Frimley Park Hospital (Frimley Primary Care Service)

Quality Report

Frimley Park Hospital
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Date of inspection visit: 21, 22 and 23 February 2017
Date of publication: 15/05/2017

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Frimley Primary Care Service on 21, 22 and 23 February 2017. Overall the service is rated as good.

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.
- Risks to patients were assessed and well managed with the exception of medicines management.
- Patients' care needs were assessed and delivered in a timely way according to need. The service met the National Quality Requirements.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- There was a system in place that enabled staff access to patient records and the out of hours staff provided other services, for example the local GP and hospital, with information following contact with patients as was appropriate.
- The service managed patients' care and treatment in a timely way.
- 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.
- 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.
- 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.
- The provider was aware of and complied with the requirements of the duty of candour.

Summary of findings

We saw one area of outstanding service:

- The standard clinical system used by the majority of out of hours providers only categorises patients as urgent or routine, however the dispositions (recommended course of action) given by NHS 111 provide more options, for example, to be contacted within 30 minutes, one hour, two hours, six hours. The provider realised that patient prioritisation would be improved if the clinical system options matched the NHS 111 dispositions. The provider has developed in- house options within the clinical system so that the system shows patients in the same priorities as the dispositions that were assigned by NHS 111. We saw evidence that since this had been implemented there was month on month reduction in the time patients who had received each disposition were waiting for contact with the primary care centre.

The areas where the provider must make improvement are:

- Review the proper and safe management of medicines, including the quantity and variety of all medicines, including controlled medicines, that are held on site and in the vehicles and implement a system for recording the use of these medicines, and ensuring that sharps safes are labelled and used appropriately.

The areas where the provider should make improvements are:

- Undertake spot checks on clinician's personal equipment to ensure it is calibrated and fit for purpose.
- Monitor the complaints system to ensure that all complaints are identified correctly and copies of all communications are retained for an appropriate period.
- Ensure vehicle checklists reflect the checks expected by the provider, including daily checks of the oxygen level in the cylinders.

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 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.
- The out-of-hours service had clearly defined and embedded system and processes in place to keep patients safe and safeguarded from abuse.
- 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. All visits were triaged in advance by a clinician and cars had a driver and clinician.
- 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.
- Risks to patients were assessed and well managed with the exception of medicines management.

Are services effective?

Good

The service is rated as good for providing effective services.

- The service was consistently meeting National Quality Requirements (performance standards) for GP out of hours services to ensure patient needs were met in a timely way.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.

Summary of findings

- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- 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 provider had developed in house options within the clinical system to improve patient prioritisation.

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 was very 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.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Patients were kept informed with regard to their care and treatment throughout their visit to the out-of-hours service.

Are services responsive to people's needs?

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. North Hampshire Urgent Care was working with local health care providers to develop models of care to support patients living in care homes.
- 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.
- Information about how to complain was available and easy to understand and evidence showed the service responded quickly to issues raised. A central log of complaints was maintained including time lines and actions. Learning from complaints was shared with staff and other stakeholders. However not all the correspondence could be found and made available to the team on the day of the inspection.

Summary of findings

Are services well-led?

Good

The service is rated as good for being well-led.

- The service had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The service had a number of policies and procedures to govern activity and held regular governance meetings.
- 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 strong focus on continuous learning and improvement at all levels.

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 on an ongoing basis and included in their contract monitoring reports. Data from the provider for the period of January 2016 to December 2016 inclusive showed that responses from at least one per cent of patients were recorded each month and these were discussed at medical directors' meetings and actions or lessons recorded in the minutes in line with the expectations of the National Quality Requirements.

- For example in July 2016 94% of patients who returned a survey found the service excellent or good and in September 2016 94% felt that they had received either an excellent or good service from Frimley Primary Care Centre.
- The service also showed us many examples of positive comments that had been sent in by patients to the service. Patients used words such as fantastic, amazing and brilliant to describe both the service and individual members of staff.

All four of the patients Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the service offered an excellent, efficient and friendly 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.

We spoke with three patients during the inspection. All three patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

Frimley Park Hospital (Frimley Primary Care Service)

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 additional CQC inspectors and a CQC assistant inspector.

