Urgent Care Centre Newham General Hospital Trust

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.

Summary of findings

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Summary of findings

Overall summary

Newham GP Cooperative provides telephone advice, face-to-face consultations and home visits to people who require medical advice or treatment outside of normal GP working hours. The service provides out-of-hours cover for people who live in the London Borough of Newham.

Our inspection team included a CQC inspector, a GP, two specialist nurses and a person with experience of using services we call an 'expert by experience'. Before our inspection we carried out an analysis of data which did not highlight areas of risk across the five key question areas.

There were a number of areas of good practice we found such as learning from incidents and an openness to develop the service quality. We also found calls were prioritised based on need and risk and that GPs were knowledgeable about the local population they served.

We also found that some systems were not formalised such as auditing of consultation notes, GP's lone working procedures or the checking of equipment. Elsewhere we found that systems that were in place were not being correctly followed such as with medicines management and criminal records bureau (CRB) or disclosure and barring service (DBS) checks.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found that the service demonstrated that it had safe processes for call handling and for prioritising patients based on risk and need. The centre was clean and hygienic and there was a structure in place to learn from incidents. We were given examples where the service worked with others when they suspected children might be at risk.

However we also found that GPs used their own cars for home visits but the service had not made checks to ensure that GPs were insured for commercial use or that cars were road safe. GPs visited patients alone and although the service had some procedures to follow they were informal and there was not a lone working policy. There was no record of medicines used by home visiting GPs which left it open to the possibility of misuse of medicines.

There was not a policy or position on when it might be appropriate for the service to renew Criminal Records Bureau/ Disclosure and Barring Service checks. This meant the service could not assure itself that doctors working for them were cleared to work with children or vulnerable adults.

GP's used their own equipment andthere was no process in place for the service to check that it was in good working order or calibrated. Medicines management procedures were not being followed. We fed back our concerns regarding medicines management at the time of our visit and the service took immediate steps.

Are services effective?

Records of consultations that took place on the premises were sent to patients' own GPs through an electronic information system at set stages through the night. Home visits however, were recorded on paper and the call was closed on the computer system before details of the home visit had been added. This meant there was no record in the notes and the person's local GP was unaware of any treatment, referrals, admissions or drugs given when the electronic record was sent back to them.

The service was not measuring itself correctly against a national rating known as National Quality Rating no. 2. Newham GP Cooperative rated themselves against the percentage of call information sent to GP practices by 8am the following day rather than details of all OOH consultations as the standard states.

Training sessions and case discussions took place in the GP's forum which was held every other month. However, the service was unable to demonstrate that staff, including GPs, were up to date with safeguarding training including level 3 safeguarding children, Mental Capacity Act, basic life support and infection control. The service could not demonstrate whether core training had been carried out as there were no training records regarding this.

The service enjoyed a good relationship with the local A&E and urgent care centre which were based on the same site as the service. GPs asked appropriate questions in a clear way and their responses to people were caring. From the rotas viewed the service appeared to be well staffed.

We reviewed a sample of consultation records and found good clear documentation with clear steps and decision making was demonstrated. However, there was no quality framework to audit notes against. There was no evidence of completed clinical audit cycles.

Are services caring?

People told us they were treated with dignity and respect. Everyone we spoke with told us that the service respected their religion and culture. This included a number of people who had used the service on more than one occasion.

Summary of findings

People were treated in individual consultation rooms which observed people's privacy. We did however, observe that the rooms were not sound proof and what was being said could sometimes faintly be overheard from outside of the room.

Are services responsive to people's needs?

The service was based on working with patient need, volume and prioritisation rather than by appointment. This meant it could be responsive to patient need and risk. GPs we spoke with were aware of the support needs of vulnerable adult groups.

The staff group were representative of the diverse cultural make up of the local population but there was no information explaining to patients that there was an interpretation service available or that information was available in different languages if required. However, the service was unable to demonstrate that staff, including GPs, were up to date with training such as safeguarding and Mental Capacity Act training.

Complaints received by the service were acknowledged, investigated and responded to appropriately. The service also carried out customer satisfaction surveys which showed positive feedback about the service. Doctors we spoke with were aware of the needs of different population groups such as elderly and those with chronic conditions.

