Urgent Care Centre (Paulton)

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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the Urgent Care Centre, Paulton on 28 February and 1 March 2017. Overall the service is rated as requires improvement.

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

- There was an open and transparent approach to safety and an effective system in place for recording, reporting and learning from significant events.
- Patient's care needs were assessed and delivered in a timely way according to need. The service had difficulties meeting two of the national quality requirements and had completed remedial action plans to improve this in November 2016.
- Staff assessed patient's 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. However, not all staff that chaperoned had received adequate training.
- There was a system that enabled staff to access patient records, and the out-of-hours staff provided other services, for example the local GPs and hospital, with information following contact with patients as was appropriate.
- The service managed patient's care and treatment in a timely way. However, this service was often centralised to the Royal United Hospital (RUH) in Bath, due to a lack of GP cover. This ensured the patients clinical need was met although some patients had further to travel.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Improvements were made to the quality of care as a result of complaints and concerns.
- The service worked proactively with other organisations and providers to develop services that supported alternatives to hospital admission where appropriate and improved the patient experience.
- 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.

Summary of findings

Clinical equipment that required calibration was calibrated according to the manufacturer's guidance. However, the equipment in the bag for the vehicle had not been calibrated.

- There was a leadership structure, however, some members of staff informed us that they did not feel supported by local management at the RUH and felt isolated at Paulton.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider must make improvement are:

- Establish and operate an effective system to check, manage and mitigate the risks associated with the emergency equipment and medicines. Ensure that all equipment is calibrated in line with manufacturers guidance or replaced when necessary.
- The provider must undertake and record appraisals or performance reviews for all staff members every 12 months.
- Ensure that all staff receive training specific to their roles, such as chaperone training.

The areas where the provider should make improvement are:

- Ensure that Paulton staff are supported by a visible management team.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- There was an effective system in place for recording, reporting and learning from significant events.
- Lessons were shared via emails, meetings and newsletters to make sure action was taken to improve safety in the service.
- When things went wrong patients were informed in keeping with the Duty of Candour.They were given an explanation based on facts, an apology if appropriate and, wherever possible, a summary of learning from the event in the preferred method of communication by the patient. They were told about any actions to improve processes to prevent the same thing happening again.
- When patients could not be contacted at the time of their home visit or if they did not attend for their appointment, there were processes in place to follow up patients who were potentially vulnerable.
- There were systems in place to support staff undertaking home visits.
- The out-of-hours service had clearly defined and embedded systems and processes in place to keep patients safe and safeguarded from abuse. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. However, on the day of our inspection staff were unable to access the safeguarding policy on the intranet which contained the safeguarding referral forms and details of the safeguarding leads.
- Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, out of date medicines were found and there was no checklist log to evidence that emergency drugs and equipment were regularly checked although we were informed they were checked weekly.

Are services effective?

Requires improvement

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

Summary of findings

- Data showed the service historically had failed to meet two of the National Quality Requirements (NQR / performance standards) for GP out-of-hours services. The service had received contract performance notices, these were closed in November 2016 as remedial actions had been completed and improvements made by the provider.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. Staff had access to online mandatory training via Vocare's E-Learning Academy (VELA) which provided a suite of eLearning modules for all staff. The provider also had a programme which specifically focused on talent management and further enhanced leadership skills during an academic year in order to support staff to grow within the business.
- There was evidence of personal development plans for all staff. However, GPs and drivers had not received an appraisal, or performance review within the past 12 months.
- Clinicians provided urgent care to walk-in patients based on current evidence based guidance.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- The service had worked collaboratively with the Sepsis Trust and had developed several GP decision tools for different population groups.

Are services caring?

Good

The service is rated as good for providing caring services.

- Feedback from the large majority of patients through our comment cards and collected by the provider were positive.
- 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. The provider had developed several patient information leaflets including how to recognise if your child is seriously ill and finding the right service.
- 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.

Summary of findings

- Results from the GP survey published in July 2016 showed that the service had performed higher than the national average in all areas.

Are services responsive to people's needs?

