# PC24

## Quality Report

Primary Care 24
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

## Ratings

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

# Key findings

## Contents



## Letter from the Chief Inspector of General Practice

**This service is rated as Good overall.** (Previous inspection 17 & 20 April 2015 and was rated as Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an unannounced comprehensive inspection at PC24 Out of Hours, also known as PC24 Kings Mill Hospital on 12 October 2018. We carried out this inspection in response to information of concern we had received. As part of this we also inspected the provider's headquarters (NEMS Community Benefit Services Limited) based in Fanum House, Nottingham on 18 October 2018.

At this inspection we found:

- The service had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes.
- The provider demonstrated effective joint working arrangements with key partners to develop-coordinated care.
- The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Regular audits were carried out on the quality of care being provided by clinical staff. Actions were taken to improve any performance that falls below expectations.
- The service was responsive to patients' needs. It provided face-to-face consultations, telephone consultations and home visits depending on the needs of patients.
- This was an unannounced inspection therefore, we were unable to receive feedback from patients during the inspection. However, patient feedback received by the service demonstrated that staff involved and treated people with compassion, kindness, dignity and respect.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs. Processes were in place to identify patients that needed more urgent attention.
- The service was aware of some of the challenges to deliver quality care and was taking action to address them.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

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

# Summary of findings

- Consider appropriate signage in the waiting room to alert patients on action to take if their condition is worsening.
- Develop the staff induction programme to include a site specific induction.
- Ensure appropriate oversight of risk assessments by the hospital. For example, those in relation to legionella, health and safety and fire.
- Consider record keeping for consent when using a chaperone for intimate examinations.

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

# Key findings

## Areas for improvement

**Action the service SHOULD take to improve**

- Consider appropriate signage in the waiting room to alert patients on action to take if their condition is worsening.
- Develop the staff induction programme to include a site-specific induction.
- Ensure appropriate oversight of risk assessments by the hospital. For example, those in relation to legionella, health and safety and fire.
- Consider record keeping for consent when using a chaperone for intimate examinations.

# PC24

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team at PC24 was led by a CQC lead inspector. The team included a second CQC Inspector and a GP specialist adviser.

Our inspection team at the headquarters (provider) based at Fanum House was led by a CQC inspector and a second CQC inspector.

## Background to PC24

PC24 Out of Hours provides primary medical services across North Nottinghamshire

when GP practices are closed. The area covered incorporates Mansfield, Ashfield, Newark and Sherwood areas. The service is provided across two locations, PC24 at Mansfield Hospital and a satellite site at Newark Hospital. The provider is NEMS Community Benefit Services Limited and their administrative base is located at Fanum House, 484 Derby Road, Nottingham (http://www.nems.org.uk/).

Most patients access the out-of-hours service via the NHS 111 telephone service. Patients may be seen by a clinician, receive a telephone consultation or a home visit, depending on their needs. Patients can also access the locations as a walk-in patient or be referred from the hospital accident and emergency departments or urgent care centre.

We carried out an unannounced inspection of PC24 on 12 October 2018 based at Kings Mill Hospital due to concerns we had received. We then carried out an announced visit at the administrative headquarters of the provider (NEMS Community Benefit Services Limited) based in Fanum House, Nottingham on 18 October 2018 to review the administrative and management processes in place to deliver a quality service.

Good

# Are services safe?

## Our findings

**We rated the service as good for providing safe services**

**Safety systems and processes**

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

- The service was located in Kings Mill Hospital, Mansfield next to the Emergency Department. The building was managed by Kings Mill Hospital and risk assessments such as fire safety and legionella was carried out by them. The service did not have access to these assessments on the day of the inspection. The service forwarded evidence of actions they were taking following a legionella risk assessment. However, they were unable to provide evidence that a risk assessment had been carried out.[DV1]
- The service was located in purpose built premises and looked visibly clean and tidy. The cleaners were contracted by Kings Mill Hospital and the service did not have any mechanisms in place to assure themselves that cleaning was being carried out according to expected standards. We were told that the hospital carried out spot checks on the quality of cleaning but these were not shared and therefore the service did not have a good oversight of all safety processes.
- The provider conducted some safety risk assessments. It had safety policies, including Control of Substances Hazardous to Health (COSHH). For example, the services employed drivers for various functions. As part of their role, drives maintained their vehicles by ensuring brake fluids were topped up and we saw COSHH sheets for these were available.
- Health & Safety policies were available and there was evidence that risks had been considered. Staff received safety information from the provider as part of their induction and refresher training. The provider had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The service worked with other agencies to support patients and protect them from neglect and abuse. For example, we saw evidence of special notes and alerts on the system designed to inform staff and forward any concerns to other organisations. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There were effective systems in place to assure the provider all clinicians and nursing staff had current registration with their respective professional body. There was a system to ensure that GPs were unable to book or complete sessions if their professional indemnity was not current.
- There was an effective system to manage infection prevention and control.
- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