Are services well-led?

There was a clear leadership structure in place although policies and processes were often not in place or not implemented. There was an informal approach to governance arrangements. We found the leadership open to our inspection findings and genuinely committed to improving the service.

Summary of findings

What people who use the out-of-hours service say

People we spoke with on the evening of our visit told us they felt treated with dignity and repsect. We spoke with a number of people who had used the service on more than one occasion. They told us doctors and other members of staff were always respectful, helpful and polite. We were told the doctor was kind and patient by one person who also told us that when they had used the service before they waited a long time but left feeling they had received a good service. Another person told us they were happy with service and they had used the service many times and always felt their religious and cultural needs had been met.

People also told us that the initial call handlers were helpful and spoke to them with repsect. People told us the service was accessible as they could always see a doctor instead of going through nurse triage at A&E.

People at our listening event told us that people's mental health needs in Newham were not met by out of hours services and included Newham GP Cooperative in this. We were also told that people felt they sometimes waited a long time to see a doctor when they visited in person. We were also told that sometimes the phones were engaged when they tried to call. We were also told that the signs were not clear and it was easy to get the service confused with the urgent care centre or the A&E department.

Areas for improvement

Action the out-of-hours service MUST take to improve

The service must implement a lone working policy for home visiting GPs.

Safe medicines management and storage procedures must be followed.

A system of checking that GP's equipment is in good working order and/or calibrated must be introduced.

The service must make arrangements for records of home visit consultations to be communicated to people's local GP in a timely manner.

The service must rate themselves correctly against National Quality Rating no. 2; all OOH consultations rather than just call information sent to GP practices by 8am the following day.

The service must maintain staff training records and identify and meet any outstanding training need. This includes level 3 safeguarding children.

The service must develop its current informal approach to clinical auditing and the auditing of the quality of consultation notes.

Action the out-of-hours service COULD take to improve

Checks to ensure that GPs are insured for commercial use or that cars are road safe could be implemented.

Good practice

Urgent Care Centre Newham General Hospital Trust

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP and the team included specialist nurses and an expert by experience.

Background to Urgent Care Centre Newham General Hospital Trust

The Newham GP Co-operative is a group of local GPs who decided to join together to cover each other's patients out of hours. The co-operative was established to improve patient care in Newham by using local GPs who have local knowledge and expertise. Newham GP Co-Operative reports to NHS Newham Clinical Commissioning Group. The commissioning group has not provided feedback on the provider.

The Newham GP Coop Out Of Hours (OOH) Service offers care outside of the normal GP Surgery opening times. GP Surgeries are normally required to be open between 0800hrs and 18:30hrs. Outside of these hours the public have the choice of a number of options through which they can access care.

Newham Coop OOH service provides non-emergency care and advice outside of GP Surgery hours 365 days a year. A large percentage of consultations are dealt with via telephone consultations. Often routine calls are able to be resolved via telephone advice from duty GPs. The service also provides face to face consultations from their base located at Newham University Hospital or via home visits.

Why we carried out this inspection

We inspected this out-of-hours service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the out-of-hours service and asked other organisations to share what they knew about the service. We carried out an announced visit on 12 March 2014. During our visit we spoke with a range of staff. This included the call handlers, GPs, people who used the service, managers, the chief executive and the medical director. We observed how people were being cared for

Detailed findings

and talked with carers and/or family members and reviewed personal care or treatment records of patients. We held a listening event where patients and members of the public shared their views and experiences of the service.

Are services safe?

Summary of findings

We found that the service demonstrated that it had safe processes for call handling and for prioritising patients based on risk and need. The centre was clean and hygienic and there was a structure in place to learn from incidents. We were given examples where the service worked with others when they suspected children might be at risk.

However we also found that GPs used their own cars for home visits but the service had not made checks to ensure that GPs were insured for commercial use or that cars were road safe. GPs visited patients alone and although the service had some procedures to follow they were informal and there was not a lone working policy. There was no record of medicines used by home visiting GPs which left it open to the possibility of misuse of medicines.

