Nestor Primecare Services Ltd t/a Primecare - East Kent

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Nestor Primecare Services Ltd t/a Primecare - East Kent on 9,10 and 11 May 2017. Overall the service is rated as inadequate.

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

- Not all staff were clear about reporting incidents, near misses and concerns. Although the service carried out investigations when there were unintended or unexpected safety incidents the investigations were superficial. There was some evidence of lessons learned but they were not communicated systematically to all staff.
- There were some arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However the arrangements had failed to recognise and address some risks.
- Patients' care needs were not always assessed and delivered in a timely way. The provider failed to meet some key National Quality Requirements.
- There was little monitoring of whether staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff training was not comprehensive.
- Some staff reported that they could not access patients' records.
- 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. However there were long delays in dealing with complaints. Analysis of the root cause of complaints was superficial. There was limited evidence of learning from complaints.
- The service worked with other organisations and providers to develop services that supported alternatives to hospital admission where appropriate.
- The service had good facilities and was well equipped to treat patients and meet their needs. The vehicles used for home visits were clean and well equipped.
- The leadership structure was not clear to staff and some staff did not feel supported by management.
- The provider had not sought feedback from staff. There were no regular staff meetings. Feedback from patients was very limited.

Summary of findings

- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider must make improvement are:

- In the clinical and managerial governance arrangements
- In the recording of complaints
- In the deployment of suitably qualified, competent, skilled and experienced staff
- In the provision of safe care and treatment

Following the inspection we took enforcement action against the provider namely the service of three warning notices:

- Safe care and treatment 12.—(1) Care and treatment must be provided in a safe way for service users.
- Good governance 17.—(1) Systems or processes must be established and operated effectively
- Staffing 18.—(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

Professor Steve Field CBE FRCP FFPH FRCGPChief 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?

Inadequate

The service is rated as inadequate for providing safe services and improvements must be made.

- Staff were not clear about reporting incidents, near misses and concerns. Although the service carried out investigations when there were unintended or unexpected safety incidents the investigations were superficial. Lessons learned were not communicated and so safety was not improved.
- Patients did receive an explanation or an apology when one was appropriate.
- Patients were at risk of harm because systems and processes were not effective in keeping safe. There were not enough staff to keep patients safe. For example too many patients had to wait too long to be seen whether they were emergency, urgent or other patients.
- There was insufficient attention to safeguarding children and vulnerable adults. Staff did not understand their roles or know who led the East Kent locality in safeguarding. Training for safeguarding was incomplete.
- The business continuity plan to manage significant issues that might impact on service delivery was inadequate.

Are services effective?

Inadequate

The service is rated as inadequate for providing effective services, as there are areas where improvements should be made.

- Data showed the service was not meeting the National Quality Requirements (performance standards) for GP out of hours services or for NHS 111 services. Areas included face to face consultations with patients and the percentage of patients whose calls answered within 60 seconds.
- Compliance with national guidelines was not systematically monitored.
- There was limited evidence that audit was driving improvement in patient outcomes.
- Compliance with mandatory training was poor. Staff reported that they had not had an induction into the providers systems or, in some cases, to their role locally.
- There was a lack of clinical supervision.

Are services caring?

Requires improvement

The service is rated as requires improvement for providing caring services.

Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Patients were kept informed with regard to their care and treatment throughout their visit to the out-of-hours service.

Are services responsive to people's needs?

Requires improvement

The service is rated as requires improvement for providing responsive services and improvements must be made.

- Although the service had reviewed the needs of its local population, a plan to secure improvements for all of the areas identified was not yet effective.
- Patients reported considerable difficulty in accessing the service. Patients with priority conditions were not always identified or did not always receive treatment in a timely manner.
- Patients were not always directed to Primary Care Centre (PCC) where there was a clinician able to treat them. Mobile clinicians were sometimes directed to patients whom they could not treat.
- Complaints and concerns were not always handled appropriately. There were long delays in dealing with complaints. Records of the analysis of complaints were superficial and the provider's response to complaints was not clear. There was limited evidence of learning from complaints.

Are services well-led?

Inadequate

The service is rated as inadequate for being well-led and improvements must be made.

- The service did not have a clear vision and strategy. Staff were not clear about their responsibilities in relation to the vision or strategy. The vision did not relate to the Out-of-hours or NHS 111 service.
- The leadership structure was not clear to staff and staff did not feel supported by management.
- Regular governance meetings had ceased about a year ago and had only just recommenced.
- Management performance meetings did not examine failures to meet the National Quality Requirements; that is the failure to meet patients' needs.

Summary of findings

- The service had not sought feedback from staff. Feedback from patients was very limited. There was no patient participation group.
- Staff told us they did not have personal development plans as the provider's Statement of Purpose required. There were no regular staff meetings.

Summary of findings

What people who use the service say

There is a requirement on providers to regularly audit a random sample of patients' experiences of the service. The provider had not conducted surveys under this requirement.

The East Kent locality provided a "friends and family" questionnaire at each of its primary care centres. It could be handed in to the reception staff or posted to the provider at no cost to the patient. There had been a limited uptake of the survey in the East Kent locality which had received six results.

These had been analysed and the results were positive. When asked about the helpfulness of the call handlers and the quality of the telephone consultation the answers ranged through good to very good and excellent. There was one negative response about the attitude of a clinician but patients were positive about the promptness of treatment. All the patients in the survey were satisfied with the service.

The national GP patient survey asks patients about their satisfaction with the out-of-hours service. However this survey was published in July 2016 so predates The provider's services.

Care Quality Commission comment cards, on which members of the public could report their views on the service, were sent to the East Kent locality but we told they had not been received.

We spoke with four patients during the inspection. Three patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. One patient was dissatisfied about the waiting time but was satisfied with the care they had received.

Areas for improvement

Action the service MUST take to improve

The areas where the provider must make improvement are:

- In the clinical and managerial governance arrangements
- In the recording of complaints
- In the deployment of suitably qualified, competent, skilled and experienced staff
- In the provision of safe care and treatment

Nestor Primecare Services Ltd t/a Primecare - East Kent

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector**.** The team included two GP specialist advisers, two emergency care specialist advisers, three CQC inspectors, a member of the CQC medicines team and a practice manager specialist adviser.