**Risks to patients**

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective system in place for dealing with surges in demand. For example, the provider had reviewed previous demand in peak periods such as Christmas and Easter and extrapolated the future requirements to ensure demand was met. A decision had been made to meet he additional demand solely with GPs to ensure all areas of business were covered.
- There was an induction system for both employed and temporary staff tailored to their role. However, where GPs worked across different locations there was no assurance that they received an induction for all sites. We highlighted this to the provider who gave assurance

that they would put in place a system whereby the clinical team co-ordinator at each site would have responsibility to ensure that staff received site specific induction.

- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis. Staff had received training and posters had been put in place as a result of this training. Staff confirmed that guidance was available and were discussed in clinical meetings. We saw sepsis risk identification tools available on the system.
- Systems were in place to manage people who experienced long wait times to be seen. There was a triage system in place to prioritise and identify patients that required more urgent attention. Patients who arrived through the 111-system received an initial triage conducted on arrival by a healthcare assistant using standard observations tools. Any patient scoring high were immediately referred to appropriate clinicians to be reviewed to ensure they were in the appropriate area or safe to wait. Patients who self-presented to the Emergency Department (Kings Mill Hospital) were triaged by hospital staff and then referred to PC24 if appropriate. However, there were regular patients being received by PC24 who fell outside of their remit and were referred to the Emergency Department stream.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse. We saw a poster in the waiting area advising patients on the actions to take if they felt their condition was getting worse. However, it made it difficult to read due to the small font size. We informed the service which agreed to replace the notices in larger font.
- When there were changes to services or staff the service assessed and monitored the impact on safety.

**Information to deliver safe care and treatment**

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way. For example, we saw records where there were special notes and safeguarding alerts in place for relevant patients.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. The service could access the patients GP records if there was a clinical reason following consent from the patient. Notes were inputted onto the computer system and were immediately available by the patients GP and secondary care.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance. The service could directly admit patients to wards (Kings Mill Hospital) if clinically necessary.

**Appropriate and safe use of medicines**

The service had reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, including medical gases, emergency medicines and equipment, and controlled drugs and vaccines, minimised risks. The service kept prescription stationery securely and monitored its use. Arrangements were also in place to ensure medicines and medical gas cylinders carried in vehicles were stored appropriately. This included those prescriptions taken off site in the vehicles for home visits and a recording system for medicines which were dispensed during these visits.
- The vehicles were issued with equipment and medical gas cylinders which were stored appropriately and regularly checked. Medicines and equipment of value was stored in a secure room and issued to the vehicle as needed at the beginning of shift. This was routinely checked and records kept so items, locations and usage could be effectively monitored.
- The service carried out regular medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The service had audited antimicrobial prescribing. There

Good

# Are services safe?

was evidence of actions taken to support good antimicrobial stewardship. Clinical staff members we spoke with confirmed that they had attended prescribing training delivered by the provider.
- Processes were in place for checking medicines and staff kept accurate records of medicines.
- Arrangements for dispensing medicines kept patients safe. There was an auditable process to demonstrate this.
- Palliative care patients were able to receive prompt access to pain relief and other medication required to control their symptoms.

**Track record on safety**

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues. However, some risks such as fire safety and legionella was managed by Kings Mill hospital and the service told us that risks related to these were assessed by the Hospital. However, the service was unable to provide evidence of this, we were informed the hospital had not shared this with them.
- The service monitored and reviewed activity. This helped them to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- There was a system for receiving and acting on safety alerts. We saw evidence of safety alerts that had been received by staff and any relevant action taken.