There was not a policy or position on when it might be appropriate for the service to renew Criminal Records Bureau/Disclosure and Barring Service checks. This meant the service could not assure itself that doctors working for them were cleared to work with children or vulnerable adults.

GP's used their own equipment andthere was no process in place for the service to check that it was in good working order or calibrated. Medicines management procedures were not being followed. We fed back our concerns regarding medicines management at the time of our visit and the service took immediate steps.

Our findings

Call handling; assessment and prioritisation

Patients were triaged, assessed and prioritised by the service's out of hours GPs with a target of being triaged within one hour. Triage times were colour graded. Green was within 20 minutes, yellow was after 20 minutes, red was after 40 minutes and black was when calls breached one hour. We were told by a GP and a manager that the triage GP filtered between 33 - 50% of patients who needed advice only and that there were very few breaches. During our visit no breaches were witnessed. GPs also prioritised patients as routine or urgent. Urgent cases were seen as soon as they arrived. This meant the service demonstrated safe call handling, assessment and prioritisation of patients accessing the service.

Home visiting

Home visiting GPs worked from home and used their own transport. They were called by reception when a visit was required. If there were a number of calls for home visits the GP would contact patients to prioritise. We were told that generally home visiting not usually busy.

GPs used their own cars for home visits. The service did not make checks to ensure that GPs' cars were insured for commercial use and whether cars were road safe.

GPs visited people's homes on their own. The receptionist told us they were in regular contact with GPs carrying out the home visits before and after each visit which mitigated the risk. However, the service did not have a lone working policy and any procedures being followed were informal.

We also found there was no medicines management policy covering home visiting GPs. At present GPs took medication from the service's stock, signed for them but were not asked for any evidence of when and who these had been given too. There was no record of medicines used by home visiting GPs which left it open to misuse of medicines.

Learning from incidents

We saw recent examples of incident reporting that showed they were being completed by GPs with sufficient detail. All incident reports were reported to the service's leadership board. Examples of reports that had been taken to the board showed that incidents had been analysed and solutions or learning had been identified. For instance, report headings included outcomes from the incident, what was learnt and what changes had been made as a result. Every incident was also categorised in to causal types such as human error, clinical error, equipment failure and systems failure. Examples we saw of learning from incidents through this reporting structure included some learning for one individual doctor and having one extra GP shift put on a Saturday evening.

Management of medicines

Staff told us that they followed the Newham GP Co-operative Limited Storage and administration of drugs policy. People who used the service were issued with a

prescription from a doctor and had access to in excess of 30 pharmacies within a two mile radius. Information leaflets about pharmacy arrangements were on display at the service.

On occasions people were supplied with urgent and emergency medicines by the GP from a stock held at the service. The policy stated that any medicines issued should be recorded by the GP in the 'drugs log book'. We looked at the drugs log book and saw that the issuing of medicines by doctors was not generally recorded in accordance with the policy as the log book was not being completed on a regular basis. Staff we spoke with told us this was not always happening. This meant that people who used the service and others may be at risk.

We spoke with staff about the procedures they followed to ensure the safe storage and supply of prescription forms. We were told that the prescription forms were stored and issued to the doctors by the administrative staff and that records were maintained to show how and when they had been distributed. We looked at the records and found that although serial numbers of prescription forms were logged it was not clear when prescription forms had been issued to authorised prescribers or by whom, or how lost or destroyed prescriptions were recorded and accounted for. Staff were not following the NHS Protect Security of prescription forms guidance, August 2013, in relation to prescription form stock control. This could lead to controlled stationery (prescriptions) being diverted meaning people who used the service and others may be at risk.

We were told that stocks were checked every morning and restocked accordingly. However, there was no record of these checks being carried out or of instructions from managers being given to the staff who carried out these checks. There were no arrangements in place for monitoring the temperature at which medicines were stored or for storing medicinal products which required refrigeration. This meant that some medicines were not kept at the quality intended.

Staff we spoke with told us that all medicines given to people in their care were supplied and administered by a doctor's prescription in accordance with the approved local formulary and the British National Formulary. We saw that paper and electronic formularies were available to relevant clinical staff, however the paper copies were not always the most recent version.

