MHRA alerts. Quality improvement activity was often at a provider level and not location specific. Furthermore, the service did not have a Controlled Drugs Home Office license which was required as the service used Controlled Drugs.
- There was a clear leadership structure and staff felt supported by management. This was evident at local level and senior level. Staff were always able to contact senior managers and who were visible across the service.
- The views of patients and staff were gathered by means of questionnaires and comments cards and responded to.
- The service complied with the requirements of the duty of candour and encouraged a culture of openness and honesty.
- In areas where we found some concerns, such as relating to the lack of formal chaperone training, the service responded quickly to address the issues raised from our feedback.

Summary of findings

- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs. The service was seeking innovative approaches to accessing relevant patient information in conjunction with other providers, through the use of a system called the Medical Interoperability Gateway (MIG) which provided wider access to records.

Summary of findings

What people who use the service say

The provider completed a site specific patient experience survey between 1st January 2016 and 31st March 2016. Although uptake was low (8 responses), results showed Herschel medical centre primary care centre was performing well and patients were satisfied with the service. For example:

- All 8 respondents rated the attitude of receptionists as excellent, very good or good.
- All 8 respondents said the GP explained their condition and treatment in a way they could understand.
- All 8 respondents said they were treated politely and with respect by the healthcare professional they spoke with.
- All 8 respondents said they would recommend the service to friends and family if they needed similar care or treatment.

We gathered the views of patients using the out-of-hours service. We received 31 Care Quality Commission comment cards completed by users of the service. Feedback indicated that staff were caring, helpful and polite.

Herschel Medical Centre Primary Care Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included two specialist advisors (one GP and one operational manager; both with experience of working in an out-of-hours service).

Background to Herschel Medical Centre Primary Care Centre

East Berkshire Primary Care Out Of Hours Services Limited is a not-for-profit social enterprise that provides urgent medical care and advice out-of-hours (OOH) for approximately 400,000 patients in Berkshire, 30,000 in South Buckinghamshire and 250,000 in Richmond and Twickenham from its operational headquarters in Bracknell.

Herschel medical centre primary care centre is one of the registered locations for the OOH GP service provided by East Berkshire Primary Care Out Of Hours Services Limited. The full address for this location is:

Herschel Medical Centre, Osborne Street, Slough, Berkshire, SL1 1TT.

The administrative base and headquarters for East Berkshire Primary Care Out Of Hours Services Limited is located at Abbey House, Bracknell in Berkshire.

Herschel Medical Centre is situated in rented spaces within Herschel Medical Centre GP practice. The provider is contracted by the NHS clinical commissioning groups across Berkshire and provides OOH primary medical services to registered patients and those requiring immediately necessary treatment in Slough, Berkshire and the surrounding area when GP practices are closed. This includes overnight, during weekends, bank holidays and when GP practices are closed for training.

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.

The health of people in Slough is similar when compared with the national averages. For example, 49% of people within Slough have a long-standing health condition, similar to the national average which is 54%.

The population of Slough has a higher proportion of people aged 25 to 50 years when compared to national averages and a lower proportion of people aged over 50. Life expectancy for both men and women is similar when compared with the national average.

Why we carried out this inspection

We inspected the service delivered at Herschel medical centre primary care centre as part of our new comprehensive inspection programme. This was part of a wider East Berkshire Primary Care Out Of Hours Services Limited inspection.

Detailed findings

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew. We carried out an announced visit on 4 October 2016. During our visit we:

- Spoke with other organisations such as commissioners to share what they knew about the performance and patient satisfaction of the out of hour's service.
- Spoke with a range of staff including receptionists, a driver, clinical staff, managers and board members. We spoke with sessional GPs and clinical staff.
- Observed how patients were treated at reception areas and received feedback from patients, carers and/or family members who used the service.
- Reviewed 31 Care Quality Commission (CQC) comment cards where patients and members of the public shared their views and experiences of the service.
- Checked the mobile vehicles for transporting the GPs and equipment on home visits.