Good

The service is rated as good for providing responsive services.

- Service staff reviewed the needs of its local population and engaged with its commissioners to secure improvements to services where these were identified. For example, the service participated in the Commissioning for Quality and Innovation (CQUIN) national goals which was a Department of Health framework launched to encourage healthcare providers to continuously demonstrate improvements and innovation in the quality of the care they provided. The service had achieved their goals in antimicrobial stewardship and voice of the child pilots, demonstrating a commitment to active engagement in quality improvement with local commissioners.
- The provider implemented an arrangement with an insurance brokerage firm which ensured that clinicians working out-of-hours for this provider no longer had to pay a premium on their own indemnity insurance. In addition to this the provider could also cover the indemnity of clinicians within their service at a vastly reduced cost.
- The service had good facilities and was well equipped to treat patients and meet their needs.
- The service had systems in place to ensure patients received care and treatment in a timely way and according to the urgency of need. However, this service was often centralised to the Royal United Hospital (RUH) in Bath, due to a lack of GP cover. This ensured the patients clinical need was met although some patients had further to travel.
- Information about how to complain was available and easy to understand and evidence showed the service responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Requires improvement

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

- The service had a vision and a strategy but not all staff were aware of this and their responsibilities in relation to it. The leadership structure had recently been redesigned to

incorporate a local management team in the South West to provide local support. There was a documented leadership structure and most staff felt supported by management but at times they weren't sure who to approach with issues.

- The service had a number of policies and procedures to govern activity and held regular governance meetings. However, on the day of our inspection staff were unable to access the safeguarding policy on the intranet.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The provider encouraged a culture of openness and honesty. The service had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The service proactively sought feedback from staff and patients, which it acted on.
- There was a health and well-being lead for the service who updated the monthly newsletter with health topics and groups.
- The provider had implemented an employee of the month scheme to recognise exemplary behaviour and commitment, details of this were published in the monthly newsletter.
- There was a focus on continuous learning and improvement at all levels and the provider actively encouraged and supported clinicians to undertake additional training to enhance the service. However, we were informed that some staff members who chaperoned had not received chaperoning training.
- All staff had received inductions but not all staff had received regular performance reviews and appraisals.

Summary of findings

What people who use the service say

We looked at various sources of feedback received from patients about the out-of-hours service they received. Patient feedback was obtained by the provider via the friends and family test on an ongoing basis and was included in their contract monitoring reports. Data from the provider showed that they had received feedback from 21 patients where 100% were likely or extremely likely to recommend the service to friends and family.

The national GP patient survey asks patients about their satisfaction with the out-of-hours service. Data from the GP national patient survey published in July 2016 found:

- 67% of patients said they were satisfied with how quickly they received care from the out-of-hours provider compared to the national average of 62%.
- 71% of patients were positive about their overall experience of the out-of-hours GP service compared to the national average of 70%.
- 89% of patients had confidence and trust in the people they spoke with or saw from the out-of-hours provider compared to the national average of 86%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 28 comment cards, 26 of which were all positive about the standard of care received. The cards described a respectful and kind service where they felt listened to. One of the two negative responses related to patient expectation of the service and did not align with other comments received.

Urgent Care Centre (Paulton)

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP Specialist Adviser and two additional CQC Inspectors.

Background to Urgent Care Centre (Paulton)

Urgent Care Centre, Paulton is the registered location for the GP out-of-hours (OOH) service provided by Vocare Limited based at Paulton Memorial Hospital and known locally as Vocare.

Vocare provides two services within Bath and North East Somerset (BaNES) under a contract with the BaNES Clinical Commissioning Group. The Urgent Care Centre Royal United Hospital (RUH) Bath is a GP OOH service and urgent care centre provided at RUH, Bath which shares the staff and processes with the GP OOH service based at Paulton, it has been inspected seperately as it is registered as a separate location with the CQC.

The service covers a population of approximately 540,000 people across the county of Bath and North East Somerset. Deprivation in BaNES overall is lower than the national average and it has relatively low numbers of patients from different cultural backgrounds.

