Barndoc Healthcare Limited OOH - Churchwood House

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This service is rated as Good.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at Barndoc Healthcare Limited Out of Hours Service (Barndoc OOH) on 20 and 22 February 2018. This inspection was to confirm that the provider had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 16 and 20 February 2017. At that time we rated the service as inadequate for providing safe services, requires improvement for providing effective services, good for providing caring services, good for providing responsive services and requires improvement for providing well led services. Overall we rated the service as requires improvement.

This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

At this inspection we found that:

- Risks to patients were well assessed and managed. For example, the provider had taken action to address infection prevention and control risks; and risks associated with medicines management which we had identified at our February 2017 inspection.
  - The service had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes.
  - The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- The service's three primary care base locations had good facilities and were well equipped to treat patients and meet their needs.
  - Primary care base GPs and receptionists treated people with compassion, kindness, dignity and respect.
  - Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
  - The provider was aware of and complied with the requirements of the duty of candour.
  - There was a strong focus on continuous learning and improvement at all levels of the organisation.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The service proactively sought feedback from staff and patients, which it acted on.
- Governance arrangements supported the delivery of safe and patient centred care.

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

- Review the newly implemented procedure for monitoring the storage of medicines and equipment at primary care bases, to ensure that the risks of storage at temperatures outside of the recommended range are managed.
- Review the way in which unused prescriptions are recorded following home visits, in line with its protocols.
- Review the procedure for disposing of part used ampoules of controlled drugs on home visits.
- Revisit the risk assessment into its decision not to carry oxygen in home visit vehicles, so as to ensure that this takes into account all reasonable circumstances.

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

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- Review the newly implemented procedure for monitoring the storage of medicines and equipment at primary care bases, to ensure that the risks of storage at temperatures outside of the recommended range are managed.
- Review the way in which unused prescriptions are recorded following home visits, in line with its protocols.
- Review the procedure for disposing of part used ampoules of controlled drugs on home visits.
- Revisit the risk assessment into its decision not to carry oxygen in home visit vehicles, so as to ensure that this takes into account all reasonable circumstances.

Barndoc Healthcare Limited OOH - Churchwood House

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, three members of the CQC medicines team, a service manager specialist adviser and a second CQC inspector.

Background to Barndoc Healthcare Limited OOH - Churchwood House

Barndoc Healthcare Limited Out of Hours Service (Barndoc OOH Service) provides urgent medical care and advice out-of-hours (OOH) for over one million residents of Barnet, Enfield and Haringey who are registered at general practices within these London Boroughs.

On 4 October 2016, five north central London Clinical Commissioning Groups: Barnet, Camden, Enfield, Haringey and Islington launched an integrated NHS 111 out of hours service. The contract to provide the service is held by London Central and West Unscheduled Care Collaborative (LCW).

The integrated NHS 111 out of hours service is delivered in partnership with Barndoc OOH Service who is a material subcontractor. Barndoc OOH Service is subcontracted by LCW to provide the GP out of hours element of the service for Barnet, Enfield and Haringey CCG areas. The service includes telephone clinical assessments with GPs and nurses, GP home visits and face to face consultations at primary care base locations in Barnet, Enfield and Haringey.

Together, Barndoc OOH Service and LCW work in partnership to deliver a single IUC service across North Central London.

The service is provided for registered patients and those requiring immediately necessary care when GP practices are closed; namely overnight, during weekends, bank holidays and when GP practices are closed for training.

Barndoc's managerial and administrative staff are based at its operational headquarters in Cockfosters, Barnet. The service's three primary care base locations are located at:

Enfield

Chase Farm Hospital

The Ridgeway

London

EN2 8JL

Barnet

Finchley Memorial Hospital

Granville Road

London

N12 0JE

Haringey

The Laurels

256 St Ann's Road

Detailed findings

London

N15 5AZ

Barndoc OOH service's staff team includes a chief operating officer, a medical director, a deputy medical director, a head of operations, a head of governance, a head of corporate services, a rotamanager, finance team, call handling staff, drivers, nurses and GPs. There is also an external pharmacy contractor for the management of medicines. The service employs sessional (self-employed contractor) GPs directly and occasionally through agencies.

The opening hours are seven days a week from 6:30pm to 8am and 24 hours at weekends and bank holidays. Barndoc OOH Service sees an average of 500 patients per week.

Patients access Barndoc OOH Service via the NHS 111 telephone service. Depending on their needs, patients may be seen by a GP at one of the service's three base locations, receive a telephone consultation or a home visit. The service accommodates overnight walk in patients at one of its bases (Chase Farm Hospital).