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 National Quality Requirement data, this relates to the most recent information available to the CQC at that time

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was an effective system for reporting and recording significant events.

- There was a policy on what constituted a significant event and how this should be reported. The policy and the reporting forms known as 'IR1' forms were available on the intranet 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 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. This included sharing investigation findings and relevant learning from incidents that happened at other locations within the service.
- The provider did not have appropriate system in place for actioning safety alerts including medicine and equipment alerts. administrative base and headquarters located in Bracknell. Information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance was received by the operations manager and one of the medical directors.

Overview of safety systems and processes

We saw there was systems, processes and practices to keep patients safe and safeguarded from abuse. However, the inspection highlighted several systems which required a review:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. There were policies were accessible to all staff, which clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a nominated lead member of staff for safeguarding. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child safeguarding level 3.
- The provider had designed a computerised system to make referrals into many health and social services across Berkshire. The system allowed the user to input the referral details and send it automatically to all the relevant services. The following working day, within hours, the administration team checked that the referral had been received. The provider had collated all the contact details from the services and agreed that the service would accept this form of referral. This meant that any delay or risk of referrals not going to the appropriate service was mitigated. This system was used to notify social services and the patients named GP of any safeguarding concerns. The lead GP for safeguarding was also copied in to the referral and they ensured that the named GP was aware of the concerns.
- We saw notices advising patients that chaperones were available if required. All staff had access to a comprehensive service specific chaperone guide. This was accessed via 'web manuals' and mobile devices (for mobile GPs and drivers who saw patients in their own homes) and included 12 different sections about the role of a chaperone. For example, one section clearly detailed chaperone policy consent and another section included a 10 stage checklist for consultations involving intimate examinations. All staff 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). However, staff who acted as chaperones referred only to guidance and had not received training for this role. Following the inspection, we saw the provider had prioritised chaperone training and approximately five members of staff across the service were completing chaperone training each day with a view for full compliance by the end of October 2016.
- The provider maintained appropriate standards of cleanliness and hygiene. The primary care centre was located at another NHS property and the provider had limited control over their environment. We saw the premises were clean and tidy. We reviewed the latest

annual infection control audit which was undertaken in April 2016. Some of the recommendations had not been actioned due to the service not being able to make building changes as it is not their building. For example; one corrective action identified was that all taps should be lever action or sensor operated in clinical hand wash basins. The service had informed the landlord that these changes were required. Plans were provided which demonstrated these changes would be made in November 2016.

- Infection control checks were not being regularly undertaken to identify ongoing concerns. For example; the sharps bins in both of the rooms that were being used were not changed after three months in accordance with current guidelines. A sharps bin is a specially designed rigid box with a lid to dispose of medical supplies such as needles and syringes.
- We reviewed a sample of five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS checks).
- There were systems to check whether sessional GPs met requirements such as having current professional indemnity, registration with the General Medical Council, DBS checks and were on the Performers' list (the Performers' list provides a degree of reassurance that GPs are suitably qualified, have up to date training, have appropriate English language skills and have passed other relevant checks such as with the Disclosure and Barring Service).

Medicines Management

- The arrangements for managing medicines at the service, including emergency medicines and vaccines, did not always keep patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). The service carried out regular medicines audits, with the support of the local CCG medicines management team, to ensure prescribing was in accordance with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- In September 2016, the provider introduced a new process and supporting policies to manage prescription security. During the inspection we saw blank prescription forms and pads were securely stored in locked cupboards accessible by receptionists, the nurse and GPs. Staff we spoke with explained the system the service used to monitor the use of prescriptions. This included a batch of prescriptions placed into the lockable printer tray on the reception desk, the prescription did not print until the receptionist or GP entered a security pin code into the printer. The person who prescribed the medicine signed the prescription and the receptionist recorded the date, serial number and Adastra case number onto the prescription monitoring log. We did however find blank prescription stationery in the vehicle. This was against the service policy which had recently been implemented.
- Processes were in place for checking medicines, including those held at the service and also medicines bags for the out of hours vehicles.
- Controlled drugs were stored securely and there was a system to record when staff accessed them. During the inspection, we checked stock levels, specifically the balance of each controlled drug; all balances were correct and recorded on Adastra. All the medicines we checked, issued by the provider were, in date.
- During the inspection and from discussions with the provider medicines management lead it was noted the service did not have the required Controlled Drugs Home Office licence to possess controlled drugs. This license is required for all services if they wish to supply or possess Controlled Drugs.