The OOH service based at Paulton works alongside OOH service and the urgent care centre based at RUH and provides GP services to patients when practices are closed. Patients access the service via the NHS 111 service, if the NHS 111 assessment concludes that the most appropriate course of action is for the patient to be managed by the GP OOH service then NHS 111 schedule an appointment directly into the GP OOH computer system. Patients may also be allocated an appointment for a home visit with a GP or may receive a telephone consultation depending on the clinical needs assessed by NHS 111. The GP OOH service is open from 6.30pm to 12am Monday to Friday and 8am to 12am Saturday, Sundays and bank holidays. During the out-of-hours periods where Paulton is not open overnight cover and support is provided from the RUH service.

There are two CQC registered managers for this service who are not based locally. Due to service growth in the South West of England Vocare have employed a regional director, local clinical director, clinical services manager and lead nurse who are all based locally to this particular service to provide visible local management and support. There are 11 salaried GPs and 54 GPs contracted on a sessional basis to provide the out of hour's service. The service also employs a variety of other clinicians including seven salaried advanced nurse practitioners and 12 bank nurse practitioners. The service is supported by a team of operational and administrative staff.

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.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the service and asked other organisations such as local GP practices, Healthwatch and Bath and North East Somerset (BaNES) Clinical Commissioning Group to share what they knew. We carried out an announced visit on 28 February and 1 March 2017. During our visit we:

- Spoke with a range of staff including the two registered managers, a local clinical director, a regional manager, a clinical services manager, two GPs, one dispatcher and one driver.
- Observed how patients were provided with care and talked with carers and/or family members.
- Inspected the out of hours premises, looked at cleanliness and the arrangements in place to manage the risks associated with healthcare related infections.
- Looked at the vehicles used to take clinicians to consultations in patient's homes, and we reviewed the arrangements for the safe storage and management of medicines and emergency medical equipment.
- Reviewed 28 comment cards where patients and members of the public shared their views and experiences of the service.

To get to the heart of patient's 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.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they would inform the local clinical director or the clinical support manager of any incidents and there was a recording form available on the service's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received support; an explanation based on facts, an apology where appropriate and were told about any actions to improve processes to prevent the same thing happening again.
- The service carried out a thorough analysis of the significant events and ensured that learning from them was disseminated to staff and embedded in policy and processes. Monthly clinical governance meetings focussed on risk management discussion and ensured that systems were in place to manage and learn from incidents. Staff were informed of significant events and incidents via various monthly meetings, email updates, monthly newsletters and clinical governance meeting minutes.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the service. For example, following an incident that occurred due to non-adherence to a medicines management process the guidance was re-circulated immediately and the process was re-iterated in the monthly newsletter.

Overview of safety systems and processes

The service had clearly defined and embedded systems, processes and services to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements and safeguarding reporting to the clinical commissioning group (CCG) had been improved following the receipt of a contract performance notice. Improvements included ensuring policies were accessible to all staff on the intranet, a central place to store safeguarding referrals electronically had been implemented, and regular meetings with relevant local safeguarding leads had been put in place. However, on the day of our inspection staff were unable to access the safeguarding policy on the intranet. The regional director advised staff how to access the policies and ensured that hard copies of the policies were placed in the service the following day to prevent this from reoccurring in the future. There were two lead members 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 three. One of the safeguarding leads was trained to child safeguarding level four. All staff had received online safeguarding adults training and we noted that both of the safeguarding leads had only received the online training for safeguarding adults.
- A notice in the waiting room and all consulting rooms advised patients that chaperones were available if required. We were informed that drivers and dispatchers carried out chaperoning however not all staff who acted as chaperones were trained for the role. All staff that chaperoned had received a Disclosure and Barring Service (DBS) check. (DBS
- The service maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. There was an infection control lead, an infection control protocol and clinical staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- There was a system to ensure equipment was maintained to an appropriate standard and in line with manufacturer's guidance e.g. annual servicing of fridges including calibration where relevant.
- We reviewed 11 personnel files for bank and permanent staff 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