**Lessons learned and improvements made**

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. The provider met regularly with partner organisations involved in the provision of urgent care services to improve joint working arrangements and the delivery of care. We saw evidence that incidents were discussed across the organisational boundaries.
- The service currently had a paper based system to report incidents which were then populated onto a database. This allowed the service to identify themes and trends and share findings with the wider team. The service sent out a quarterly report to the managers of the service who were then responsible for sharing any learning with their team. If there were organisational learning these were emailed out on to the rota system. We were told that a pop up message appeared on the rota when staff logged on to the system. This ensured all staff were aware of any learning.
- We were told that the service was currently exploring an electronic system for incident reporting to further improve the process.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**We rated the service as good for providing effective services.**

**Effective needs assessment, care and treatment**

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

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed. We saw a number of relevant and up to date guidelines and protocols in the services shared drive such as pregnancy (early bleeding) and anaemia.
- Telephone assessments were carried out using a defined operating model and staff were aware of the model. Clinicians we spoke with told us that they had quarterly audit of their work and results were shared in a standardised format. We saw examples of these audits which used structed assessment tools based on the Royal College of General Practitioners (RCGP) template.
- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. We were told that patients were managed holistically so if they came in for one issue and wanted to discuss other issues the service not refuse this. Clinicians we spoke with told us that they were not under any time pressure.
- Care and treatment was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients. There was a system in place to identify frequent callers and patients with particular needs, for example palliative care patients, and care plans/guidance/ protocols were in place to provide the appropriate support. The providers attended meetings quarterly with the hospital team and discussed any frequent attenders and alerts were in place on the system.
- When staff were not able to make a direct appointment on behalf of the patient, clear referral processes were in place. These were agreed with senior staff and clear explanation was given to the patient or person calling on their behalf. The service was located next to the hospital and staff told us that they escorted patients to the ward if they were admitted following review.
- Staff assessed and managed patients' pain where appropriate. Patients were triaged by a healthcare assistant and prioritised where relevant.

**Monitoring care and treatment**

The service had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. The service carried out quarterly audits of telephone and face to face consultation through review of reports and listening to telephone conversations. GPs and nurses were reviewed by separate audit teams comprised of peers.

From 1 January 2005, all providers of out-of-hours services were required to comply with the National Quality Requirements (NQR) for out-of-hours providers. The NQR are used to show the service is safe, clinically effective and responsive. Providers are required to report monthly to their clinical commissioning group (CCG) on their performance against the 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 provider shared with us their NQR results for the service from May 2016 to September 2018 which was reported monthly. Full compliance against the NQRs is reported as achieving above 90%, partial compliance between 85% and 90% and non-compliance is achieving less than 85%.

- The data supplied by the service demonstrated an improvement in performance since the service started in May 2016.
- Generally, the service was meeting its locally agreed targets as set by its commissioner over the last 12 months. For example, the service was complaint over the last 12 months where there was a requirement to see patients within two hours and six hours.
- The service made improvements through the use of completed audits. Clinical audit had a positive impact

Good

# Are services effective?

## (for example, treatment is effective)

on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality. The clinical audit committee ensured performance of clinicians were reviewed quarterly to ensure quality care. Where improvements were identified this was monitored.

- The service was actively involved in quality improvement activity. Where appropriate, clinicians took part in local improvement initiatives. For example, clinicians took part in peer review of their work and learning was shared in a generic way without identifying individuals.