Background to Nestor Primecare Services Ltd t/a Primecare - East Kent

Nestor Primecare Services Ltd t/a Primecare - East Kent is the registered location for the out-of-hours (OOH) GP and NHS 111 service provided by Nestor Primecare Services Limited.

Nestor Primecare Services Limited is a commercial enterprise that provides primary healthcare services across the UK. These services include: GP practices, walk-in centres, dentistry, OOH, NHS 111 and healthcare in secure settings. Nestor Primecare Services Limited is part of a larger group, Allied Healthcare. Allied Healthcare is in turn owned by Aurelius UK, a pan-European investment group.

Nestor Primecare Services Ltd t/a Primecare - East Kent provides urgent medical care and advice out-of-hours for patients across East Kent. It provides the NHS 111 service to the same community. It serves four clinical commissioning groups (CCG) namely: NHS Ashford, NHS Canterbury and Coastal, NHS South Kent Coast and NHS Thanet CCGs

There is a single contract to provide OOH and NHS 111 services. Previously there had been separate contracts and separate providers for these services.

The East Kent call centre and management are based at Canterbury. They provide primary medical services outside of usual working hours (OOH) when GP practices are closed, this includes overnight, during weekends and when practices are closed for training. They provide NHS 111 services 24 hours a day 365 days a year. The service covers a population of approximately 700,000 patients.

Most patients access the out-of-hours service via the NHS 111 telephone service. Patients may be seen by a clinician, at a local primary care centre (PCC) often located adjacent to a hospital Accident and Emergency (A&E) facility, or patients may receive a telephone consultation or a home visit depending on their needs. The provider employs various clinicians including GPs, nurses (with various skill levels such as diagnosis or prescribing) and emergency care practitioners. Clinicians are engaged as locum or agency staff, they are supported by drivers and receptionists who are employees of the provider. Some patients access the primary care centres by walking in or are referred from the hospital A&E departments or other urgent care centres.

The health of people in Kent is generally better than the England average. Deprivation is lower than average, however about 17.6% (48,300) of children live in poverty. Life expectancy for both men and women is higher than the England average.

Detailed findings

The out-of-hours service, for East Kent, is provided from all the sites shown below.

The inspectors visited the following sites:

Nestor Primecare locality office and call centre

Charter House

St Georges Place

Canterbury

Kent

CT1 1UQ.

Primary Care Centres

Fracture Clinic

William Harvey Hospital

TN24 0LZ

Fracture Clinic

Margate

QEQM

Ramsgate Road

CT9 4BF.

Fracture Clinic

Canterbury

Kent & Canterbury Hospital

Ethelbert Road

CT1 3NG

Dover

Buckland Hospital

Coombe Valley Road

CT17 0HD.

Folkestone

Royal Victoria Hospital

CT19 5BN.

The inspectors did not visit the following sites:

Herne Bay

Queen Victoria Memorial Hospital

King Edward Avenue

CT6 6EB.

Deal

Victoria Hospital

London Road

CT14 9UA.

New Romney

New Romney Health Centre

Station Road

TN28 8LQ.

Why we carried out this inspection

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 9, 10 and 11 May 2017. During our visit we:

- Spoke with a range of staff including GPs, emergency care practitioners, receptionists, drivers, call handlers, administrators and managers. We spoke with patients who used the service.
- Inspected the out of hours premises, looked at cleanliness and the arrangements to manage the risks associated with healthcare related infections.

Detailed findings

- Looked at the vehicles used to take clinicians to consultations in patients' homes, and we reviewed the arrangements for the safe storage and management of medicines as well as the emergency medical equipment.
- Care Quality Commission comment cards, on which members of the public could report their views on the service, were sent to the East Kent locality but we told they had not been received.
- We asked the provider to email all staff, with the contact details of the lead inspector, so that the staff might have the opportunity to contact the inspection team directly. Several staff did so.

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.

Inadequate

Are services safe?

Our findings

Safe track record and learning

The system for reporting and recording significant events did not fully meet operational demands.

- Staff told us they would inform a manager of any incidents. There was a recording form available on the service's computer system however only supervisors could make an entry on the system. Most clinical staff at the primary care centres (PCC) did not know how to raise significant events directly. They said they would report it to the driver or the receptionist. These staff do not work office hours and this could be a barrier to communicating incidents.
- Management of significant events was weak. For example one report concerned the recall of certain medicines and the documented learning from the event was that ... "All management staff to complete the Meds Management training… ". The report was closed but it was not clear whether the training had happened. The learning was sometimes not specific, for example, one report concerned a long delay in the handover of a patient to another provider. The learning was, "Having single provider for NHS 111 and OOH (out of hours) should reduce opportunity for this form of collaborative error".
- There was a section in the significant events' log for root cause analysis. The person completing this had had no training in root cause analysis. Sometimes the analysis was simplistic. A significant event report highlighted the high volume of patients waiting to be seen or spoken to on the January bank holiday Monday 2017. The person reported that there was a huge clinical risk to patients. They highlighted an excessive number of home visits where one hour (emergency) calls were taking too long and that death in care may have happened. The risk status of this report was moderate. The root cause analysis section reads high volume of calls, when it was the low volume of staff that was the issue. The learning reads, Been undertaken and new staff joining in April 2017. There was no mention that Easter bank holiday weekend fell in the middle of April and contingencies might be needed if the anticipated staff were not trained and available.
- The report identified the lack of staff, the reporter also made some suggestions as to where additional staff might be sourced. The suggestions of the reporter were not acknowledged and there was nothing to suggest they had been acted upon.
- There were no regular mechanisms to feedback to staff at PCCs about significant events. Staff at the PCC told us they had not received feedback about significant events. A frequently raised significant event concerned the management of medicines, these were raised by the pharmacy that provided support to the service. The provider had acted on these and we saw that staff had received instruction and training about the medicines management system that the provider was using.
- We spoke with staff from the NHS 111 call centre. They told us they received feedback on any such events via their monthly one to ones, or more immediately when needed. We reviewed safety records, incident reports, audit reports and safeguarding referrals. We saw evidence that lessons from these were sent out to staff but there was no method to capture whether the information had been seen by staff or whether they had understood the lessons.
- Managers were aware of the duty of candour requirements and how they would meet them if necessary. (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).
- However, the provider was able to demonstrate that some issues, raised as significant events, had resulted in changes to processes.. For example, they had recognised that some events, complaints and performance were as a result of the skills mix of staff available as well as the numbers of staff. They conducted a comprehensive review and remodelled the service employing many more GPs and fewer nurses and emergency care practitioners at the PCCs. We saw a significant event about clinical supervision, received at a high management level, which was recorded and actioned quickly.
- There was a well organised and effective system to manage medicines alerts.