Monitoring risks to patients

There were procedures for monitoring and managing risks to patient and staff safety.

- There was a health and safety policy, although there was no poster displayed to identify local health and safety representatives. We were told there were restrictions as to what the provider was allowed to display. There were up to date fire risk assessments and regular evacuation fire drills. All electrical equipment was checked to ensure the equipment was safe to use (portable appliance testing). Clinical equipment had been tested and calibrated. An asset register was held by the IT department which included all details of calibration and PAT testing information.
- There was a variety of other risk assessments to monitor aspects of safety. Furthermore, 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.

- 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.
- However, the equipment checks in place to ensure that all equipment was in date and fit for purpose were not always effective. For example, we found blood glucose test strips were dated July 2015, the urine dipsticks were dated February 2013 and the blood glucose machine had not been checked for accuracy in accordance with the manufacturing guidelines. This meant that blood glucose levels could not be tested if needed when out at home visits.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. We reviewed the rotas for August 2016 and September 2016 and found there were enough staff to cover the call centres, primary care centres and GP cover requirements. Where there were anticipated and actual gaps, GPs were contacted and offered an enhanced pay rate to cover the shifts. Home based GPs were also able to securely log on to the Adastra system and triage calls when the demand increased.

Arrangements to deal with emergencies and major incidents

The provider had adequate arrangements to respond to emergencies and major incidents.

- Basic Life Support training was included as part of the services mandatory training. Staff we spoke with and records we viewed confirmed they had received annual basic life support training.
- Emergency medicines and emergency equipment was available within the primary care centre and mobile vehicles, all staff we spoke with knew of its location. The emergency medicines we checked were within date and fit for use. There were defibrillators and oxygen with adult and children's masks.
- There was an instant messaging system on the computer system and all mobile devices which alerted staff to any emergency, urgent cases or issues.
- The provider had a comprehensive business continuity plan for major incidents such as power failure, telephony outage including serious malfunction or failure of telephone system used by the NHS 111 service. There were plans to move services from Herschel medical centre to other provider primary care centres or a local GP practice in the event of being unable to access the centre. We also saw the contingency plans if one of the vehicles used for home visits was to breakdown. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Access to the Out of Hours GP service is via the national NHS 111 service. In Berkshire this service is provided by the South Central Ambulance Service (SCAS) from their base at Bicester, Oxfordshire. Occasionally, some patients accessed the service as a 'walk-in' patient and or following a referral from the Urgent Care Centre which is located in the same building.

Following a telephone triage (clinical assessment) completed by the national NHS 111 service patients may be referred to the Out of Hours (OOH) GP service.

- Referred patients received a telephone call from one of the OOH GPs who undertook a further assessment of their needs. From the outcome of 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). Decisions made depended on people's diverse needs. This meant that the appropriate care and treatment was delivered to meet people's individual needs.

The provider 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.

- There were systems 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. We saw all staff members had access to service process, policies, procedures and national guidelines via interactive 'web manuals' accessed via all work stations including mobile devices. Other guidelines published by organisations such as NICE and Public Health England (PHE) were disseminated in different ways.

Management, monitoring and improving outcomes for people

The service used National Quality Requirement (NQR) and other quality indicators which it submitted to the Clinical Commissioning Group (CCG) to monitor the quality of the service patients received. NQRs for GP OOH services were set out by the Department of Health to ensure these services were safe and clinically effective.

We reviewed NQR standards for the previous 12 months. For the Herschel medical centre, we found that the service had continually met the vast majority of primary care centre (NQR12) standards required. For example data for August 2016 showed:

- 100% of emergency calls received a face to face consultation within one hour.
- 100% of urgent calls received a face to face consultation within two hours.
- 100% of less urgent calls received a face to face consultation within six hours.