Electronic records of people who had been assessed and treated at the centre showed that prescriptions for people who used the service were recorded electronically and the information was shared with the person's GP within 24 hours. This meant that, in the case of people attending the centre, clinical records were communicated to relevant parties in a timely manner to ensure continuity of care.

Medical equipment

The service did not supply any equipment. GP's used their own. There was no process in place for the service to check that equipment was in good working order or calibrated.

Infection control and prevention

The centre was clean, hygienic and clear from clutter. There were suitable hand washing facilities and instructions in place for staff and people who used the service, and arrangements for the safe disposal of clinical waste were being followed at the centre. We saw that there was a designated consulting room for people with known or suspected infections.

Safeguarding

Contact numbers for local safeguarding children and adult safeguarding teams were kept on file that was easily located and retrieved. Newham safeguarding inter agency referral forms, safeguarding children and adults policies and NICE guidance on safeguarding (2013) were in place which clearly identified how to recognise and report abuse. We spoke to some of the GPs and the chief executive who told us they had never made a referral through these established routes. However, GPs we spoke with gave us examples where they had sought the advice from paediatric doctors located in the paediatric accident and emergency unit next door to their unit at Newham University Hospital. We were given examples where they had checked child protection registers and flagged concerns back to local GP surgeries and advised follow up by health visitors.

Recruitment and vetting

When the service recruited staff a number of pre-employment checks took place. These included references, identity, eligibility to work in the UK and Criminal Records Bureau/Disclosure and Barring Service clearance. (DBS took over from CRB checks in 2012 to identify candidates who may be unsuitable for certain work that involve children or vulnerable adults.) Checklists were used to complete checks and only when these had been satisfied were people approved for employment.

Are services safe?

Doctors also had to demonstrate GMC registration, indemnity insurance and details of the performers' list (this provides a layer of reassurance for the public that GPs practicing in the NHS are suitably qualified).

All GPs who worked for the service had self-employed status. This meant they were not directly employed by the service but worked on a sessional basis under contract.

We checked 14 doctor's personnel files and found that CRB or DBS checks were not carried out by the service but that doctors provided evidence of clearance when they began employment. Four CRB checks were nine years old while the rest were between seven and two years old. Managers of the service told us there was not a policy or position on when it might be appropriate for the service to renew these checks. This meant the service could not assure itself that doctors working for them were cleared to work with children or vulnerable adults.

We also found that where doctors had provided evidence of indemnity insurance, half did not state whether they were covered for out of hours work. We spoke to the managers of the service who could not assure themselves that these doctors were covered for out of hours working.

Are services effective?

(for example, treatment is effective)

Summary of findings

Records of consultations that took place on the premises were sent to patients' own GPs through an electronic information system at set stages through the night. Home visits however, were recorded on paper and the call was closed on the computer system before details of the home visit had been added. This meant there was no record in the notes and the person's local GP was unaware of any treatment, referrals, admissions or drugs given when the electronic record was sent back to them.

The service was not measuring itself correctly against a national rating known as National Quality Rating no. 2. Newham GP Cooperative rated themselves against the percentage of call information sent to GP practices by 8am the following day rather than details of all OOH consultations as the standard states.

Training sessions and case discussions took place in the GP's forum which was held every other month. However, the service was unable to demonstrate that staff, including GPs, were up to date with safeguarding training including level 3 safeguarding children, Mental Capacity Act, basic life support and infection control. The service could not demonstrate whether core training had been carried out as there were no training records regarding this.

The service enjoyed a good relationship with the local A&E and urgent care centre which were based on the same site as the service. GPs asked appropriate questions in a clear way and their responses to people were caring. From the rotas viewed the service appeared to be well staffed.

We reviewed a sample of consultation records and found good clear documentation with clear steps and decision making was demonstrated. However, there was no quality framework to audit notes against. There was no evidence of completed clinical audit cycles.

Our findings

Reporting back to GPs

Records of contact were sent to patients' own GPs electronically at set stages through the night; at 2am, 4am and 8am. A back up process was in place if this failed. All failed records were faxed over the next working day. We were also given examples when support staff had called a patient's GP surgery the next day to pass on vital information on the out of hours GP's instruction. Patients who lived out of area or not registered with a local GP had their records sent to shared business services (SBS) who shared the information with the CCG.