Overview of safety systems and processes

- There were arrangements to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible though the provider's intranet.

Staff reported difficulties in accessing policies because of information technology issues. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare but some staff did not know who the appointed local safeguarding lead was.

- The provider had completed a safeguarding audit, against Section 11 of the Children Act 2004. This statutory obligation is a self-assessment of the degree to which an organisation is meeting its obligation to safeguard and promote the welfare of children. These self-assessments are sent to the relevant local safeguarding children board that is under a duty to ensure the arrangements are robust. The Kent Safeguarding Children Board (KSCB) sent the audit to the provider on 16 December 2016 with a return date of 24 February 2017. The audit was returned on 28 April. The Board had accepted the audit. We contacted the Board to discuss to what extent the audit provided a degree of independent scrutiny of the provider's arrangements for safeguarding children but the Board declined to discuss this. There was a national lead for safeguarding and a local lead for safeguarding. The person identified as the local lead for safeguarding, in the relevant policy, did not know that they were so named so they were not aware of their responsibilities in relation to this role.
- We spoke with staff who had completed training that included radicalisation under the Home Office Prevent strategy, human trafficking and female genital mutilation.
- Not all had received training on safeguarding children and vulnerable adults relevant to their role. Health advisers within the NHS 111 call centre had been trained to safeguarding level one which was below the required standard of level two. The provider had started to take action to remedy this during our inspection. Clinical advisers had undergone training to level two but staff records also showed that some staff had not received refresher training within the appropriate timescale.
- GPs were trained to child safeguarding level three. There was training planned, for June 2017, at level four for staff with relevant responsibilities.
- There were notices in the consultation rooms advising patients that chaperones were available if required. 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).
- The service maintained appropriate standards of cleanliness and hygiene. The PCCs were clean and tidy. There was an infection control lead locally. There was an infection control protocol. The provider had commissioned an analysis of their compliance against infection control principles and had identified some gaps, such as training being too basic and there being no annual report. There was a plan, with timescales to rectify this.
- Staff were not provided with a safe environment in which to work. Some risk assessments and actions, required to ensure the safety of the premises, had been completed. Some had not. The call centre did not have height adjustable work stations. The local Health and Safety representative had not undertaken health and safety audits. The call centre was documented as requiring weekly fire alarm tests and monthly emergency lighting checks but the template forms for recording this were blank. We were told that these had not been done. A fire drill was scheduled March 2017 but did not happen. Staff at the call centre were required to read and understand the fire and emergency evacuation plan and sign to declare that they had done so. At the time of inspection only five staff had signed to say they had read and understood this plan. At the time of the inspection the Primecare NHS111 employed 70 whole time equivalent (wte) staff within the East Kent NHS 111 service.
- There was a building security risk assessment in January 2017. This had identified areas to be addressed such as visitor badges and a missing key policy. At the time of inspection these issues had not been addressed.
- We reviewed 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, appropriate indemnity and the appropriate checks through the Disclosure and Barring Service.

Medicines Management

- There were medicines policies and a set of standard operating procedures. However these were not always

followed. The service did not have a local lead for medicines. The service employed four clinical staff and used agency staff. The service was unable to provide training records for these staff.

- The service carried out prescribing audits to ensure prescribing was in accordance with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored. However, serial numbers of prescriptions not recorded, contrary to the service's own policy.
- Patient Group Directions (PGDs) were used by nurses and paramedics to supply or administer medicines without prescriptions. PGDs in use had been ratified in accordance with the Medicines and Healthcare products Regulatory Agency guidance. However, the service was unable to show us that individual staff members had been authorised and trained to use the PGDs.
- The service held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential for misuse). Policies and procedures that governed how controlled drugs were managed not always followed. There were frequent medicine discrepancies reported from doctors' bags and staff told us this was due to poor medicines' recording. As a result a decision was made to hold all controlled drugs at one PCC. Thus these medicines were not always readily available when needed.
- Medicines were stored securely and storage temperatures were monitored. All the medicines we looked at during the inspection were within their expiry date. There were effective processes were for re-ordering medicines. There was an appropriate range of medicines available.
- Emergency medicines were not always easily accessible, for example, the only oxygen available at one PCC was in the vehicle so was unavailable if the vehicle was on a call. We were told that this PCC was dependant on oxygen from the hospital's accident and emergency (A&E) department that was situated next door. Access to oxygen in an emergency situation could be delayed if the A&E was busy. We found some staff, at the PCCs, who did not know where the emergency medicines were located

Monitoring risks to patients

Risks to patients were not assessed or well managed.