Barndoc Healthcare Limited (Out Of Hours Service) is registered for the Regulated Activities of Transport services, triage and medical advice provided remotely; and Treatment of disease, disorder or injury. The service has been registered since January 2012.

This inspection was conducted to check that improvements planned by the service to meet legal requirements had been made.

Good

Are services safe?

Our findings

We rated the service as good for providing safe services.

At our previous inspection on 16 and 20 February 2017, we rated the service as inadequate for providing safe services as the arrangements in respect of medicines management and infection prevention and control were inadequate.

These arrangements had significantly improved when we undertook a follow up inspection on 20 and 22 February 2018. The service is now rated as good for providing safe services.

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- The provider conducted safety risk assessments. It had safety policies, including Control of Substances Hazardous to Health and Health & Safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction and refresher training. The provider had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The service worked with other agencies such as local authority safeguarding teams to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. This was confirmed when we looked at three personnel records. We also confirmed that Disclosure and Barring Service (DBS) checks were undertaken where required. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.
- All staff received up-to-date safeguarding and safety training appropriate to their role. Staff such as base GPs and reception staff knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- When we inspected in February 2017, we noted that although the provider had undertaken a recent Infection Control Compliance Assessment, this did not evidence how key areas such as hand hygiene, safe handling and disposal of sharps and the appropriate use of personal protective equipment had been assessed against preventing, detecting and controlling the spread of infections. We asked the provider to take action.
- At this inspection we noted that an effective system was in place for managing infection risks. For example, recent IPC audits had taken place and actions taken as necessary (such as the provider liaising with its NHS landlord and introducing disposable curtains at one of its base locations). We also noted that protocols had been introduced to clarify infection prevention and control responsibilities between Barndoc and London Central and West Unscheduled Care Collaborative (LCW).
- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective system in place for dealing with surges in demand.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections For example, a recent edition of the provider's 'Learning From Experience' e-bulletin highlighted that Sepsis (a common and potentially life-threatening condition

triggered by an infection) was characterised by low blood pressure and high temperature; and stressed the need for GPs to include these elements in their clinical assessment.

- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.
- When there were changes to services or staff the service assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

When we inspected in February 2017, we highlighted risks associated with medicines management. The provider's Head of Medicines Management had recently reduced their hours from thirty hours per week to one hour per week but we did not see evidence that the provider had taken action to ensure that medicines management was sufficiently resourced to keep patients safe.

Consequently, we identified concerns regarding the safe disposal of Controlled Drugs (CDs) and protocols for checking emergency medicines. For the period 1 January 2017 – 15 February 2017 we also noted an absence of records confirming that medicines cassettes were being checked upon their return to headquarters. We asked the provider to take action.

At this inspection we noted that more effective systems had been introduced for the appropriate and safe handling of medicines.

- For example, an external pharmacy contractor had been appointed shortly after our inspection in February 2017. We saw that processes were in place for checking medicines and that staff kept accurate records of checking and replenishing medicines cassettes upon their return to headquarters.
- Improved systems were now also in place to ensure that CDs were monitored and/or disposed of as necessary (including weekly pharmacist visits to audit and replenish stock). We saw that errors in the CD register were crossed through but not corrected by a footnote as specified in the provider's standard operating procedure. However, we noted that the external pharmacy contractor had reported this issue to the provider and that the correct procedure had been communicated to staff. We also noted an absence of guidance to staff regarding how to dispose of part used ampoules on home visits.
- The systems and arrangements for managing emergency medicines and equipment had also improved. When we inspected in February 2017 emergency medicines kept at base locations were not stored in a manner which facilitated immediate access in an emergency and we did not see documentation confirming that emergency boxes were routinely checked. At this inspection we noted that the external pharmacy contractor supplied and monitored emergency medicines (including oxygen) and equipment used at base locations and for home visits. They were stored securely in 'Grab Bags' which facilitated immediate access in an emergency and the provider was also in the process of introducing regular checks.
- We noted that the temperatures in the medicines stores at primary care bases had sometimes been above the range recommended for medicines storage. However, the provider had identified this and there was a newly introduced procedure for monitoring the temperature. The external pharmacy contractor was supporting the provider to assess the risks and develop an action plan to ensure that the medicines remained safe to use.
- The service kept prescription stationery securely and monitored the use at the primary care bases. We saw that a recent discrepancy had been identified through the recording system and had been reported and

investigated. However the provider did not always record unused prescriptions returned to the headquarters after home visits, meaning that they did not have a complete audit trail.