The 31 Care Quality Commission comment cards we received were positive about the timeliness and efficiency of the consultations.

In August 2016, the service dealt with 3,702 patient consultations, these consultations consisted of advice calls, primary care centre appointments, walk in patients and home visits. Specifically, in August 2016 the service had:

- 1,967 patient consultations of 'advice to referral' (advice calls assessed and referred to a primary care centre or home visit).
- 1,582 patient consultations were advice calls - including a clear set of worsening instructions (a set of instructions should patients conditions worsen/ deteriorate).
- 1,576 patient consultations finished as appointments at primary care centres. In August 2016, 719 of these consultations (45% of all appointments) were appointments.
- 391 patient consultations were recorded as home visits.

Furthermore, the service presented a breakdown of the number of patient consultations and the impact on the local health economy including consultations escalated to hospital services. For example, in August 2016:

- 55 consultations (1.5%) were considered a life threatening condition and referred to local emergency services.
- 232 consultations (6.3%) were referred to an emergency department.
- 58 consultations (1.6%) were admitted to hospital.

Good

Are services effective?

(for example, treatment is effective)

- 3 consultations (less than 0.5%) referred to the community nursing team.
- 12 consultations (less than 1%) referred to the crisis team.

We saw further information that the service audited cases to ensure patients were managed appropriately.

Quality improvement activity was mostly undertaken at a provider level and was not always site specific. We reviewed three clinical audits completed in the last 12 months; two of these audits had a second cycle to complete the full audit cycle and we saw information to show improvements had been made. The common theme throughout all three audits was to review antibiotic (antibiotics are used to treat or prevent some types of bacterial infection) prescribing habits for the service when they assessed patients with suspected or confirmed infections.

- One of the audits we reviewed commenced in November 2015 and evaluated antibiotic prescribing for sore throat symptoms against the NICE clinical guidelines, Public Health England (PHE) guidelines and local infection management guidelines.
- We saw 22 consultations had been analysed to determine overall compliance with NICE and PHE guidance.
- Using guidance, this audit reviewed the total number of patients prescribed an antibiotic, to assess (using four parameters) if the antibiotic was the correct choice and if the dosage, frequency and course length was correct.
- Of the 22 consultations, four parameters of correct antibiotic prescribing was correct in 14 cases, this equated to 64%. The parameter which had the lowest levels of compliance was the correct course length.
- Findings were used by the service to endeavour to improve antibiotic prescribing. Actions included a themed antibiotic review using clinical guardian and increased awareness of correct course length.
- The second cycle of this audit, reviewed a further 22 consultations in July 2016. Using the same parameters, the four parameters of correct antibiotic prescribing was correct in 17 cases; this equated to 77% and was a 13% improvement on the previous results. Despite the improvement, the provider wished to further increase the adherence of correct antibiotic prescribing and implemented a four point action plan. Further actions on this plan was a full discussion in the next Quality, Governance, Patient Safety and Risk Group (QGPSR), continued feedback on prescribing through clinical guardian and a third cycle of audit six months' time.

One of the NQRs for all OOH GP services to meet is the requirement of regular audit of a random sample of patient contacts. The audit process must be led by a clinician, appropriate action must be taken on the results of those audits and regular reports of these audits should be made available to the Clinical Commissioning Groups (CCGs).

In 2012, the provider implemented a clinical guardian system where staged reviews were undertaken for each clinician. We saw this was an integral part of the services governance structure and the audit team consisted of 10 experienced GPs. The clinical guardian system is a traffic light system identifies the quality of each clinicians work and the level of quality reviews are determined by this. For example, those clinicians with a green rating will have 5% of their call records reviewed. Those with amber rating (those identified with areas of concern) will have 100% of their call records reviewed. These audits were undertaken by the medical director and/ or staff peers using the clinical guardian system and feedback was provided to clinicians via email or during meetings. We saw a further review of cases by a group of clinicians, allowing triangulation of data and clinical trends.