**Effective staffing**

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

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff. This covered such topics as fire safety, lone working and infection prevention and control. However, we found that in the case of agency and locum GPs, the provider did not have any documented assurance that they had completed required training such as basic life support, fire safety training or infection prevention and control. We raised this with the provider on our inspection in18 October 2018 and were assured that they would review their process in light of our observations. Following the inspection, the service developed a policy of mandatory training requirements which was shared with us. The policy included infection prevention and control, fire training, information governance and mental capacity. The policy also outlined how the provider would monitor compliance to this.
- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required. All new clinicians had their work audited within the first two shifts to ensure they were working according to expected standards. If clinicians were unable to reach the expected competence levels they were not offered any further shifts.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. The provider was currently supporting two nurses to develop as Advanced Nurse Practitioners. We were told that relevant staff had recently attended gynaecology study day. All staff had also attended paediatric training day to help assess children.
- The provider offered staff with ongoing support. This included one-to-one meetings, appraisals and clinical supervision and support for revalidation. The provider could demonstrate how it ensured the competence of staff employed in advanced roles, including locum, agency and sessional GPs by audit of their clinical decision making. Staff members we spoke with confirmed that they were supported to work within their competencies.
- There was a clear approach for supporting and managing staff when their performance was poor or variable. There was an 11-member audit group (one for nurses and another for GPs) that reviewed consultations and clinical notes. This was based on the Royal College of General Practitioners (RCGP) template. There was a scoring system and if learning was identified the GP met with the member of the audit group to discuss strategy for improvement. Special audits were triggered if a clinician's performance was below what was expected. This was based on the accumulated scores of previous four quarterly audits. Clinicians were expected to improve following findings from the special audit. If a clinician failed to improve following a re-audit after three months, they were unable to continue to work for the provider.

**Coordinating care and treatment**

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

- We saw records that showed all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. Clinical staff members told us that systems were in place to monitor patients discharged with advice. This was through audits with clear action points. Care and treatment for patients in vulnerable circumstances was coordinated with other services. The

Good

# Are services effective?

## (for example, treatment is effective)

provider met regularly with partner organisations involved in the provision of urgent care services to improve joint working arrangements and the delivery of care. This was being led through one of the local CCGs.

- Staff communicated promptly with patient's registered GP's so that the GP was aware of the need for any further action. Staff also referred patients back to their own GP to ensure continuity of care, where necessary. There were established pathways for staff to follow to ensure callers were referred to other services for support as required. Clinical staff members told us that they could generate specific actions required by their own GPs.
- The service worked with patients to develop personal care plans that were shared with relevant agencies. As mentioned above, the service met with other services to develop a plan to manage these patients.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- The service ensured that care was delivered in a coordinated way and took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that required them. However, staff members we spoke with also told us that if patients were referred to the service inappropriately following assessment at the Emergency Department (located in Kingsmill Hospital) then it was difficult to refer them back.

**Helping patients to live healthier lives**

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

- The service identified patients who may need extra support. There was a facility on the electronic patient management system (Adastra) to provide specific action to their GP.
- Where appropriate, staff gave people advice so they could self-care. Systems were available to facilitate this.
- Risk factors, where identified, were highlighted to patients and their normal care providers so additional support could be given.
- Where patient needs could not be met by the service, staff redirected them to the appropriate service for their needs.

**Consent to care and treatment**

The service obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The provider monitored the process for seeking consent appropriately.
- The service did not undertake any procedures and sought verbal consent only for example, if chaperones for intimate examinations were used. However, we were told that this would now be documented in record going forward.

Good

# Are services caring?

## Our findings

**We rated the service as good for caring**

**Kindness, respect and compassion**

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information. Call handlers gave people who phoned into the service clear information. There were arrangements and systems in place to support staff to respond to people with specific health care needs such as end of life care and those who had mental health needs. Staff members told us that they attended training events across the organisation which also helped to network and discuss learning.
- We carried out a responsive inspection and did not give out Care Quality Commission comment cards. The service received and monitored patient feedback through various means such as the NHS Friends and Family test (FFT), patient questionnaires and NHS choices website. We saw a total of 181 feedback through the FFT since April 2018 (for both sites, PC24 and NEMS). Generally, feedback was positive about the service experienced.

**Involvement in decisions about care and treatment**

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

- Interpretation services were available for patients who did not have English as a first language. The service had access to a telephone interpretation service; interpreters could also be booked in advanced where appropriate. We saw notices in the reception areas, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them. Information leaflets were available in easy read formats, to help patients be involved in decisions about their care.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment. Clinicians we spoke with told us that they did not feel under pressure to see patients quickly.

**Privacy and dignity**

The service respected and promoted patients' privacy and dignity.