Background to Frimley Park Hospital (Frimley Primary Care Service)

The Frimley Primary Health Care Centre, which provides an out of hours GP service, is run by North Hampshire Urgent Care (NHUC) which is a not for profit, community benefit society, run by a membership. North Hampshire Urgent Care's head office is based at:

The Meads Business Centre, 19 Kingsmead, Farnborough, Hants GU147S

NHUC also runs another service from the same head office based at Basingstoke Hospital, which is the subject of a separate report. The two locations have a total catchment of about 640,000 patients.

Frimley Primary Care Centre is located in the out patients one department of:

Frimley Park Hospital, Portsmouth Rd, Frimley, Camberley GU16 7UJ

The service sees approximately 43,000 primary care patients per year and is open from 6.30pm to 8am Monday to Friday and 24 hours a day on Saturdays, Sundays and bank holidays. Approximately 41% of patients receive self-care advice over the phone, 51% are seen at the primary care centre and 8% receive visits at their home. The service is commissioned by three clinical commissioning groups (CCGs). These are North East Hampshire and Farnham; Surrey Heath; and Ascot and Bracknell CCGs.

Patients can access the service via the NHS 111 service.

NHUC employs a total of 185 staff across the Frimley Park and Basingstoke locations including 60 nurses, 38 drivers and 25 receptionists. GPs are self-employed and therefore not included in the employee numbers. All staff, including contracted GPs are supported by a clear leadership structure, which consists of two medical directors, a chief executive, a chief nurse and a board of executive and non-executive directors. They are responsible for oversight of service provision and there are a range of meetings to monitor performance, such as clinical and risk governance. Senior leadership staff were also visible at the base, for example medical directors had a remit to work a shift at least once a week.

The clinical workforce is made up almost entirely of local GPs and nurses and there is a low use of locum staff. Of the nursing staff 74% are advanced practitioners with prescribing rights.

Two medical directors, one GP elected to the NHUC council, a chief nurse and lead nurse all work at the Frimley service clinically as well as at a senior level behind the scenes.

Detailed findings

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew. We carried out an announced visit to the service and the provider's head office on 21 to 23 February 2017. During our visit we:

- Spoke with a range of staff including the Chief Executive, Service Manager, Operations Manager, Chief Nurse, Medical Director, Human Resources Consultant, GPs, nurses, administration staff, reception staff and drivers and spoke with patients who used the service.
- Observed how patients were provided with care and talked with 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 patients' homes, and we reviewed the arrangements for the safe storage and management of medicines and emergency medical equipment.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

Please note that when referring to information throughout this report, for example any reference to the National Quality Requirements data, this relates to the most recent information available to the CQC at that time.

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 service 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.

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, a patient with a chronic condition did not receive appropriate care for suspect sepsis. In line with the duty of candour the provider gave a full apology to the relative of the patient. The GPs involved in treating the patient were interviewed about what had occurred; the reasons for not carrying out an urgent home visit within two hours; and poor record keeping. It was identified that there had been an increase in workload which was not adequately covered and management support for the shift was not clear. In addition the escalation plan for when there is an unexpected increase in demand was not clear and sepsis guidance was not followed. Learning and actions taken included recirculating sepsis guidance to all clinicians and an increase in managerial support availability for overnight clinicians. A system was developed for rating service activity to identify areas where there was a risk to the health and safety of patients and the implementation of an appropriate escalation plan where demand increased.

Overview of safety systems and processes

The service had clearly defined and embedded systems, processes and services in place 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. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs and Advanced Nurse Practitioners were trained to child safeguarding level 3.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The service maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. There was an infection control lead. There was an infection control protocol in place and 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 in place to ensure equipment was maintained to an appropriate standard and in line with manufacturers' guidance.
- We reviewed eight personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employment in the form of references, qualifications, registration with the appropriate professional body, appropriate indemnity and the appropriate checks through the Disclosure and Barring Service.

Medicines Management

Requires improvement

Are services safe?