- There was a health and safety policy available with a poster in areas accessible to all staff that identified local health and safety representatives. The service had up to date fire risk assessments. All individual electrical equipment was checked to ensure the equipment was safe to use. However we saw that some equipment was run by using repeated extension leads and cabling was loose as opposed to being run through trucking. This was discussed with managers and this issue was rectified before the inspection ended.
- Clinical equipment was checked to ensure it was working properly. Clinical equipment that required calibration was calibrated according to the manufacturer's guidance. All the equipment had been purchased at the start of the service, that is within the last year, and there was a contract for its maintenance.
- There were systems to help ensure the safety of the out of hours vehicles. Checks were undertaken at the beginning of each shift. These checks included areas such as a physical check of the vehicle and a check of items within the vehicle such as the first aid kit.
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. These had identified that the skill mix, used from the commencement of the service, was unable to meet the needs of patients. It had employed too many nurses, paramedical staff and emergency care practitioners. Many of these staff had restrictions on their practice and were not able to see, for example very young children or pregnant women nor could many of them prescribe medicines. The provider has increased the numbers of GPs employed at the PCCs and decreased the numbers of other staff.
- For the call centre operation there were arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. However, the call centre in East Kent locality did not have sufficient staff available to enable the identified changes to be made effectively.
- There was a significant number of agency staff deployed within the call centre. We were informed that in April 2017 45.6% of health advisers hours were from agency staff and 77.8% of clinical advisers hours' were agency.

Arrangements to deal with emergencies and major incidents

The service had arrangements to respond to emergencies and major incidents.

- There was a system to alert staff to an emergency.

Inadequate

Are services safe?

- Not all staff had received basic life support training, including use of an automated external defibrillator. Emergency medicines were not always easily accessible throughout the service. For example, the only portable medical oxygen available at one PCC was stored in the vehicle so was unavailable in the building if the vehicle was out on a call. We were told that this PCC would use the medical oxygen from the hospital's A&E department that was situated next door. We were further told that Primecare could use the hospital's "crash call" system in case of a medical emergency. We found some staff, at the PCCs, who did not know where the emergency medicines were located.
- All other PCCs had defibrillators and oxygen with adult and children's masks. A first aid kit and accident book were carried on each car.
- The service had a business continuity plan for major incidents such as power failure or building damage. The plan relied on another call centre (Cardiff), run by the provider, taking the calls in the event of failure. The East Kent locality was also the contingency for Cardiff in the event of that locality failing. The plan was for calls from the affected centre to be diverted to the other. The receiving call centre would deploy supernumerary staff such as trainers or auditors to manage the additional workload. On the first day of inspection the call centre had one health adviser and two clinical advisers on duty. It was unclear how these three staff would be able to service the level of calls for two call centres should the need arise. It was difficult to see how sufficient staff could be contacted quickly to make this plan practicable.
- A manager told us that there was a contingency to use agency staff if the performance of the East Kent call centre fell below a certain level. We were informed that should service performance drop below 70% then a plan, to use short term agency staff, would be mobilised. We saw evidence that, on numerous dates, that performance had dropped below 70% but no plan was activated to assist in service recovery. This contingency was not in writing. It did not take account of the time delay in contacting agency staff particularly at a weekend.
- During the inspection the clinical patient management system, which serves the PPCs, failed. There were paper records for staff to use but staff were not clear about how the ensuing paperwork should be managed. One clinical staff member, on being asked if there was a contingency plan for this type of failure, said that there was not.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The service did not always assess needs and deliver care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best service guidelines.

- The service had systems to help keep all clinical staff up to date. Staff had access to guidelines from NICE through the provider's intranet. Some staff we spoke with were aware of and used this, others found it difficult to use and some did not know how to access the guidelines. Most clinicians we spoke with had not had an induction, during which information about how to access the provider's intranet would normally be imparted.
- We saw a recent example of updated guidance. This was from NHS Pathways (this is a system used to triage public telephone calls for medical care and emergency) regarding amended guidance for NHS 111 calls received concerning heart surgery and a potential related infection.
- The service monitored the use of NICE guidance through clinical audit.
- Clinical staff who undertook baseline observations when patients arrived at the service had information relating to normal values and vital signs, which enabled them to easily escalate concerns.

Management, monitoring and improving outcomes for people

All health advisers and clinical advisers had completed a mandatory training programme to become licensed in using the NHS Pathways software. Pathways enabled a specially designed clinical assessment to be carried out by a trained member of staff who recorded the patients' symptoms during the call. When a clinical assessment had been completed, a disposition outcome (i.e. what the patient needed next for the care of their condition) and a defined timescale was identified to prioritise the patients' needs.

Data from December 2016 to March 2017 showed that The provider NHS111 East Kent was performing below (worse than) the national average for calls answered within 60 seconds and from limited data performance for calls abandoned was higher (worse than) when compared to the national average. For example:

Data for calls answered within 60 seconds (for which the national target is 95%) Showed:

- In December 2016, 74% were answered within 60 seconds compared to the national average of 86%.
- In January 2017, 79% were answered within 60 seconds compared to the national average of 88%.
- In February 2017, 88% were answered within 60 seconds compared to the national average of 89%.
- In March 2017, 84% were answered within 60 seconds compared to the national average of 91%.

Calls abandoned is a marker of patient experience, a high call abandonment rate is considered unsafe and may reflect a high level of clinical risk for patients. The validated data for NHS 111 providers is published on the NHS website under the section NHS Minimum data set.

Data for calls abandoned (the national target is less than 5%) showed:

- In November 2016, 4% of calls were abandoned compared to the national average of 2.5%.
- In December 2016, 7% of calls were abandoned compared to the national average of 3.8%.

The NHS Minimum data set entries for the percentage of abandoned calls for Primecare for January, February and March all read NCA which stands for not currently available. This data was available on the NHS England website for the other NHS 111 contracts.

Primecare provided the inspection team with data for abandoned calls for January, February and March 2017. The data for abandoned calls is technically complex so it is not possible to say if the data provided by Primecare is precisely comparable to that which is published in the Minimum data set.

However the abandoned calls data provided by Primecare indicates:

- In January 2017, 3.3% of calls were abandoned compared to the national average of 2.7%.
- In February 2017, 3.1% of calls were abandoned compared to the national average of 2.2%.
- In March 2017, 4.3% of calls were abandoned compared to the national average of 1.8%.

NHS 111 services are measured against patient outcomes in comparison to the national average for the numbers of

people sent to an accident and emergency department (A&E), or referred for an ambulance disposition or referred for a primary care pathway. Call outcomes were already in line with national averages, for example:

In January 2017:

- 12% of patients were referred to an ambulance disposition, compared to the national average of 13%.
- 7% of patients were referred to A&E compared to the national average of 8%.
- 54% of patients were referred to a primary care pathway compared to the national average of 60%.