- The arrangements for managing medicines at the service, including emergency medicines and vaccines, did not 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.
- There were processes for checking medicines, including those held at the service and also medicines bags for the out of hour's vehicles. However, we found several medicines were out of date on the day of our inspection and there was no medicines log to evidence that these were regularly checked.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available that identified local health and safety representatives. The service had up to date fire risk assessments and regular fire drills were carried out by the hospital. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. Clinical equipment that required calibration was calibrated according to the manufacturer's guidance. However, the equipment in the bag for the vehicle had not been calibrated. We were informed that the sphygometer could not be calibrated and it only needed to be replaced if it looked damaged or not suitable for use, the sphygometer had been purchased in 2014 and therefore had not been calibrated for three years. The service had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a bacterium which can contaminate water systems in buildings).
- There were systems in place to ensure the safety of the out of hours vehicles. Checks were undertaken at the beginning of each shift and there was a lead driver for additional support. There was one vehicle used for home visits, we inspected the vehicle and found it to be clean, tidy and well equipped. The vehicle was serviced and maintained through a lease car scheme.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patient's needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty, we were advised that at times of sickness Paulton would be closed and additional cover moved to Royal United Hospital (RUH), Bath for all patients to be seen at RUH. On these occasions the CCG were notified and an agreement to close Paulton was sought. Data submitted to the CCG identified that the service had filled 92% of clinical shifts from October to December 2016 inclusive. This data was a combined figure for GP OOH RUH and Paulton. The provider had implemented a National Triage Service which provided additional cover from GPs based at home to cope with surges in demand by carrying out remote triage via secure computer systems.

Arrangements to deal with emergencies and major incidents

The service had adequate arrangements in place to respond to emergencies and major incidents.

- There was an effective system to alert staff to any emergency.
- All clinical staff received annual basic life support training, including use of an automated external defibrillator.
- The service had a defibrillator available on the premises and oxygen with adult and children's masks.
- A first aid kit and accident book were available.

Requires improvement

Are services safe?

- Emergency medicines were easily accessible, stored securely and all staff knew of their location. However, we found several medicines were out of date on the day of our inspection and there was no medicines log to evidence that these were regularly checked.
- The service had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The service 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 service guidelines.

- The service had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patient's needs.
- The service had worked collaboratively with the Sepsis Trust and had developed several GP decision tools for different population groups, which included a RAG rating tool.
- The service monitored that these guidelines were followed.

Management, monitoring and improving outcomes for people

From 1 January 2005, all providers of out-of-hours services have been required to comply with the National Quality Requirements (NQR) for out-of-hours providers. The NQR are used to show the service is safe, clinically effective and responsive. Providers are required to report monthly to the clinical commissioning group on their performance against standards which includes audits, response times to phone calls, whether telephone and face to face assessments happened within the required timescales, seeking patient feedback and actions taken to improve quality.

Data showed the service historically had failed to meet two of the National Quality Requirements (NQR) performance standards for GP out-of-hours services. The practice had received contract performance notices and these were closed in November 2016 as remedial actions had been completed and improvements made by the provider.

The quality requirements

We reviewed NQR standards from the previous measured quarter, October 2016 to December 2016 which was combined for Paulton and RUH. We found that the service had met the standards required, with the exception of patients being seen within 2 hours by the GP OOH service in March 2017. Data over the three months showed:

NQR4: Providers must regularly audit 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).

The local clinical director was responsible for auditing samples of patient contacts for clinicians in relation to home visits, centre contacts and telephone triage. There was a clinical audit policy, clinical supervision policy, face to face audit process, audit schedule and audit calendar in place to support this. The service monitored telephone triage calls and completed a checklist as part of the performance review process, we saw copies of reviews and subsequent letters to clinicians with the outcomes detailed. However, we were informed that not all GPs had received regular performance reviews.