Between April 2016 and September 2016, 3,676 patient consultations had been reviewed, these reviews were audits derived from 147 GPs completed caseloads. For this period,

- One patient consultation (less than 1%) was graded as 'above expectations',
- 3,516 patient consultations (96%) were graded as 'meets expectations',
- 159 patient consultations (3%) 'required reflection'
- (0%) were graded as 'below expectations'.

More recently in August 2016, 559 patient consultations had been reviewed; these reviews were derived from 85 GPs completed caseloads. Data we reviewed for August 2016, indicated

- 531 patient consultations (94.6%) were graded as 'meets expectations',
- 28 patient consultations (5.4%) 'required reflection' and no consultations were graded as 'below expectations'.

Good

Are services effective?

(for example, treatment is effective)

One of the audit team who we spoke with described how results were shared with the GPs 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.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. The management of training and development was undertaken at the provider's head office in Bracknell.

- The provider employed 170 members of staff, this included substantive staff, bank and self-employed staff. This included 10 members of staff who formed the QGPSR Group, 13 members of staff who were provider Council Members and 10 members of staff who formed the clinical guardian audit team.
- Overseen by the Chief Executive, Council Members and Directors; the operations manager, departmental managers, together with a team of GPs, nurses, drivers, call handlers administration staff undertake the day to day management and running of the service.
- There was an induction programme for all newly appointed staff. This enabled new staff members to become familiar with the way the provider operated, the systems the service used and services ethos.
- During the inspection staff told us they were given sufficient time for training, including training on changes to policies, process and standard operating procedures. For example, all staff we spoke with were aware of the recent changes to how prescriptions were stored, recorded and monitored within the service.
- The service employed staff who had the appropriate skills and training to perform their required duties. This included medical, nursing, managerial and administrative staff. 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 told us that they received regular communication informing them of any outstanding training, during the inspection we saw that throughout all staff groups 94% of training had been completed. The remaining 6% had been scheduled and where we identified gaps in training records the service was able to describe why staff had not received the 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, coaching and mentoring. We saw out of 170 staff, 147 (86%) have had an appraisal within the previous 12 months. All other staff have had received an appraisal previously or were due to receive one (except new starters). For the remaining 23 members of staff whose appraisal was due, we saw an individual log detailing when managers had been in contact with staff and other mitigating circumstances. Part time staff working once a week or less told us they had the option for either a full or mini appraisal.

Coordinating patient care and information sharing

- 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 in Berkshire, 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 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 robust.
- Furthermore, information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the service's easy to use 'web manuals'.
- 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 in line with the performance monitoring tool, NQR. Staff

Good

Are services effective?

(for example, treatment is effective)

told us systems ensured this was done automatically and any failed transfers of information were the responsibility of the duty manager to follow up to ensure GPs received information about their patients.

- NQR data showed the service was consistently meeting this requirement over the previous 12 months. More recently, between March 2016 and August 2016, in five of the six months over 98% of patient records (36,294) with details of consultations were sent to the patients GP practice before 8am.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005 and the Children's Acts 1989 and 2004. Where a patient's mental capacity to consent to care or treatment was unclear the clinician assessed the patient's capacity and recorded the outcome of the assessment. Staff also described how they seek consent in an emergency situation in line with the services consent policy.
- 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. However the provision of this information was dependent on GP practices adding such notes on to the patient notes. We saw examples of 'palliative/special care' cases identified to GPs via a Special Notes field on the computer system. The system alerted the GPs through a 'pop up' information screen when first accessing the patient's case details to ensure awareness of any notes available. The SPNs contained information from the patient's own GP practice that may include a diagnosis, medication, DNR requests and any additional notes that are relevant such as whether the patient, family or carers are aware of the prognosis and in some cases preferred place of death.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We obtained the views of patients who used the Out of Hours service through the Care Quality Commission comment cards patients had completed. We received 31 comment cards from patients who had used the service. All feedback positively described the service including comments about the facilities, the staff and the care received.