In February 2017:

- 13% of patients were referred to an ambulance disposition, compared to the national average of 13%.
- 8% of patients were referred to A&E compared to the national average of 8%.
- 53% of patients were referred to a primary care pathway compared to the national average of 60%.

In March 2017:

- 14% of patients were referred to an ambulance disposition, compared to the national average of 13%.
- 8% of patients were referred to A&E compared to the national average of 9%.
- 54% of patients were referred to a primary care pathway compared to the national average of 60%.

All providers of out-of-hours (OOH) services are required to comply with the National Quality Requirements (NQR). The NQRs are used to show that the service is safe, clinically effective and responsive. Providers are required to report monthly to the clinical commissioning group (CCG) on their performance against standards which includes audits, response times to telephone calls, whether telephone and face to face assessments happened within the required timescales, seeking patient feedback and actions taken to improve quality.

Department of Health, National Quality Requirements in the Delivery of Out-of-hours Services documentation sets out the national targets that providers are expected to achieve. It defines three contractual states: Fully compliant, where average performance was within 5% of the requirement, partially compliant, where average performance was between 5% and 10% below the requirement and non-compliant, where the average performance was more than 10% below the requirement.

NQR 10 is the measure used for monitoring that patients who attend a primary care centre (PCC) receive clinically safe and effective assessment which prioritises their needs. These must be started within the following timescales: The requirement for this measure is 100%.

Urgent needs, within 20 minutes of the patient arriving in the centre.

All other patients, within 30 minutes of the patient arriving in the centre.

We examined the data for this provider from January, February and March 2017. Results were as follows:

January;

- Urgent patients 100%
- All other patients 77%

February;

- Urgent patients none attended
- All other patients 77%

March;

- Urgent patients none attended
- All other patients 84%

NQR 12 is the measure used for monitoring face-to-face consultations (whether in a PCC or in the patient's home). The requirement for this measure is 100%. The timescales are:

- Emergency: Within 1 hour.
- Urgent: Within 2 hours.
- Less urgent: Within 6 hours

We examined the data for this provider from January, February and March 2017. Results were as follows:

In January the figures for patients attending the PCCs were:

- Emergency: 30%
- Urgent: 70%
- Less urgent: 90%

For patients who needed home visits they were:

- Emergency: 28%
- Urgent: 42%
- Less urgent: 62%

In February the figures for patients attending the PCCs were:

Inadequate

Are services effective?

(for example, treatment is effective)

- Emergency: 37%
- Urgent: 62%
- Less urgent: 85%

For patients who needed home visits they were:

- Emergency: 22%
- Urgent: 48%
- Less urgent: 68%

In March the figures for patients attending the PCCs were:

- Emergency: 31%
- Urgent: 69%
- Less urgent: 89%

For patients who needed home visits they were:

- Emergency: 28%
- Urgent: 59%
- Less urgent: 77%

NQR 11: States that providers must ensure that patients are treated by the clinician best equipped to meet their needs.

- This was not always achieved, the skills mix in use by the provider was 60% emergency care practitioners and other qualified staff and 40% GPs. Many of the non GP staff had restrictions on their practice and were not able to see, for example very young children or pregnant women nor could many of them prescribe medicines. Staff said that patients were sent to PCCs where the staff on duty could not treat them because of these restrictions. Those patients then had to be referred to another centre where suitable qualified staff were available. The provider themselves had recognised this problem. They had reviewed the skills mix and were deploying more GPs and less other qualified staff.

There was evidence of some clinical audit for individual health professional staff (NQR4) within the OOH service.

- In March there were 79 clinicians recorded on the provider database for OOH East Kent. Forty had had individual consultations audited and were on a regular cycle of audit. GPs told us they had found the audit process constructive and it had identified areas for individual improvement. The audit stressed the importance of recording key data such as temperature, blood pressure and oxygen saturation of the blood. It identified when a clinician's performance was concerning and we saw evidence that this was effectively addressed. Twenty six clinicians were new to the provider and due to be audited over the next few months. The audits reviewed recorded telephone consultations
- Some clinicians told us that it was extremely difficult to get their calls recorded as it required a long string of numbers to be entered on the telephone to activate the recording system. Sometimes this failed and, in any event, was impractical during busy periods.
- Twelve clinicians (15%) had not been audited because their telephone consultations had not been recorded. It was not clear if the provider had taken steps to ensure that the same clinicians were not missing audit on a regular basis.
- The service had not participated in local audits but was involved in local benchmarking through the data it provided to the client clinical commissioning groups (CCG).

Evidence of audit for individual health advisers and clinical advisers in the NHS 111 staff was less consistent.

- The provider used health advisers and clinical advisers to undertake call auditing appropriate to their skill set. We saw these advisers had received specific training to do this ensuring they audited to the NHS 111 commissioning standards. We saw a variety of systems and tools used by the provider to record auditing, each system and tool identified different numbers of calls had been audited. The provider therefore could not say how many call audits had been completed each month or the total number of audits since the service launched. We discussed this with the clinical quality performance manager who advised that now the service was becoming embedded and the number of advisers who could complete audits had increased the service would soon be auditing to the required levels within the required timescales.
- From the call audit activity we saw both health and clinical advisers were audited using the NHS 111 standard audit tool. There was no local audit levelling process (a process to ensure consistency amongst call auditors) and auditing at East Kent was still partially being undertaken by agency staff. This had been noted, as poor practice, at the NHS England peer review visit made in January 2017.

Inadequate

Are services effective?

(for example, treatment is effective)

- Any audit which scored below 86% was considered a fail and was reviewed by an NHS Pathways coach. There were action plans for staff who fell below the 86% bar, but additional audits to check those staff members' progress, against the action plan, not been completed.
- During the inspection we saw when gaps in the advisers' performance had been identified (through significant event investigation and call audits), this was discussed with the adviser and an agreed plan of support implemented. We saw an example for a clinical adviser who received additional support, including one to one meetings and on the job coaching to address performance issues.