NQR 10 - Providers must have a system for identifying all immediate life threatening conditions and need to assess patients at consultations within 20 minutes of arrival for adults and 15 minutes of arrival for children. The service had achieved 93% for October to December 2016 and 95% year to date (April 2016 to January 2017) compared to a target of over 95%.

NQR 12: Face-to-face consultations (whether in a centre or in the patient's place of residence) must be started within the following timescales, after the definitive clinical assessment has been completed:

Results for the GP OOH service for October to December 2016 showed:

- Urgent: Within 2 hours – 76% of patients were seen within this timeframe, the results for April 2016 to January 2017 were 95%.
- Less urgent: Within 6 hours – 93% of patients were seen within this timeframe.

There was evidence of quality improvement including clinical audit. The provider undertook a number of clinical audits including asthma audits, urinary tract infection audits, medicines audits and post event message audit. Findings were used by the service to improve services. For example, recent action taken as a result included a clinical audit undertaken in February 2017 which looked at 50 random cases where patients were seen face to face over the past few months either at a centre or as a home visit

Requires improvement

Are services effective?

(for example, treatment is effective)

from the service. The audit objective was to ensure consistent quality of recording of the post event message (PEM), which is an electronically generated message containing all of the clinical information relating to the consultation which is submitted to the patient's own GP. The audit identified that quality was generally high with 96% of PEMs in the proficient or borderline category which was an improvement on the previous audit which was recorded as 86%. The audit results were fedback to all clinicians with specific feedback to individual clinicians.

Information about patient's outcomes was used to make improvements such as: the provider had worked with the Sepsis Trust to develop guidance tools for different population groups that clinicians could refer to when assessing patients, which included a RAG rating. The advice on antibiotic prescribing was regularly updated, the use of antibiotics was audited across the service and any areas for improvement highlighted. The findings were shared across the relevant staff groups through newsletters, meetings and mandatory training days.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The service had an induction programme for all newly appointed staff including bank. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. New staff were also supported to work alongside other staff and their performance was regularly reviewed during their induction period.
- The service could demonstrate how they ensured role-specific training and updating for relevant staff. Staff had access to online mandatory training via Vocare's E-Learning Academy (VELA) which provided a suite of eLearning modules for all staff. The provider also had a programme which specifically focused on talent management and further enhanced leadership skills during an academic year in order to support staff to grow within the business.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of service development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, and clinical supervision. However not all staff had received an appraisal or regular performance review within the last 12 months. We were informed that not all GPs' performance had been reviewed including mandatory GP record review within this timeframe however there was now a schedule in place to rectify this.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.
- Staff involved in handling medicines received training appropriate to their role.

Coordinating patient care and information sharing

NQR 2 and 3 states that providers must have systems in place to send details of all consultations electronically to the practice where the patient is registered by 8am the following day and ensure systems are in place to support and encourage the regular exchange of up-to-date and comprehensive information between all those who may be providing care to patients with predefined needs. This was met 100% by the provider from October 2016 to December 2016 compared to a target of over 95%.

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

- This included access to required special notes and summary care records which detailed information provided by the person's GP. This helped the out-of-hours staff in understanding a person's need.
- The service shared relevant information with other services in a timely way, for example when referring patients to other services.
- The provider worked collaboratively with the NHS 111 providers in their area.
- The provider worked collaboratively with other services such as the minor injury unit.
- If patients needed specialist care, the out-of-hours service, could refer to specialties within the hospital or the urgent care centre in the Royal United Hospital, Bath. Staff also described a positive relationship with the mental health and district nursing team if they needed support during the out-of-hours period.

Requires improvement

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

Staff sought patient's 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.

When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

- 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.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patient's privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Dispatchers located at the RUH 'comfort called' patients if there was a delay to check whether their symptoms had worsened and to advise of the delay. Dependent upon the call outcome the patient's priority could be increased if their symptoms were worsening.

Twenty-six of 28 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the service offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Comment cards also highlighted that staff responded compassionately when they needed help and provided support when required. One of the two negative responses related to patient expectation of the service and did not align with other comments received.