- The arrangements for managing medicines at the service, including emergency medicines and vaccines, did not always keep patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Medicines were not always provided to patients with an appropriate patient information leaflet and recording of stock levels was not sufficient. For example; in the medicines box for one vehicle we saw two out of three boxes of a medicine used to treat anxiety, muscle spasms and convulsions had been opened and medicines used leaving only a few tablets in each box. In the medicines box for the other vehicle we saw one of the two boxes of the same medicine only contained half the number of tablets stated on the box. We saw guidelines in the medicines boxes for the vehicles that the box should be checked before going out on a visit to ensure sufficient stock but staff we spoke with told us that this did not happen. The guidelines also said that only full courses should be prescribed and staff we spoke with told us that boxes of medicines from the medicines box should not be split, but we found that they had been. The service carried out regular medicines audits, with the support of the local clinical commissioning group (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. Following a significant event where a GP left patient medical records in another patients home the provider had installed lockable boxes in each vehicle where completed prescriptions for stock medicines and all medical records were placed straight after use. Staff we spoke with told us this box was only emptied every few days but the managers we spoke with told us they believed it was emptied daily. The provider told us that they would immediately investigate the discrepancy and ensure the box was emptied daily.
- The service held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had standard operating procedures in place that set out how controlled drugs were managed in accordance with the law and NHS England regulations. These included auditing and monitoring arrangements, and mechanisms for reporting and investigating discrepancies. Due to advice the provider had previously received they did not hold a Home Office licence to permit the possession of controlled drugs within the service. However they had applied for a licence. There were also appropriate arrangements in place for the destruction of controlled drugs.
- Processes were in place for checking medicines, including those held at the service and also medicines boxes for the out of hours vehicles. However we noted that the processes were not sufficient to ensure that stock levels were appropriate.
- Arrangements were in place to ensure medicines and medical gas cylinders carried in the out of hours vehicles were stored appropriately. For example, medicines were only stored in the vehicle during the shifts the vehicle was in use and removed after the last visit was completed.
- Staff we spoke with, including one of the medical directors, told us that they had already identified weakness in the medicines management and were planning to review it and update systems, policies and processes to ensure they were in line with best practice guidelines.

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 with a poster in the service office at Frimley Park Hospital. It was accessible to all staff and identified local health and safety representatives. Hard copies of service risk assessments and policies were stored in the office. Hospital and service risk assessments and policies were easily accessible on the computer. The service had up to date fire risk assessments but could not carry out regular fire drills as they were based in a large district general hospital. However a pictorial version of the hospital fire policy was available at reception and staff understood the process. 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. Clinical staff were expected to provide their own personal clinical equipment and ensure that it was in a useable condition. This was made clear to them and signed for at their induction; however spot checks were

not carried out to ensure this was the case. Spare sets of personal equipment owned and calibrated by the service were available for use if required. The service had access to a variety of other risk assessments (some of which had been carried out by the hospital) 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). The service had also carried out assessments of their local environment such as an accessibility assessment that included photographs.

- There were systems in place to ensure the safety of the out of hours vehicles. Checks were undertaken at the beginning of each shift. These checks included general safety checks on the car and equipment checks. We noted that the oxygen cylinder was only required to be checked at the weekends and bank holidays, when we brought this to the attention of the management they believed it was being checked daily and took action within 24 hours to update the vehicle checklist. Records were kept of MOT and servicing requirements. We checked the vehicles and found that they had for example, oxygen, a defibrillator and pads, personal protective equipment such as gloves and masks, laptops, medicines reference books, safety and guidance protocols. Medicines were not left in the car when they returned to the base. We also noted that in one of the vehicles two of the three sharps safe used for disposal of sharps clinical waste had been open longer than the best practice guidelines and had not been labelled completely. We brought this to the attention of the staff who took action to review this within 24 hours.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. Records were retained of staffing levels and the inspection team saw evidence that the rota system was effective in ensuring that there were enough staff on duty to meet expected demand. For instance we saw that on the previous Sunday 117 hours cover were required and 117 hours (100%) had been filled. There was a clear policy on the wall in the office with escalation triggers for calling senior management (with their telephone numbers) should there be staffing issues that required resolving at short notice.
- The National Quality Requirements (NQR) key performance indicators (capacity planning) expects the service to demonstrate an ability to match capacity to meet predictable fluctuations in demand for their contracted service (including robust contingency plans). Records showed that the Frimley service met these requirements for each month from January 2016 to December 2016 inclusive.

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 staff received annual basic life support training, including use of an automated external defibrillator.
- The service had access to oxygen and a defibrillator on the premises. A first aid kit and accident book were available. However a risk assessment determined that as the service was based within an acute hospital, the on call emergency team could be alerted if required.
- Emergency medicines were easily accessible. The medicines were the property of the hospital and stored securely.
- 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.