- Arrangements were also in place to ensure medicines carried in vehicles were stored appropriately. Oxygen was not taken on home visits. We were shown a copy of a risk assessment which had determined that factors such as vehicles carrying emergency drugs ,defibrillator and diagnostic equipment; and staff having received basic life support training mitigated the risks associated with not carrying oxygen in vehicles. We also noted however that the risk assessment did not account for a scenario whereby a patient's condition rapidly deteriorated.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. Doctors prescribed from a formulary which included antibiotics and individual prescriptions were monitored to ensure that the formulary was followed.
- Medicines were available to support palliative care patients to receive prompt access to pain relief, and a pharmacist was contactable at all times in case additional supplies were needed.
- Medicines management training was provided to all staff as part of their induction. There was a medicines policy which was updated regularly and a range of standard operating procedures in place.

The Medical Director spoke positively about the impact of these changes such as emergency call outs for drug replenishments dropping to zero and an improved ability to provide immediate and targeted responses to defective medicines recalls by manufacturers and/or the Medicines and Healthcare Products Regulatory Agency(MHRA).

Track record on safety

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements. For example, the pharmacist reviewed prescribing regularly and highlighted non-formulary prescriptions or unusual quantities to the medical director, allowing prompt feedback to the prescriber.
- There was a system for receiving and acting on safety alerts.
- Joint reviews of incidents were carried out with partner organisations including GP out-of-hours and NHS111 services.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons identified themes and took action to improve safety in the service. For example, records showed that an incident had been logged whereby a Type 1 diabetic patient at triage stage had not been asked if they had the ability to test their own blood glucose level. Following this incident, the next edition of the provider's 'Learning From Experience' clinician's bulletin included an article highlighting the importance of how this information would help determine whether a face to face assessment was required (and the level of urgency) or whether an emergency ambulance was required.
- The service learned from external safety events and patient safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.
- The provider took part in end to end reviews with other organisations. We saw evidence that learning was used to make improvements to the service.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the service as good for providing effective services.

At our previous inspection on 16 and 20 February 2017, we rated the service as requires improvement for providing effective services. This was because at the time we were advised that since the October 2016 amalgamation of the service into the North London Integrated Urgent Care service, National Quality Requirements (performance standards) data was not being collected. (After the publication of our report we were advised that daily reports in relation to the new service were reported to the CCGs and copies circulated by the IUC lead provider to Barndoc OOH Service on a daily basis in line with the new IUC contract requirements).

Performance monitoring arrangements had significantly improved when we undertook a follow up inspection on 20 and 22 February 2018. The service is now rated as good for providing effective services.

Effective needs assessment, care and treatment

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

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed.
- Telephone assessments were carried out using a defined operating model. Staff were aware of the operating model which included use of a structured assessment tool.
- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- Care and treatment was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- There was a system in place to identify frequent callers and patients with particular needs, for example palliative care patients. Care plans, guidance and protocols were in place to provide the appropriate support.
- When staff were not able to make a direct appointment on behalf of the patient clear referral processes were in place. These were agreed with senior staff and clear explanation was given to the patient or person calling on their behalf.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

When we inspected in February 2017 we were advised that following the October 2016 amalgamation of the service into the North London Integrated Urgent Care (IUC) service, National Quality Requirement (NQR) data was now not being collected. NQR data is used to show out of hours services are safe, clinically effective and responsive and are reported monthly to providers' clinical commissioning group (CCG). (After the publication of our report we were advised that daily reports in relation to the new service were reported to the CCGs and copies circulated by the IUC lead provider to Barndoc OOH Service on a daily basis in line with the new IUC contract requirements).

At this inspection we were advised by the IUC's overall commissioners that Barndoc (as a material partner of LCW and sub contracted to deliver the GP out of hours service for Enfield, Haringey and Barnet) was not required to submit performance data and that the overall IUC service performance reports the commissioner received did not include Barndoc specific performance data.

Commissioners told us that the overall IUC targets had been introduced as an interim measure because, at the time of the overall IUC service going live in October 2016, national Integrated Urgent Care (IUC) service specifications had yet to be established. We were further advised that these locally agreed targets were currently being revised to reflect the national IUC specification.

Although Barndoc was not reporting on NQR key performance indicators, latest available NQR performance data (December 2017) generated by the service showed that it was generally meeting its 95% NQR performance targets. For example:

Good

Are services effective?

(for example, treatment is effective)

• 100% of face-to-face emergency consultations (whether in a centre or in the patient's place of residence) were started within 1 hour of the definitive clinical assessment having been completed.