Patient feedback was obtained by the provider via the friends and family test on an ongoing basis and was included in their contract monitoring reports. Data from the provider for the period of October 2016 to December 2016 showed that they had received positive feedback from 71 patients where 100% were likely or extremely likely to recommend the service to friends and family. Patients repeatedly commented on a fast, helpful and friendly service.

The national GP patient survey asks patients about their satisfaction with the out-of-hours service. Results published in July 2016 showed that the service had performed higher than the national average in all areas. For example:

- 67% of patients said they were satisfied with how quickly they received care from the out-of-hours provider compared to the national average of 62%.
- 71% of patients were positive about their overall experience of the out-of-hours GP service compared to the national average of 70%.
- 89% of patients had confidence and trust in the people they spoke with or saw from the out-of-hours provider compared to the national average of 86%.

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. Patient feedback from the comment cards we received was also positive and aligned with these views.

The service provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- The service had facilities for people with hearing impairment such as a hearing aid loop in reception and notices to make patients aware of this facility.
- The provider had worked with the Sepsis Trust to develop patient information leaflets such as 'How to recognise if your child is seriously ill'.
- The provider had developed a patient information leaflet advising patients of what care and services were available to empower them to contact the correct service when requiring out of hours care.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The service reviewed the needs of its local population and engaged with its commissioners) to secure improvements to services where these were identified. For example, the service participated in the Commissioning for Quality and Innovation (CQUIN) national goals which was a Department of Health framework launched to encourage healthcare providers to continuously demonstrate improvements and innovation in the quality of the care they provided. The service had achieved their goals in antimicrobial stewardship and voice of the child pilots, demonstrating a commitment to active engagement in quality improvement with local commissioners.

- Home visits were available for patients whose clinical needs resulted in difficulty attending the service.
- There were accessible facilities, a hearing loop and translation services available.
- The provider supported other services such as the minor injury unit based in the same building at times of increased pressure.

Access to the service

The GP out-of-hours (OOH) service worked alongside the GP OOH service and urgent care centre at RUH, Bath to provide GP services to patients when practices were closed. Patients accessed the service via the NHS 111 service, if the assessment concluded that the most appropriate course of action was for the patient to be managed by the GP OOH service then NHS 111 scheduled an appointment directly into the GP OOH computer system. Patients could also be allocated an appointment for a home visit with a GP or could receive a telephone consultation depending on the clinical need assessed by NHS 111. The GP OOH service was open from 6.30pm to 12am Monday to Friday and 8am to 12am Saturday, Sundays and bank holidays. However, we were informed that the service at Paulton was often centralised to the Royal United Hospital (RUH) in Bath, due to a lack of GP cover. This ensured the patients' clinical need was met although some patients had further to travel. There were arrangements in place for patients at the end of their life so they could contact the service directly.

Feedback received from the CQC comment cards and from the National Quality Requirements scores indicated that in most cases patients were seen in a timely way.

The service had a system in place to assess:

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

Listening and learning from concerns and complaints

The service had an effective system in place for handling complaints and concerns and reported anonymised details of each complaint, and the manner in which it had been dealt with, to the local clinical commissioning group (CCG).

- Its complaints policy and procedures were in line with the NHS England guidance and their contractual obligations.
- There was a designated responsible person who co-ordinated the handling of all complaints in the service.
- We saw that information was available to help patients understand the complaints system such as complaints leaflets and details of how to complain on the provider's website.

We looked at three complaints received in the last 12 months and found that these were handled in a timely manner with openness and transparency. A summary of complaints and learning from them was submitted on a monthly and quarterly basis within a quality and governance report that was discussed at local, regional and national level before being sent to the CCG. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken as a result to improve the quality of care. For example, following complaints relating to waiting times over peak periods the provider reviewed their workforce structure, placed additional telephone triage into the rota and implemented comfort calling to notify patients of a delay and ensure that their symptoms had not worsened. Learnings from complaints was shared via newsletters, meetings and emails.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The service had a vision and a strategy but not all staff were aware of this and their responsibilities in relation to it. There was a documented leadership structure and most staff felt supported by management but at times they weren't sure who to approach with issues. The leadership structure had recently been redesigned to provide additional management support at a local level, we were informed that support was improving as a result of this.