Effective staffing

The provider could not show that all staff had all the skills, knowledge and experience to deliver effective care and treatment.

- The provider had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, governance policies and processes, health and safety and confidentiality. However staff at the PCCs reported that they had not been through the induction process. This had led to problems using the technology and a lack of knowledge about local information such as the locations of emergency medicine at the PCC.
- There was an NHS 111 induction programme for all newly appointed staff. Some members of staff advised they had a corporate induction when they joined the provider, whilst others said that they had not. There was inconsistent monitoring of which members of staff had completed specific training relating to their place of work, for example some members of staff had completed fire training whilst others had not. This was exacerbated by the provider using two different software systems to document training, one for health advisers and one for clinical advisers. During the inspection, we cross referenced the dates of the corporate inductions and found the recorded dates were not accurate. The provider advised that all staff had a corporate induction, yet the correspondence and staff told us this was not accurate.
- Evidence that the learning needs of staff were identified and met was limited. The service was new and there had been no appraisals at which staff learning needs might have been identified. Staff had access to a corporate database for mandatory training. The inspectors were provided with figures which showed 21% of staff had completed their mandatory training and 34% of non-clinical staff had completed mandatory training. Staff told us the system, for accessing training, was difficult to use, that they had had to go to an office to use it (though this had recently been remedied), and that the technology frequently failed.
- Staff had access to and made use of e-learning training modules. Staff were able to complete training during quieter shifts or had protected time allocated. Local managers were endeavouring to arrange specific in-house training for advisers. For example palliative care and end of life training and specific in-house dementia awareness training for advisers. However the training and record keeping for non-clinical staff, specifically health advisers did not demonstrate they had appropriate role-specific training. For example, safeguarding training for health advisers was not to the appropriate levels.
- There were gaps in clinical supervision. For example on 18 January 2017 the CCG carried out an announced visit to one of the bases which identified a lack of clinical supervision. The report on the visit noted that "This is to be rectified immediately". It also noted that "Concerns identified during the visit have already been escalated within the organisation and they are being addressed". The issue was raised again by the CCG with the provider on 5 April 2017. However by 5 May 2017 the staff concerned had not received such support. None of the staff we spoke with had had one-to-one meetings with their manager. One staff member had had a one-to-one meeting with a manager, shortly before the service had commenced and they said that this had been productive. None of the staff we spoke with had a personal development plan as set out in the statement of purpose for the East Kent location.
- Not all staff involved in handling medicines had received training appropriate to their role.

Coordinating patient care and information sharing

Providers must send details of all OOH consultations (including appropriate clinical information) to the practice where the patient is registered by 8am the next working day (NQR2). We saw that this was achieved 99% to 100% of the time.

- The information needed to plan care and treatment was not always available to staff. There were problems with delivery of information through the patient record and

intranet systems. GPs and healthcare staff had experienced difficulties with accessing patients' notes. There was a medical interoperability gateway which linked the patient record operating systems. Some staff reported they had no access to patients' notes, others that the calls transferred from the NHS 111 service did not have the NHS patient number attached so that clinicians could not access the notes and another that they could only see data that had been entered on that day. The issue of NHS patient number may be a national problem.

- NHS 111 staff knew how to access and use patient records for information and when directives may impact on another service for example advanced care directives or do not attempt resuscitation orders. The service used systems to identify 'frequent callers' and staff were aware of any specific response requirements including care plans and special patient notes.
- 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. For example, there was a meeting planned with the clinical commissioning groups and South East Coast Ambulance service in the weeks following the inspection to discuss referral rates to the ambulance service. We saw when safeguarding concerns were raised staff followed the correct referral pathway for each of contracted local authority areas.
- Information about previous calls made by patients was available, staff could use this if callers rang back and the information was relevant to support the decision making process
- Patients who could be more appropriately seen by their registered GP or an emergency department were referred. Patients needing specialist care could be referred to other specialties.

Consent to care and treatment

- Staff sought patients' consent to care and treatment in line with legislation and guidance.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Where a patient's mental capacity to consent to care or treatment was unclear clinical staff assessed the patient's capacity and, recorded the outcome of the assessment.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff and listened to telephone calls. Staff were courteous and very 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.
- We noted that consultation and treatment room doors were closed during consultations and people could not be overheard.

The national GP patient survey asks patients about their satisfaction with the out-of-hours service. However this survey was published in July 2016 so predates the provider's services.

Care Quality Commission comment cards, on which members of the public could report their views on the service, were sent to the East Kent locality but we were told they had not been received.

We listened to health advisers and clinical advisers use the NHS pathways assessment tool. We only listened to the health advisers or clinical adviser, not to the patient. We heard staff were courteous and helpful to patients and treated them with dignity and respect.

All the caller interactions we heard were non-judgmental and treated each patient as an individual whatever their circumstances.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

There were systems were to identify repeat callers and staff used the 'special notes' facility to log information. Special notes were a way in which the patient's usual GP can raise awareness about their patients who might need to access the out-of-hours service, such as those nearing end of life or those with complex care needs and their wishes in relation to care and treatment.

To comply with National Quality Requirement five (NQR 5) providers must regularly audit a random sample of patients' experiences of the service. The provider had not conducted surveys under this requirement.

Primecare East Kent provided a "friends and family" questionnaire at every primary care centre. We were told that it had been available at the primary care centres for about four weeks. It could be handed in to the counter or posted at no cost to the patient. There had been a limited uptake of the survey in East Kent which had received six results.

When asked about the helpfulness of the call handlers and the quality of the telephone consultation the answers ranged through good to very good and excellent. There was one negative response about the attitude of a clinician but patients were positive about the promptness of treatment. All the patients in the survey were satisfied with the service.

We heard that health and clinical advisers spoke respectfully with patients, and treated callers with care and compassion. Staff had had training in how to respond to a range of callers, including those who may be abusive. Our observations were that staff handled calls sensitively and with compassion. We heard that the patient was involved and supported to answer questions thoroughly. Health advisers always doubled checked with the patient that they had the right details for home address, GP and telephone contact details. The final disposition (outcome) of the clinical assessment was explained to the patient and in all cases, patients were given advice about what to do should their condition worsen. Staff used the Directory of Services to identify available support close to the patient's geographical location. Staff took the time to answer patients' questions and to ensure they understood the information provided.