• 92% of face-to-face urgent consultations (whether in a centre or in the patient's place of residence) were started within 2 hours of the definitive clinical assessment having been completed.

• 100% of patients (where it was deemed clinically appropriate), were able to have a face-to-face consultation with a GP including where necessary, at the patient's place of residence.

The service made improvements through the use of completed audits. Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality.

The service was also actively involved in wider quality improvement activity. For example, the provider had an audit policy in place which stipulated auditing 1% of each GP's and nurse's case load every quarter (with a 75% pass mark) to assess the quality of clinical care given. We noted that the audit methodology was based upon the Royal College of General Practitioner (RCGP) Audit Toolkit and included areas such as appropriate assessment, documentation and prescribing. Records showed that quarterly findings were routinely presented to the provider's Clinical Governance Committee covering clinical performance of starter and established GPs; and starter and established nurses. We also saw evidence of action being taken as necessary to improve quality.

For example, in July 2017 an audit of 370 cases highlighted that 78 of 82 (95%) of GPs achieved the 75% pass mark. Following feedback from auditors we noted that the August 2017 audit reported that 76 of 78 GPs (97%) had achieved the 75% pass mark (335 cases).

Accurate and up-to-date information about effectiveness was used to improve care and treatment and this improvement was checked and monitored. For example, the provider regularly audited cases referred to local hospital emergency departments to see whether these were clinically appropriate.

We noted that audit themes were routinely circulated to clinicians via the provider's 'Learning From Experience' bulletin. For example, the December 2017 edition fed back that almost all of the audited GPs had either met or exceeded the 75% performance threshold. The bulletin also covered areas for improvement such as appropriate antibiotic prescribing and 'red flag' symptoms.

Information and analysis were also proactively used to identify opportunities to drive improvements in care. For example, the provider proactively undertook quarterly audits to identify any cases where there were missed opportunities to make safeguarding referrals. We were shown a template letter which was sent to clinicians who had missed such opportunities and which reiterated the importance of referring at risk children and adults to social services, in accordance with the provider's safeguarding protocol.

The provider's Medical Director had lead responsibility for audit; including implementation and monitoring of the audit policy and auditor training. He spoke positively about how the provider strove to continuously improve the quality of clinical care. Records showed how concerns regarding a clinician's audit performance had resulted in enhanced auditing and one to one support from the Medical Director.

Effective staffing

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

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff. This covered such topics as safeguarding and infection prevention and control.
- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required. For example, the deputy Medical Director provided clinical support to nursing staff.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The provider provided staff with on going support. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for

Good

Are services effective?

(for example, treatment is effective)

revalidation. The provider could demonstrate how it ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.

- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. There were established pathways for staff to follow to ensure callers were referred to other services for support as required. The service worked with patients to develop personal care plans that were shared with relevant agencies.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- The service ensured that care was delivered in a coordinated way and took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that require them. Staff were empowered to make direct referrals and/or appointments for patients with other services.

Helping patients to live healthier lives

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

- The service identified patients who may be in need of extra support.
- Where appropriate, staff gave people advice so they could self-care.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

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

Good

Are services caring?

Our findings

We rated the service as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information. Call handlers gave people who phoned into the service clear information. There were arrangements in place to respond to those with specific health care needs such as end of life care and those who had mental health needs.
- Both of the patient Care Quality Commission comment cards we received were positive about the service experienced.

Involvement in decisions about care and treatment

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

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

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The service monitored the process for seeking consent appropriately.
- When we spoke with base receptionists they stressed the importance of compassion and of treating each patient as an individual.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the service as good for providing responsive services.

Responding to and meeting people's needs

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

- The provider understood the needs of its population and tailored services in response to those needs. For example, records showed that the provider had increased the size of its home visit fleet in recognition of Barnet's older population and the increased likelihood of home visits.
- The facilities and premises were appropriate for the services delivered.
- The service made reasonable adjustments when people found it hard to access the service. For example, by offering interpreting services and ensuring that hearing loops were available at base locations.
- The service was responsive to the needs of people in vulnerable circumstances. For example, the provider proactively undertook quarterly audits to identify any patient contacts where there were missed opportunities to make safeguarding referrals.

Timely access to the service

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

- Patients were able to access care and treatment at a time to suit them. The opening hours are seven days a week from 6:30pm to 8am and 24 hours at weekends and bank holidays. Patients could access the service via NHS 111.
- Patients could access the out of hours service via NHS 111. The service did not see walk-in patients and a 'Walk-in' policy was in place which clearly outlined what approach should be taken when patients arrived without having first made an appointment, for example patients were told to call NHS 111 or referred onwards if they needed urgent care. All staff were aware of the policy and understood their role with regards to it, including ensuring that patient safety was a priority.