- The service had a mission statement and staff knew and understood the values.
- The service had a strategy and supporting business plans that reflected the vision and values and were regularly monitored.
- The leadership structure had recently been redesigned to incorporate a local management team in the South West including a local clinical director, a regional director, a lead nurse and a clinical support manager. At the time of our inspection we were advised that the provider was also recruiting a further two GP leads to support the local clinical director.

Governance arrangements

The service had an overarching governance framework that supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. However some staff advised that they had difficulty in contacting senior management and were unsure whoto contact.
- All staff had received inductions but not all staff had received regular performance reviews or appraisals. We were informed due to a gap in the local clinical director post some GP performance reviews and appraisals had lapsed. This was identified as an area for immediate attention and two GP lead roles were being recruited to ensure that this would not happen again.
- Service specific policies were implemented and were available to all staff on the intranet. However on the day of our inspection staff were unable to access the safeguarding policy on the intranet. The regional director advised staff how to access the policies and ensured that hard copies of the policies were placed in the service the following day to prevent this from reoccurring in the future.
- The provider had a good understanding of their performance against National Quality Requirements. These were discussed at senior management and board level. Performance was shared with staff and the local clinical commissioning group as part of contract monitoring arrangements.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. The provider had a schedule and audit calendar to ensure these were carried out at regular intervals.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- There was a focus on continuous learning and improvement at all levels and the provider actively encouraged and supported clinicians to undertake additional training to enhance the service. However, we were informed that some staff members who chaperoned had not received chaperoning training.

Leadership and culture

On the day of inspection the provider of the service told us they prioritised safe, high quality and compassionate care. Staff told us the local management team were approachable however, they struggled to contact senior management team members.

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

- The service gave affected patients an explanation based on facts and an apology where appropriate, in compliance with the NHS England guidance on handling complaints.

Are services well-led?

Requires improvement

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

- The service kept written records of verbal interactions as well as written correspondence.

There was a leadership structure which had recently been redesigned to provide additional management support at a local level, we were informed that support was improving as a result of this.

- There were arrangements to ensure the staff were kept informed and up-to-date. This included 121's, team meetings, emails and monthly newsletters.
- There was a health and well-being lead for the service who updated newsletters with health topics and groups.
- The provider had implemented an employee of the month scheme to recognise outstanding behaviour and commitment, details of this were published in the monthly newsletter.

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

The service encouraged and valued feedback from patients, the public and staff. It proactively sought patient's feedback and engaged patients in the delivery of the service.

- The service had gathered feedback from patients through surveys and complaints received. For example, following a complaint relating to waiting times and delays the provider implemented a workforce restructure, comfort calling for all patients to advise of the delays and check whether their symptoms had worsened and displayed waiting times on a white board in the waiting room. Staff undertaking comfort calls were trained to enable them to escalate where appropriate.
- The service had gathered feedback from staff through an annual staff survey, staff meetings and discussion.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the service. The service team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area.

- Through CQUINs, the service had achieved their goals in antimicrobial stewardship and voice of the child pilots, demonstrating a commitment to active engagement in quality improvement with local commissioners.
- The service had worked collaboratively with the Sepsis Trust and had developed several GP RAG (red, amber, green) rated decision tools for different population groups.

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
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: • The provider did not ensure that all equipment was calibrated in line with manufacturers guidance or replaced when necessary.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The registered person did not do have systems and processes to minimise the likelihood of risks and to minimise the impact of risks on people who use services. They had failed to ensure that effective procedures were in place for checking and maintaining emergency equipment and medicines.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: • We found the registered person did not have appraisal procedures in place to ensure persons employed all received a formal written appraisal every 12 months in adherence to provider policy. • We found that not all GPs had received regular performance reviews.

This section is primarily information for the provider

Requirement notices

- We found that not all staff undertaking chaperoning duites had received chaperoning training in adherence to provider policy.