The provider provided facilities to help patients be involved in decisions about their care. There were translation services for patients whose English was not sufficiently fluent to manage a clinical consultation, and we saw evidence that these were used regularly.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The provider reviewed the needs of its local population and engaged with the clinical commissions groups (CCGs) to secure improvements to services where these were identified. For example The provider East Kent had reviewed its staff skill mix at the primary care centres (PCC) and had changed it to better serve the patients' needs.

- Home visits were available for patients whose clinical needs resulted in difficulty attending the PCCs.
- There were translation services for patients whose English was not sufficiently fluent to manage a clinical consultation. For example, since November 2016, 17 advisers requested the use of this service for a range of languages.
- The provider supported other services at times of increased pressure. The provider was able to show that their assessment of patients' needs had substantially reduced the number of non-emergency ambulances being dispatched to patients' homes (green ambulance calls).
- All of the PCCs we visited were easily accessible to patients who used a wheelchair and for pushchairs with level access throughout, electronic doors, wide passage ways and disabled toilets available. However none of the PCCs we visited had signage to show patients where the Out of Hours (OOH) service was located within the hospital.

Access to the service

The Out Of Hours (OOH) service was available on weekday evenings and overnight from 6.30pm to 8am and 24 hours a day at weekends and on bank holidays. Patients accessed the OOH service via NHS 111. The NHS 111 service, also managed by The provider, triaged the calls and if it concluded that the most appropriate course of action was for the patient to be seen by a clinician booked the patient in to a PCC or a home visit as appropriate.

The service was not commissioned to see 'walk in' patients at the PCCs and those that came in were encouraged to call NHS 111 so that they could be appropriately triaged. If they needed urgent care they were seen at the PCC.

The call centre at the East Kent locality (Canterbury) closed at midnight. Appointments were booked by the call centre in Birmingham. Appointments were booked without the benefit of local knowledge. Staff told us of times when they were allocated calls outside their normal area of working for no apparent operational reason. This had led to them being unavailable to deal with more local calls for protracted periods. Staff also told us that this had become less of a problem recently.

The service had a system to assess whether a home visit was clinically necessary and the urgency of the visit. This was done using the recognised NHS Pathways triage process.

In March 2017 the NHS 111 operations manager had completed a demand and capacity audit which indicated there was increased call activity between 6.30am and 7.30am each weekend morning. As a result, the service amended shift times (the night shift started later to work this time and the early shift started earlier to work this time) to increase the availability of advisers working between these times.

The NHS 111 service was monitored against the national Minimum Data Set (MDS) and adapted National Quality Requirements (NQRs). The results were consistently better than the England average

Call backs from clinicians within 10 minutes in

- February 2017, was 67%
- March 2017 was 58%.
- England average 37% and 38% respectively.

Calls transferred for clinical advice were higher than the England averages.

- February 2017 46%
- March 2017 43%
- This was higher than the England average of 23% and 22% respectively.

Listening and learning from concerns and complaints

The service had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with the NHS England guidance and their contractual obligations. However there was evidence that NHS 111 service did not follow their complaints' policy as they neither risk assessed complaints nor recorded verbal complaints.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- Complaints for NHS 111 and OOH services were handled by separate managers.
- We saw that information was available to help patients understand the complaints system. There was a complaints leaflet available at each PCC.

There had been 49 complaints between 1 October 2016 and 31 March 2017. Seven had been upheld, six part upheld and three not upheld. Thirty three were shown as unresolved.

We looked at three complaints in detail. They were satisfactorily dealt with. Initial response letters were sent within three days. The final response letters were comprehensive, dealt with the issues raised and treated the complainant with respect. Two of the responses took a long time, 66 days and 73 days. In one case the matter was complex, involving four health services, the other was not.

The complaints' register had entries for "root cause", "response" and "learning". Records showed the text in the response column was exactly the same that as in the root cause column so it was not clear what the response to the complaint was. For example one entry read "Patients wife would like a review regarding her husbands wait for an on call doctor …" the root cause and the response was "Recruitment ongoing". The learning column read "Unexpected clinician shortage… due to sickness".

It was sometimes difficult to see how learning was shared. There were entries in the learning column such as "all staff members encouraged to manage expectations", "All staff to be made aware of …" and "Clinicians to be reminded…" but there was no evidence of how these lessons had been delivered across the service.

This was not always the case. One entry identified that a call had been logged in error, this had resulted in a personal learning for the individual and an internal communication highlighting the importance of following policy. Another complaint had led to a review of the skill sets of the clinicians working at the PCCs and in a third, concerning a staff member's attitude, a manager talked with the individual concerned.

Other entries were simply difficult to understand. For example a complaint involved a prescribing decision and the attitude of a GP. The root cause and the response were "mental health" and learning was "not applicable". However the complaint was partially upheld.

The NHS 111 service did not maintain a record of verbal complaints that had, with the complainants' consent, been informally resolved. Therefore there was no analysis of themes or trends and no organisational learning from them.

Are services well-led?

Inadequate

(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 mission statement to provide focus for staff. It was not on view in the office but staff saw the statement on their computer screens during their daily work. However the statement was based on providing domiciliary care services and appeared to be the mission statement of the parent company.

Governance arrangements

Governance arrangements were insufficient and not always implemented effectively.