Good

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 patients' needs.
- 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 (NQRs) for out-of-hours providers. The NQRs are used to show the service is safe, clinically effective and responsive. Providers are required to report monthly to the clinical commissioning group (CCG) on their performance against standards which includes audits, response times to phone calls, whether telephone and face to face assessments happened within the required timescales, seeking patient feedback and actions taken to improve quality.

The quality requirements

The provider was meeting all National Quality Requirements (NQRs) for their service. They prepared a monthly report describing how they are meeting these requirements and met regularly with the CCGs that commission the service.

Audit:

- The NQRs state that providers must regularly audit a random sample of patient contacts and appropriate action will be taken on the results of those audits. Regular reports of these audits will be made available to the contracting CCG. The service used a software system to randomly sample consultations from each clinician. The results were initially analysed anonymously by two auditors who were GP trainers using Royal College of General Practitioners (RCGP) guidelines. The results were then reviewed at a panel and if any consultations were less than satisfactory or there were concerns then they were fed back to the individual clinician concerned for comments (via email) and the appropriate action taken. Audits were reported back to the CCGs. Across the providers' two locations 3.5% of all consultations were audited. Themes were generated from the panel meetings and included in a clinical governance newsletter. The panel produced a clinical governance review plan and included a continuing rolling action plan.
- The service had a system that identified patients with life threatening conditions and had passed all such patients to the emergency department within 3 minutes during 2016.
- The service had started a clinical assessment of all patients with urgent care needs within 20 minutes of them arriving at the primary care centre (PCC).
- Between 92% and 96% of all other patients had a definitive clinical assessment commenced within an hour during January to March 2016 and 100% from April to December 2016. This could include a telephone consultation by one of the service's clinicians. At the end of the assessment all patients were clear about the outcome, including (where appropriate) the timescale within which further action will be taken (if appropriate) and the location of any face-to-face consultation.
- All of the patients seen during the year were deemed to have been treated by the clinician best equipped to meet their needs and at the most appropriate location. This may be a telephone consultation, a consultation at the PCC or a home visit.
- All patients considered to be an emergency were seen within an hour after the definitive clinical assessment had been completed.
- For eight months of the year 95% to 100% of patients triaged as urgent were seen within two hours of the definitive clinical assessment. In the remaining four months 91% to 93% of urgent patients were seen within two hours of the assessment.
- For 11 months of the year between 95% and 96% of less urgent cases were seen within six hours of the initial assessment. All these figures were in line with NQRs.
- The service analysed any deviation from their targets and put in place changes where required. For instance

on some occasions patients were choosing to delay visits until the next day, or not to attend at all. This decision by the patients had not always been recorded and therefore adversely affected the figures. Changes were made to ensure that this information was recorded. Other issues were that clinical staff who were new to the service were sometimes seeing patients as they arrived at the Primary Care Centre not realising that a more urgent patient was due to arrive imminently and therefore delaying their consultation slightly. This potentially could have had an adverse effect on patients welfare and NQR returns. We saw that this was identified as a potential issue by the service and action taken to resolve it.

- The standard clinical system used by the majority of out of hours providers only categorises patients as urgent or routine, however the dispositions (recommended course of action) given by NHS 111 provide more options, for example, to be contacted within 30 minutes, one hour, two hours, six hours. The provider realised that patient prioritisation would be improved if the clinical system options matched the NHS 111 dispositions. The provider has developed in house options within the clinical system so that the system shows patients in the same priorities as the dispositions that were assigned by NHS 111. We saw evidence that since this had been implemented there was month on month reduction in the time patients who had received each disposition were waiting for contact with the primary care centre. For example, the average time patients whose disposition was to be contacted within an hour had been reduced to under 30 minutes.

There was evidence of quality improvement including clinical audit.

- The provider had an overarching programme of clinical audits for both of its locations, these included audits of antibiotic prescribing; hand hygiene and those related to National Quality Requirements. Improvements made were implemented and monitored for example, the service carried out an assessment of dental advice and prescribing practice of their GPs. This was a completed two cycle audit carried out in October 2015 and February 2016 to see what cases were being seen by GPs and what treatment was given. Best practice indicates that advice and referral to a dentist is the most effective treatment and antibiotics should be avoided, as this could lead to further problems. During the first data collection 59 cases were received. In 40 of the cases advised was given and 12 were given a prescription for pain killers. Seven patients received a prescription for antibiotics, with only one being deemed to be appropriate treatment. All patients were advised to be followed up by a dentist.