During the inspection we saw and heard members of staff were courteous and helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- During the inspection we saw patients were either called from the waiting room individually, taken to a consultation room or we saw the GP come to the waiting area, call patients and introduce themselves before taking them to the consultation.
- We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.
- Although no feedback indicated a concern we saw that the facilities, specifically the close proximity of the reception desk to the waiting area may cause concerns regarding confidentiality. Reception staff who we spoke with said when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. During the inspection we saw that staff were mindful and adherent to the providers confidentiality policy when discussing patients' treatments so that information was kept private.

Feedback we received from patients via 31 completed Care Quality Commission comment cards and our conversations with five patients during our visit was very positive. All 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.

Further written feedback highlighted staff were polite and sensitive. One comment card received from a patient described the service as thorough and completed in a timely manner.

Some feedback from patients did indicate that it was sometimes difficult to convince reception staff to offer an appointment as they had used the service as a walk in. The provider had completed site specific patient experience surveys between 1st January 2016 and 31st March 2016. Although uptake was low (eight responses), results showed Herschel medical centre was performing well and patients were satisfied with the service. For example:

- Eight respondents rated the attitude of receptionists as excellent, very good or good.
- Eight respondents said the GP explained their condition and treatment in a way they could understand.
- Eight respondents said they were treated politely and with respect by the healthcare professional they spoke with.

The results of the patient survey from the previous year were available on the provider's website.

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. They had used it as an add-on question at the end of the patient survey.

- Eight respondents indicated they were likely or extremely likely to recommend the OOH service.

Care planning and involvement in decisions about care and treatment

The OOH service deals, generally, with single episodes of care, and the patient involvement is different from providers such as GP services who address the longer term wellbeing of patients. Patients we spoke with said that they were involved in decision making about the care and treatment they received so far as this was applicable. This was corroborated by the patients' views from the comment cards. They said they were 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.

Good

Are services caring?

Staff we spoke with had a good understanding of consent and of the need to involve patients in decision making. A range of information was available, through the services 'web manuals' and the clinical system, to staff concerning capacity and decision making, to support them.

Results from the patient experience survey showed respondents were told what to expect in the next few days and what to do if necessary. In additional respondents were given details of someone they could contact in case they had concerns after using the service.

Staff told us that translation services were available for patients who did not have English as a first language. There was no notice in the reception area informing patients this service was available. We were informed there are restrictions on what could be displayed.

Patient and carer support to cope emotionally with care and treatment

All GPs had access to the services bereavement policy via the 'web manuals'. We saw this policy included information for urgent death certificates due to religious grounds, coroner contact telephone numbers alongside local Berkshire bereavement support services and charities.

Policy and processes prioritised palliative care calls to ensure they received timely care and treatment. 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The provider engaged with the NHS England Area Team and the local Clinical Commissioning Groups (CCG) to provide the services that met the identified needs of the local population of East Berkshire and Richmond. The local CCGs conducted needs' assessments to find where services were required and the services were provided from the various primary care centres identified from the analyses.

- They understood and responded to patients' needs. For example there were translation services for patients whose English was not sufficiently fluent to manage a clinical consultation. During our inspection, staff members were aware there was a translation services available for patients who did not have English as a first language and a hearing loop was available.

Access to the service

The service operated from 6.30pm to 8.00am Monday to Thursday and from 6.30pm until 8am Friday to Monday inclusive. The service also operated on all bank holidays. Access to the service was via patients calling the NHS 111 service.

The NHS 111 service was provided by South Central Ambulance ServiceNHS Foundation Trust. The NHS 111 service triaged the calls and if it concluded that the most appropriate course of action was for the patient to speak with a GP the call details were transferred electronically. A GP from the service then contacted the patient to review the NHS 111 service assessment. Patients were then visited at home, offered telephone advice, referred to the emergency service or offered an appointment at one of three primary care centres.