Home visits were recorded in a paper based format and home visiting GPs had no access to the computer system. Paper records were kept in a file in a locked room and archived after 3 years. We were told that the home visiting GP dropped off all visit information after the visit. However, the service closed the call on the computer system before the visit had been recorded. This meant there were no records in the notes and the person's local GP was unaware of any treatment, referrals, admissions or drugs given, when the electronic records was sent back to them.

The Department of Health have National Quality Requirements (NQR). These are standards of quality that all GP OOH's measure themselves against. NQR no. 2 reads:

Providers must send details of all OOH consultations (including appropriate clinical information) to the practice where the patient is registered by 8.00 a.m. the next working day. Where more than one organisation is involved in the provision of OOH services, there must be clearly agreed responsibilities in respect of the transmission of patient data.

This is so that people's own GP know what happened during their GP OOH consultation at the earliest opportunity. Newham GP Cooperative rate themselves against the percentage of call information sent to practices by 8am the following day rather than details of all OOH consultations. This means they are not measuring themselves correctly against this quality benchmark.

Working with others

The service was based at a hospital and situated next door to the A&E unit. We were told they had a good relationship with both the A&E and the urgent care centre who both sent patients over to the service. We were also told they could call on the expertise of the hospital for advice or to refer for admission or if there was an emergency.

Triage

The service did not have access to patients' GP notes. Therefore the doctor had to establish peoples' past

Are services effective?

(for example, treatment is effective)

medical history and medication. Triage took place in private consultation rooms. We observed GPs asking appropriate questions in a clear way. GPs we spoke with felt that it was an effective service and they enjoyed working for them. They felt that they delivered an effective service which was well staffed.

Staffing

An identified member of the team was responsible for organising the staffing rotas of both the GPs and support staff. Rotas were written on a monthly basis. Some GP's had regular set sessions while other GPs were asked for their availability each month. We were told that shifts were generally filled with no problems.

There was no cancellation policy in place, but we were told that it was known by the GP's that they needed to give a weeks' notice if they were unable to do a previously agreed shift. In this instance or if a GP went off sick an identified member of the team phoned other GPs to fill the session. From the rotas viewed the service appeared to be well staffed.

We were told that the board looked at demand and capacity, and increase and decrease of staff was agreed at this meeting. There had been a staffing increase since winter pressure funding and the GP streaming service had been successfully bid for.

Training

Training sessions and case discussions took place in the GP's forum which was held every other month. For instance, a recent email inviting all GPs to the GP's forum showed its content included a training session on irritable bowel disease, case discussions and a briefing on new commissioning arrangements. Other items we saw included 111 prioritisation and medicines management. We were told that forums counted towards GP's continued professional development hours and that the sessions were well attended. Attendance was not recorded but we were shown invitation lists and told that attendance was actively encouraged by the clinical executives who were also GPs.

We were shown a glossy brochure that was produced by the adjoining hospital and informed that the non- clinical staff had access to the hospital's core training sessions. However, the service was unable to produce evidence of attendance. We were told "it's difficult for staff to attend as they have other jobs during working hours."

The service did not keep records of GP's or support staff's mandatory training or proof of training completed elsewhere. This meant that the service was unaware of the staff's training needs, especially for those who worked solely for the service. The service was unable to demonstrate that staff, including GPs, were up to date with safeguarding training including level 3 safeguarding children, Mental Capacity Act, basic life support and infection control. The service could not demonstrate whether core training had been carried out. There were no training records regarding this.

Induction

For new doctors, the medical director would interview. Once cleared, they came in for a 1 to 1 induction meeting and on line records management training. New doctors would shadow doctors to start with and monitored thereafter before being cleared to work independently. New doctors were on duty at the time of our visit and being shadowed and monitored by a senior doctor.

Pathways and evidence based guidance

We evidenced care pathways being observed. For instance, NICE guidance of the sick child, NQR4- regular audit of the quality of care.