Although the service was not reporting on NQR key performance indicators, latest available NQR performance data (December 2017) showed that the service was meeting 95% NQR performance targets in areas such as timely access to initial assessment, diagnosis and treatment. For example:

- 100% of patients with urgent needs received a definitive clinical assessment within 20 minutes of arrival at a primary care base.
- 100% of patients unable to communicate effectively in English were provided with an interpretation service within 15 minutes of initial contact.

Commissioners told us that the overall IUC targets had been introduced as an interim measure because, at the time of the overall IUC service going live in October 2016, national Integrated Urgent Care (IUC) service specifications had yet to be established. We were further advised that these locally agreed targets were currently being revised to reflect the national IUC specification.

We noted that patients with the most urgent needs had their care and treatment prioritised.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. We noted that 31 complaints were received during 2017. We reviewed a selection and found that they were satisfactorily handled in a timely way.
- Issues were investigated across relevant providers, and staff fedback to other parts of the patient pathway where relevant.
- The service learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For

Good

Are services responsive to people's needs?

(for example, to feedback?)

example, in 2017 a complaint was upheld regarding the unempathetic attitude of a Barndoc clinician, following a patient highlighting that the local 111 service had failed to create their primary care base appointment.

Records showed that a meeting had subsequently taken place with a senior manager, the clinician and their clinical supervisor where the call was reviewed and key action points identified (such as conflict resolution role playing training). Records also highlighted that the clinician was reminded that the incident should have been logged as a significant event so that learning could be shared with the 111 service.

Are services well-led?

Good

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

Our findings

We rated the service as good for leadership.

At our previous inspection on 16 and 20 February 2017, we rated the service as requires improvement for providing well led services as the governance arrangements in respect of medicines management and infection prevention did not always operate effectively.

These arrangements had significantly improved when we undertook a follow up inspection on 20 and 22 February 2018. The service is now rated as good for providing well led services.

Leadership capacity and capability

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

- When we spoke with the Chair and Chief Operating Officer they demonstrated the experience, capacity and skills to deliver the service strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- Senior management was accessible throughout the operational period, with an effective on-call system that staff were able to use. For example, base GPs spoke positively about the accessibility of the service's Medical Director.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Vision and strategy

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

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- The service developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The provider monitored progress against delivery of the strategy.
- The provider ensured that staff who worked away from the main base felt engaged in the delivery of the provider's vision and values. This was confirmed during discussions with base GPs and receptionists.
- The service developed its vision, values and strategy jointly with patients, staff and external partners. The external pharmacist contractor told us that there were plans to develop the clinical pharmacy service to include medicines audits, attendance at clinical governance meetings and involvement in medicines policy development.

Culture

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

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional time for professional development and evaluation of their clinical work.

Are services well-led?

Good

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

- There was a strong emphasis on the safety and well-being of all staff.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff felt they were treated equally.
- There were positive relationships between staff and teams. For example, staff employed by the external pharmacy contractor told us there was a collaborative working relationship with the provider.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities .
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- We noted that governance arrangements for medicines management and Infection Prevention and Control had improved since our last inspection.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The provider had processes to manage current and future performance of the service. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of MHRA alerts, incidents, and complaints. Leaders also had a good understanding of service performance against local key performance indicators. Performance was regularly discussed at senior management and board level. Performance was shared with staff and local commissioners as part of contract monitoring arrangements.
- Clinical audit had a positive impact on quality of care and outcomes for patients. We saw clear evidence of actions to resolve concerns and improve quality.
- The providers had plans in place and had trained staff for major incidents.
- The provider implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service used information technology systems to monitor and improve the quality of care.
- The service submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

Are services well-led?

Good

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example one base GP spoke positively about how the provider had promptly acted on their suggestion to provide personal alarms whilst another told us that the provider had acted on their suggestion to extend the duration of appointments.
- Staff were able to describe to us the systems in place to give feedback. For example, base reception staff who worked remotely told us they were kept informed engaged and able to provide feedback through electronic bulletins.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement at all levels within the service. For example, we noted that since our last inspection improved medicines management and Infection Prevention and Control governance arrangements had been introduced.
- Staff knew about improvement methods and had the skills to use them.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements. For example through the provider's 'Learning From Experience' bulletin.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- There was a strong culture of innovation and systems to support improvement and innovation work.