- The service also saw walk in patients who had not called the NHS 111 service first. In the three months of August 2016, July 2016 and June 2016 95 patients had been seen as a walk in patient. Managers we spoke with described how they prioritised walk in patients if they arrived for an appointment, were referred from an emergency department or walked in themselves. Patients who were triaged as less urgent cases were offered the next available appointment after patients with more urgent needs were seen first.
- The premises had locked doors at the entrance to the building, there was a bell but this did not appear to be working and we saw a patient waiting for a little while to gain access, the centre had a clear, obstacle free access, disabled toilets and height adjustable couches were available in the treatment rooms. This made movement around the service easier and helped to maintain patients' independence. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for access to consultation rooms.
- The OOH service is situated in rented spaces within Herschel medical centre and the facilities are managed by the respective organisation. During the inspection, we saw that the outside sign displayed the incorrect telephone number. This was raised with the management team who advised that they would rectify this.
- Palliative care or end of life patients were able to contact the service directly if they had a health concern out of hours.

Written and verbal feedback and information from patient experience surveys indicated patients were satisfied with the appointments system and the timeliness of the service. For example:

- Four of the eight respondents said they did not have to wait to be seen by a GP and the remaining four said they had to wait between 11 and 30 minutes.

Performance monitoring data we reviewed (across all three primary care centres) showed the average wait time for patients in August 2016 was nine minutes.

Listening and learning from concerns and complaints

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

- We found the service had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England and the NQR standard.
- One of the senior medical directors was the designated person and was supported by the patient experience manager who handled all complaints and feedback received into the service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The service reported that there had been 20 complaints received in the last 12 months, the ratio of number of complaints to patient contacts was 0.03%. Four of these complaints referred to the service received at Herschel medical centre.
- We looked at a sample of the complaints received and found they were all handled appropriately, in line with the service complaints procedure and complaints analysed to detect any themes. We noted that the responses were offered an apology, were empathetic to the patients and explanations clear.
- We saw minutes of these meetings which demonstrated a discussion of the complaints, identified the relevant learning points and action taken to as a result to improve the quality of care.
- One of the complaints we looked at in detail also highlighted the lack of a pharmacy available in East Berkshire after midnight. The provider worked in conjunction with a local hospital to highlight this issue to the local CCG.
- During the inspection we saw there was no information available to help patients understand how to make a complaint. During the inspection we saw a specific complaints information form, however this was not on display or available in mobile vehicles for patients who received care and treatment in their own homes to raise a complaint. Staff we spoke with were fully aware of the complaints process and how to explain this to patients.
- Information about how to and who to complain to was detailed in full on the services website.

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 provider had a clear vision to deliver high quality care. There was evidence of strong collaboration and support across all staff and a common focus on improving quality of care and promoting positive outcomes for patients in Berkshire and Richmond.

- The management team had re-enforced the vision and values though staff engagement events and continuing staff communications. Staff we spoke with clearly understood that quality and safety were paramount.
- We saw evidence of the provider's commitment to this aim and their proactive approach to working with other providers and commissioners to develop services that met patients' needs and improved patient experience. Staff we spoke with reflected that commitment and shared their ideas for the future.
- There were regular reviews of service performance and progress towards strategic goals or strategic change. For example, the service was aware of major changes within the NHS 111 service and had plans and processes for further integration with the proposed new service.

Governance arrangements

There were governance arrangements in place, however improvements were required.

- The service and management team were not sighted on matters contributing to patient safety such as the process for ensuring staff had completed chaperone training and the service had acted upon patient safety and MHRA alerts. Improvements were also required to the systems and processes that ensured all equipment both in vehicles and on-site was within date and regularly tested in accordance with the manufacturing guidelines; infection control audits were completed regularly and medical equipment was within its expiry date.
- We saw clinical and internal audits were used to monitor quality and to make improvements at a provider level. For example, the appropriateness of antibiotic prescribing audit. We saw that individual GP decisions were subject to scrutiny through audit. Staff told us that they received the results of their audits, for example they could tell us their score on their last audit. They said that they could act on the information to improve their clinical performance. However, there was no consideration for location specific clinical audits to review, monitor and improve outcomes for people accessing care and treatment at the different locations within the service.
- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. Staff we spoke with understood who their managers were and how to contact them. They said the Council Members and management team always responded when contacted.
- There were policies and processes available through the services intranet known as 'web manuals'. Staff said that the system was easy to use and the policies were easy to understand. We asked a number of staff to demonstrate their familiarity with the system 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.
- There was a comprehensive understanding of the performance of the service. The Chief Executive and management team closely reviewed the data and performance of the service and actions were taken to address concerns when they arose.
- There were arrangements for identifying, recording and managing the majority of risks, issues and implementing mitigating actions.