Audit

Two clinical executives (senior doctors within the practice) carried out audits. A sample of consultations and triage that doctors had carried out were checked. Timekeeping records were also checked to establish doctor productivity. One clinical executive told us they carried out a minimum of four audits of a doctor's consultations per month.

Audited consultation notes we saw showed they had been ticked when consultations were okay or acceptable and had words such as 'satisfactory' written on them. There was no quality framework to audit notes against and doctors were not provided with feedback following the audit. If there was a cause for concern we were told they would report this to the leadership team. This meant that doctors would only receive feedback if it was negative and were not given guidance on what was expected of their note taking.

There was no evidence of completed clinical audit cycles.

Consultation records

We reviewed a sample of consultation records. We found good clear documentation with clear steps and decision making was demonstrated.

Are services caring?

Summary of findings

People told us they were treated with dignity and respect. Everyone we spoke with told us that the service respected their religion and culture. This included a number of people who had used the service on more than one occasion.

People were treated in individual consultation rooms which observed people's privacy. We did however, observe that the rooms were not sound proof and what was being said could sometimes faintly be overheard from outside of the room.

Our findings

People we spoke with told us they felt treated with dignity and repsect. A mother and father who had attended with young child both felt they had a very good service. We were told the doctor was kind and patient and had also signposted them to a pharmacy. They told us they had used the service before and felt they waited a long time but left feeling they had received a good service.

Another couple with a young child told us they were happy with service, "the doctors are great here". A young man who was translating for his mother told us he felt unhappy with the medical opinion they had received but was very happy with the service itself. They told us they would not prefer a translation service as they were happy to offer support as a family which the service was accommodating of. They told us they had used the service many times and always felt their religious and cultural needs had been respected.

We observed people being treated and spoken to with kindness and respect. For instance, during GP telephone consultations we observed doctors asking questions and listening to what people had to say. Doctors we observed taking the calls were polite and courteous. GPs asked appropriate questions in a clear way and their responses to people was caring.

Privacy and dignity was observed during all consultations which took place in consultation rooms with the door closed. All telephone and face to face consultations took place in private consultation room with doors closed. We did however, observe that the rooms were not sound proof and what was being said could sometimes faintly be overheard from outside of the room.

A mother with a young child we spoke with told us they felt treated with respect and dignity. They told us they had used the service before and always felt their culture was respected.

People also told us that when they felt the initial call handlers were helpful and spoke to with repsect. We observed call handlers being polite and respectful to people. Another patient told us they always used the service and were always respected and happy with their treatment. They felt the service was accessible as they could always see a doctor instead of going through nurse triage at A&E. Another patient told us they were very happy with service and had used it before. They told us doctors and other members of staff were always respectful, helpful and polite.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The service was based on working with patient need, volume and prioritisation rather than by appointment. This meant it could be responsive to patient need and risk. GPs we spoke with were aware of the support needs of vulnerable adult groups.

The staff group were representative of the diverse cultural make up of the local population but there was no information explaining to patients that there was an interpretation service available or that information was available in different languages if required. However, the service was unable to demonstrate that staff, including GPs, were up to date with training such as safeguarding and Mental Capacity Act training.

Complaints received by the service were acknowledged, investigated and responded to appropriately. The service also carried out customer satisfaction surveys which showed positive feedback about the service. Doctors we spoke with were aware of the needs of different population groups such as elderly and those with chronic conditions.

Our findings

Responding to patients – call handlers and GPs

Reception Staff had a target of picking up calls within 60 seconds with triage call backs from GPs within one hour. Patients were not given an appointment time to attend the service which was more responsive to patient need as it was based on working with volume and prioritisation. The GP would tell people to come down, explaining where they were based. If patients did not arrive after 3 hours from time of their initial call they were called by reception staff. We were told this did not happen very often. All calls we observed were responded to quickly and effectively.

The Department of Health have National Quality Requirements (NQR). These are standards of quality that all GP OOH's services measure themselves against. The service scored highly against the targets and standards that related to how quickly were responding to patients.

Availability of other languages and formats

We were told that staff came from a variety of cultural backgrounds and could speak a variety of languages. The service also had access to hospital interpreters and if none were available they used language line. There was no information explaining to patients that there was an interpretation service available or that leaflets were available in different languages if required.