A total of 24 cases were identified in February 2016; 18 of these were given advice only and 15 were signposted to see a dentist as a matter of urgency. Two patients were prescribed antibiotics and it was concluded that an urgent dental referrals would have been the most appropriate option. The service noted there was a lower number of cases of dental complaints and attributed some of the change to an improvement in the NHS 111 Service referral pathway. They also found that the antibiotic prescribing had reduced. Further learning and conclusions related to ensuring that patients were directed to appropriate dental services both in and out of hours, pain relief rather than antibiotic should be prescribed, unless the patients was displaying signs of sepsis, in which case they should be referred immediately to accident and emergency departments.

- The service participated in local audits, national benchmarking, accreditation, peer review and research.

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 permanent and locum staff. 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. For example, vehicle drivers were given a practical and written assessment carried out by ex-police drivers to make sure they were competent.
- 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

Good

Are services effective?

(for example, treatment is effective)

scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, and clinical supervision. All staff had received an appraisal within the last 12 months.

- Staff received training that included: safeguarding, fire safety awareness, basic life support, conflict resolution, equality and diversity; moving and handling 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

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 or Electronic Health 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. Patients who could be more appropriately seen by their registered GP or an emergency department were referred. The service had effective working relationships with the Emergency Department. They had employed 'peak flow supervisors' who worked at weekends and on bank holidays who made regular visits to the Emergency Department to see if they had patients waiting who would be more appropriately seen by the Primary Care Service. This helped ease the pressure on the Emergency Department. If patients needed specialist care, the out-of-hours service, could refer to specialties within the hospital. Staff also described a positive relationship with the mental health and district nursing team if they needed support during the out-of-hours period.

The service worked with other service providers to meet patients' needs and manage patients with complex needs. It sent out-of-hours notes to the registered GP services electronically by 8am the next morning.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. 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 patients' 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.

All four of the patients Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the service offered an excellent, efficient and friendly service and staff were helpful, caring and treated them with dignity and respect.

Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the provider's own survey carried out in September 2016 showed:

- Approximately three percent of patients seen were sent a survey form in the post. One third of these replied. Of those that replied 94% felt that they had received either an excellent or good service from Frimley Primary Care Centre.

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 survey and feedback forms allowed patients to make comments about the service they had received. There was also a page on the service website that allowed patients to log a comment and for the service to respond. This was introduced by the service in response to patient requests. These were reviewed by the Chief Nursing Officer and Medical Directors and where appropriate acted on by the service. Comments and responses could be seen on the website. The service also showed us examples of positive comments that had been sent in by patients to the service. Patients used words such as fantastic, amazing and brilliant to describe both the service and individual members of staff. If individual staff were mentioned in a survey form then the comment would be relayed to them where appropriate.

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.
- A laminated sheet containing simple pictures to aid communication was available to staff and patients.
- Information leaflets on how to complain were available.
- Facilities for people with hearing impairment included a hearing aid loop.
- The reception and clinical staff had access to folders containing a large amount of useful information and telephone numbers for support services that they could give to patients where appropriate.

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 had employed peak flow supervisors who worked at weekends and bank holidays. They liaised with the adjacent Emergency Department (ED) and where possible actively sought out patients that were appropriate for treatment by primary care staff. For example, in September 2015 2.8% of patients seen were referred from the ED. In September 2016 this figure was 4.3% of patients seen were referred from the ED.

- Home visits were available for patients whose needs resulted in difficulty attending the service.
- There were accessible facilities, a hearing loop and translation services available.
- The provider supported other services at times of increased pressure.
- A thorough assessment of the 'other reasonable adjustments' were made and action was taken to remove barriers when patients find it hard to use or access services. There was a clear text and pictorial assessment of access to the service available in the reception file.

Access to the service

The service was open between 6.30pm and 8am Monday to Friday, and 24 hours a day on Saturdays, Sundays and bank holidays.

Patients could access the service via NHS 111. The service did not officially see 'walk in' patients and trying to access the service in this way was discouraged. However those that came in were triaged by a clinician and then given a place in the queue based on the assessment.

Feedback received from patients 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.