Leadership and culture

The provider ensured 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).

- There was a culture of openness and honesty. When things went wrong with care and treatment the provider gave people who were affected reasonable support, truthful information and a verbal and written apology. There were written records of verbal interactions as well as written correspondence.
- There was a clear leadership structure in place and staff felt supported by management. There were high levels of staff satisfaction. Staff we spoke with were proud to work for the provider and spoke highly of the senior team. There were consistently high levels of constructive staff engagement which included a staff survey.
- Staff at all levels were actively encouraged to raise concerns.

Are services well-led?

Requires improvement

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

- During the inspection we spoke with a GP Locum who spoke of the quality of leadership and support received from GPs and other staff.
- There were regular team meetings. Staff at all levels were encouraged to attend. For example staff who worked nights were paid to attend local meetings which were held outside their usual working hours.
- Staff said they felt respected, valued and supported, one of the drivers we spoke with told us despite the role being remote and in unsocial hours, they felt well supported by managers and saw senior managers regularly. Staff were able to contact a duty manager at any time.

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

The provider encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback. However, improvements were required as patient survey results in most of the providers OOH services were based on very low patient responses and therefore may not have been a representative view.

- Whilst patient surveys were conducted the provider had not reviewed the low response rates. There were no plans in place to ensure that a higher response rate was seen in future surveys.
- The provider had gathered feedback from staff through staff meetings, staff surveys, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the service was run.
- The service had a whistleblowing policy which included external contacts details and how to access independent advice. Whistleblowing is the act of reporting concerns about malpractice, wrong doing or fraud. Within the health and social care sector, these issues have the potential to undermine public confidence in these vital services and threaten patient safety.

Staff told us that patient engagement was difficult as the service provided single episodes of care; this resulted in low numbers of patient surveys. However they had tried innovative approaches including:

- Highlighting the role of GP OOH services via online promotional cartoon video including the difference between when to call 999 and when to access OOH.
- The provider made full use of the three most popular social media communication mediums to promote GP OOH services and acted as a method to collect patient feedback. Social media was regularly updated, was specific to East Berkshire and one recent update highlighted World Mental Health Day including information if people wanted further information about mental health.

Continuous improvement

There was a strong focus on continuous learning and improvement, specifically moving the service from a paper based service to a paper free service.

- The telephone system had been reviewed and the new system was ready to launch. This would allow 'warm transfers' (a direct transfer) from NHS 111 service and more detailed performance reporting and monitoring including audio audits.
- Introduction of web-based risk management database to record all risk management activity, including incidents, complaints, claims, coroner's inquests and queries. This will also allow the service to record and search data by severity and category.
- In November 2016, the service will launch an electronic health record and integration engine. This will combine information from GP systems, acute hospital operational systems, social care, community and mental health systems and present information in a single health care record for each patient. This shared record will be accessible by care providers across a whole health economy.

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
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **We found the provider did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users.** • Action had not been taken to ensure patient safety alerts and MHRA (Medicines and Healthcare Products Regulatory Agency) alerts had been responded to. • There was no system in place to ensure chaperone duties were carried out appropriately. • Vehicle checks were not carried out appropriately to ensure all equipment was in date and fit for purpose. • Infection control audits were not regularly undertaken to identify associated risks. • The systems to monitor the safe management of medicines were not effective including the lack of a Controlled Drug Home Office license. • The provider did not actively seek feedback and a representative view from patients to ensure improvements could be made. **This was in breach of regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**