Vulnerable patients and capacity

GPs we spoke with were aware of the support needs of vulnerable adult groups such as elderly people with dementia and people with learning disability. We were given an example where there had been recent frequent contact with a person with dementia. Doctors demonstrated a good understanding of the issues and had made contact with the person's local GP and written to local social services with concern about the person's level of community support.

We discussed the local district nurse teams with the service and were told that services stopped at 10pm. We asked a triage GP what would happen if, for instance, an end of life patient required a syringe driver. We were told they had never had this happen but would not be able to set this up. The GP explained that this was a local issue and the CCG were aware. We were told that there was a palliative care team who work 24 hours but for advice only.

Patient feedback including complaints and learning from

All complaints received by the service were acknowledged, investigated and responded to appropriately. All complaints were reviewed at leadership board meetings where recommendations were made in relation to the issue raised. The person who made the complaint was then written back to with the outcome. A complaints log recorded the details and action that had been taken. We were also provided with details of complaints and their investigation which demonstrated the service was learning from complaints.

The service also carried out customer satisfaction surveys by calling a random sample of 50 people back over a six day period. The methodology set out to assess patient satisfaction with the telephone advice service, waiting times, staff courtesy, understanding language and information and ease of access to the service. Also to assess the outcome of the advice given over the phone and identify any improvements that might be made to the service. Results showed that a large majority of people surveyed were very happy with the service they received.

Are services responsive to people's needs?

(for example, to feedback?)

Responsive to the needs of different population groups

Doctors we spoke with identified population groups such as people who were elderly, had a learning disability or those with chronic conditions such as cancer as priority groups. This meant that they would be prioritised when attending the service or allocated for a home visit. Doctors also identified parents who worked during normal hours as a group who were unable to access normal hours GP services. Doctors came from a variety of cultural backgrounds and had an understanding of the diversity of the Newham population and of languages commonly spoken such as Hindi, Bengali and Somalian.

Are services well-led?

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

Summary of findings

There was a clear leadership structure in place although policies and processes were often not in place or not implemented. There was an informal approach to its governance arrangements. We found the leadership open to our inspection findings and genuinely committed to improving the service.

Our findings

Governance

There was a council at the top of the leadership structure which consisted of five elected GPs: chair/medical director, two clinical executives, a financial manager, a member's representative and the chief executive. Below the council sat the executive board which took on a more operational role and was made up of the chair/medical director, chief executive and the two clinical executives.

Both groups met on a monthly basis which meant there was a leadership meeting every two weeks. We were also told that the more operational executive board would meet more regularly when the need arose. For instance, when preparing a contract bid or organising to meet winter pressure. We were told that hot topics or leadership issues were discussed by the executive team through group emails or informally as the need arose. Below the executive team was the day to day management structure of the office/operational manager, the rota manager. We were told that the medical director and chief executive were also hands on and that the clinical executives were in charge of quality checking.

We found there was an informal approach to managing some systems and processes such as medicines management, lone GP working, CRB/DBS checking and quality checking of consultation records. However, we found the leadership open to our inspection findings and genuinely committed to improving the service. We subsequently received a post inspection report from the service detailing actions they wished to take from our initial feedback.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision How the regulation was not being met: There was not a 'safe lone working' policy for GPs carrying out home visits. Regulation 10 (1)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment How the regulation was not being met: There was no process in place for the service to check that GP's equipment was in good working order or calibrated. Regulation 16(1)(a)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: People who use services were not protected against the risks associated with medicines because safe medicines management procedures were not being followed and medicines were not stored securely and safely. Regulation 13.

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010. Cooperating with other providers. How the regulation was not being met: Information from home visit consultations was not being communicated back to people's local GPs in a timely manner. Regulation 24.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010. Supporting workers. How the regulation was not being met: The service did not maintain staff training records and identify and meet any outstanding training need. This included level 3 safeguarding children. Regulation 23 (1)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation10 HSCA 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision How the regulation was not being met: There was no quality framework to audit consultation records against and no evidence of clinical audits. Regulation 10 (1)