Requests for home visits received a call back from the triage GP who assessed both the most appropriate venue for the consultation and also 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.

- 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.
- A comprehensive log was recorded of the progress of the complaints including the dates of type of communications.
- We saw that information was available to help patients understand the complaints system. There were complaints leaflets clearly visible in the waiting room and there was also a complaints form available on the services website.
- The service felt that their complaints service could be improved and were at the time of the inspection updating their policy.
- Staff were made aware if a complaint was made against them and were involved in the response to the complaint.
- Complaints responses were discussed by the management team at monthly operations meetings and clinical governance meetings. Learning was disseminated via a clinical governance newsletter.

We looked at four complaints received in the last 12 months and found that they appeared to have been satisfactorily handled and dealt with in a timely way with openness and transparency. 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, a complaint was made that a clinician had not really listened to them and addressed their concerns. The complaint had been considered by the service and the GP had sent the patient and their family a letter of explanation and apology. The complaint was anonymised and shared in the clinical governance

Good

Are services responsive to people's needs?

(for example, to feedback?)

newsletter. However, although the log showed a clear timeline and confirmed that all the correct steps had been taken, we were not shown copies of all of the correspondence on the day. For instance one of the complaints did not have a copy in the file of the GP's letter to the complainant although we were assured that it had been sent. Also we saw four complaints, but only three were recorded in the log that we had been sent. We were told by the service that this was because one of the complaints was actually a 'concern' not directly about the service and incorrectly filed as a complaint. Management told us that they had already identified areas in their complaints system that needed improvement and had updated their policy. We saw a copy of the updated policy that was going through the ratification process.

Are services well-led?

Good

(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 clear vision to deliver high quality care and promote good outcomes for patients.

- The service had a mission statement and staff knew and understood the values.
- The service had a robust strategy and supporting business plans that reflected the vision and values and were regularly monitored.

Governance arrangements

The service had an overarching governance framework that supported the delivery of the strategy and good quality care. All staff, including contracted GPs were supported by a clear leadership structure, which consists of two medical directors, a chief executive, a chief nurse and a board of executive and non-executive directors. They were responsible for oversight of service provision and there were a range of meetings to monitor performance, such as clinical and risk governance. Senior leadership staff were also visible at the base, for example medical directors had a remit to work out of hours shifts as regularly as possible.

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.
- Service specific policies were implemented and were available to all staff.
- 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.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection the provider of the service demonstrated they had the experience, capacity and capability to run the service and ensure high quality care. They told us they prioritised safe, high quality and compassionate care.

The service had had several changes of local management over the previous two years and had only recently achieved stability over the last year. Staff told us the current management were very approachable, always took the time to listen to all members of staff and had made positive changes to the service.

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 senior leadership team 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 people an explanation based on facts and an apology where appropriate, in compliance with the NHS England guidance on handling complaints.
- The service kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- There were arrangements in place to ensure the staff were kept informed and up-to-date. This included a clinical governance newsletter; a safeguarding update newsletter; and regular staff meetings.
- Staff told us there was an open culture within the service and they had the opportunity to raise any issues and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the providers. Staff had the opportunity to contribute to the development of the service.

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

Are services well-led?

Good

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

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

- The service had gathered feedback from staff through staff surveys, staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example, staff fed back that the laptops supplied by the service for use in the cars were slow and the service responded by replacing them with updated versions. Staff told us they felt involved and engaged to improve how the service was run.
- We saw an NHS externally run staff survey for2015 to 2016 on 'patient safety culture' in which North Hants Urgent Care (NHUC) which includes Frimley Primary Care Service scored well against the average for all organisations included in Urgent Health UK and had improved on their previous years scores in almost all areas.
- We also saw that NHUC had carried out an annual staff survey as well.

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. The service used an audit tool for clinician consultations known as the Clinical Guardian tool; this enabled them to adjust how many audits of clinicians were needed in response to any concerns that might have been identified. NHUC was working with local health care providers to develop models of care to support patients living in care homes. The service had appointed a Freedom to Speak up Guardian to enable staff to raise concerns.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service was unable to demonstrate that it had done all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. The service had failed to demonstrate the proper and safe management of medicines, including monitoring stock levels appropriately to ensure the safety of service users and to meet their needs, and had not ensured that sharps safes were labelled and used appropriately. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.