- The service's governance framework was in development. Local clinical governance was limited and appeared to be driven nationally. National clinical governance arrangements had lapsed because of the absence of key senior staff though sickness. There was an interim head of quality and governance. The East Kent locality was supported by an interim contracts manager. Both of these interim appointments had responsibilities elsewhere in the country. There was a national medical director (who had been an interim appointment until January 2017) working two days a week across all of the parent company's Out of Hours (OOH) and GP led services. The service was advertising for a local clinical director for half a day each week.
- Clinical governance meetings had recommenced nationally in April 2017. The agenda covered areas such as audit, complaints and mandatory training. Local branches submitted a report to the national meeting which included information on significant events, complaints and clinicians who were cause for concern. The meetings were for a whole day with a learning event in the afternoon. The meeting was described as a "new start" for governance.
- The staffing structure was not clear and not all staff were aware of their own roles and responsibilities. Staff we spoke with were not clear about who was in charge of the East Kent locality. We spoke with a staff member who was named on a policy document as having responsibility for a particular, and important, role but they told us they were not aware of this.
- The provider had specific policies and governance processes. These were available to all staff on the intranet but staff reported that the technology needed to access them was unreliable. At the primary care centres (PCC) we saw there were folders containing printed copies of the most important or frequently consulted policies and staff told us that these folders were well used.
- Senior staff we spoke with had an understanding of their performance against National Quality Requirements and accepted that their performance against National Quality Requirements (NQR) 12, face to face consultation at PCC and home visits, was unacceptable. We looked at the minutes of the monthly core team meeting where the performance of each locality of the parent company is reviewed. The review, for the East Kent locality, mentioned that: the locality was delivering services beyond their contract and for which they were not being paid, there had been work on reducing costs, there had been work to further engage with local providers and there had been work to recruit staff. There was no recorded discussion of performance against patient outcomes.
- Performance was discussed with the local clinical commissioning groups (CCG) as part of contract monitoring arrangements. There was a monthly report submitted by the East Kent locality to the contracting CCGs. It covered performance against the NQRs, details of the activity over time and local GP practice related information. There were sections within the report which were not filled in because the requisite information was not readily available. These included use of clinical guidance, prescribing errors, significant events (called serious untoward incidents), patient feedback and the clinical staff mix. There was a new type report in preparation in which it was planned to address this. There was no evidence that OOH performance was shared with staff. Performance for NHS 111 services was displayed in the call centre and we saw staff taking an interest in it.
- There were some arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However they had failed either to recognise or to recognise and address some relevant matters. This included but was not confined to: patient outcomes, training, staff development and significant events.

There were different arrangements for NHS 111 services.

- Complaints, concerns, health care professional feedback, significant events, safeguarding issues and non-compliant call audits were reported on in a

Are services well-led?

Inadequate

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

monthly clinical governance report. These were reviewed at monthly meetings. However the governance reports were not always fully completed. Reports for January, February and March had blank templates in relation to safeguarding and complaints. We were informed that this was due to the person completing the report not being trained in this process and that the task had been given to them without support.

- There were other areas within the clinical governance report that had not been acted upon. For example, in March 2017 it was planned that a common themes feedback sheet was to be compiled by the training team for circulation to staff. At time of inspection this had not been done.
- The information contained within the clinical governance report about completed audits did not correlate to the information supplied by the provider regarding audits within the organisation.
- The provider had submitted data for calls abandoned for November and December 2016 to the NHS. It had not submitted such data for January, February or March 2017. This data was available on the NHS England website for the other NHS 111 contracts. Calls abandoned is a marker of patient experience. The absence of data meant that the public could not compare this aspect of the service provided to them against the service provided in other parts of the country.

Leadership and culture

The provider was aware of and had systems to help 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).There were systems to help ensure that when things went wrong with care and treatment:

- The service gave affected people an explanation based on the facts and an apology where appropriate, in compliance with the NHS England guidance on handling complaints.
- The service did not always keep written records of verbal interactions. When verbal complaints were informally resolved, with the complainants' consent, no written record was kept, hence there could be no analysis of trends.
- We saw little evidence of arrangements to keep staff informed and up-to-date. For example there were no were no formal regular staff meetings and no staff told us of plans for such meetings. There were no regular management briefings such as a staff newsletter. The leadership structure was not clear to staff. Staff, at the PCCs, told us that the management felt remote.
- Most of the staff we spoke with, at the PCCs, were not aware of the reporting process for significant events. The provider was unable to demonstrate there was a feedback mechanism to inform staff, as a whole, of learning from significant events or complaints. We saw there were plans for a patient safety newsletter that was due for publication in June 2017. It had last been published in June 2016.
- Staff said that they did not have the opportunity to contribute to the development of the service. We saw that staff were keen to contribute. One staff member had, on their own initiative, organised a local staff group to make suggestions for improvement in working practices. They had arranged a meeting, in their own time, with managers to take this forward.

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

There had been recent efforts to encourage feedback from patients. There was a "friends and family" questionnaire at every PPCs. It could be handed in to the counter or posted at no cost to the patient. There had been a limited uptake of the survey in East Kent. The number of surveys returned by branch, over a three month period, was: Birmingham 143, Mid Essex 100, Walsall 16, Scarborough 47, East Kent 6. The results from the questionnaire were very positive. There were no formal arrangements for consulting with staff.

Continuous improvement

All the staff, including GPs at the PCCs said that there had been organisational improvements to the service in recent months.

This section is primarily information for the provider

Enforcement actions

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
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment to patients must be provided in a safe way:** • The reporting, recording and learning from significant events was not effective. • The provider did not have a local lead for medicines and was not able to show us training records for such staff. • Emergency medicines were not always easily accessible and we found some staff who did not know the location of emergency medicine.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed:** • Patients categorised as an emergency were not being seen within an acceptable time. Such patients should be seen within one hour. In January, February and March 2017 The provider managed this, on average for 29% of patients. • Many staff reported that they had not had a formal process of induction. • Compliance with the Primecare mandatory training requirements was reported to be at 22% and 34% for non-clinical staff. • Training for safeguarding was incomplete.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury

The clinical and managerial governance arrangements were ineffective:

- There was poor feedback to clinical staff about learning from significant events or complaints. Some staff did not know how to report significant events.
- Staff said that they did not have the opportunity to contribute to the development of the service. There were no formal regular staff meetings and no staff told us of plans for such meetings. There was little evidence of seeking and acting on patient feedback. Disaster recovery plans were unclear. There was no local clinical director.
- Managerial meetings did not discuss performance against patient centred outcomes. Key managers were interim appointments who had responsibilities elsewhere.