- Staff respected confidentiality at all times.
- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- Evidence seen during the inspection indicated that staff understood the requirements of legislation when supporting patient to make decisions. However, we found that in the case of agency and locum GPs, the provider did not have any documented assurance that they had completed required training such as mental capacity act training. Following the inspection, the service developed a policy to ensure all clinicians were up to date with their training and the process to monitor compliance.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**We rated the service as good for providing responsive services.**

**Responding to and meeting people's needs**

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

- The provider engaged with commissioners to secure improvements to services where these were identified. For example, GPs were provided with laptop computers that allowed them to work from home and alleviate pressures in the primary care centres by undertaking telephone triage and call-backs to patients.
- The provider had taken steps to hire an additional ten lap-tops from Nottingham Health Information Systems to further enhance their capacity to meet the anticipated additional demands of winter pressures.
- There was a duty GP system in place in the event of a surge in demand. Staff members we spoke with told us that this was very helpful and helped the service respond adequately to meet the needs of patients.
- The provider regularly met with the local CCGs as part of the contract monitoring arrangements which enabled them to look at performance, discuss targets and local needs.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service. We saw examples of alerts and special notes on patient records.
- Care pathways were appropriate for patients with specific needs, for example those at the end of their life, babies, children and young people.
- The service was in purpose built premises and was appropriate for the services delivered. The premises was accessible for those who had difficulties with their mobility.
- For those attending with young children, baby changing facilities were available
- The service was responsive to the needs of people in vulnerable circumstances. The service had a process in place to triage patients and ensure those in vulnerable needs were responded to appropriately. These were usually highlighted through patient special notes or information picked up by the NHS 111 service.
- The service was able to offer wound management following discharge from hospital.
- Patients who found it hard to access the service could be seen as a home visit.

**Timely access to the service**

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

- The service operated from 6.30pm to 8am Monday to Friday and all day at weekends and public holidays.
- Patients could access the service either as a walk in-patient, via the NHS 111 service or by referral from a healthcare professional. Patients did not need to book an appointment.
- The service had a system in place to facilitate prioritisation according to clinical need where more serious cases or young children could be prioritised as they arrived. The reception staff had a list of emergency criteria they used to alert the clinical staff if a patient had an urgent need. The criteria included guidance on sepsis and the symptoms that would prompt an urgent response. The receptionists informed patients about anticipated waiting times.
- Patients had timely access to initial assessment, test results, diagnosis and treatment. National Quality Requirements data supplied by the service demonstrated the provider was meeting expected timescales for patients being seen.
- For patients that needed to be seen within two hours of assessment the service had been compliant over the last 12 months.
- For patients that needed to be seen within 60 minutes as a home visit the service was fully complaint over the previous 12 months.
- For patients that needed to be seen within two hours as a home visit the service was complaint over the last 12 months except for February, March and April when it was partially complaint. Full compliance against the NQRs is reported as achieving above 90% and the service compliance data for February was 88%, March 90% and April 89%.
- During the inspection, staff advised us that regular performance meetings were held to discuss performance against NQRs and action was taken to improve where appropriate. Senior manager s told us that the service had been in a period of transition over

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

the last two years and efforts were being made to improve the service. National compliance data supplied by the provider demonstrated improvements in all areas.

- The service engaged with people who were in vulnerable circumstances and took actions to remove barriers when people found it hard to access or use services.
- The service also offered home visits where relevant.
- Patients with the most urgent needs had their care and treatment prioritised.
- Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.
- The appointment system was easy to use. Calls coming through the NHS111 system to the triage team and they allocated a slot for patients if appropriate.
- Referrals and transfers to other services were undertaken in a timely way. The service was located next to a hospital and they worked closely with the hospital team to ensure smooth patient pathway where possible.

**Listening and learning from concerns and complaints**

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

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately. The complaint policy and procedures were in line with recognised guidance. Complaints were reviewed as part of the providers quarterly governance meeting. Governance report from April to June 2018 for this service and associated services (Ashfield and Newark & Sherwood Clinical Commissioning Groups) showed that 11 complaints were received. The report documented if complaints had been acknowledged and responded to within timescales; whether they had been upheld or refereed to the parliamentary ombudsman. According to the report, one complaint had not been responded to within the timescale.
- The service learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. We saw evidence that individual complaints were reviewed, learning outcomes identified and shared.
- Issues were investigated across relevant providers, and staff were able to feedback to other parts of the patient pathway where relevant. Staff surveys were carried out and a training day/workshop was set up with staff so that action could be taken to improve service.

# Are services well-led?

Good

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

## Our findings

**We rated the service as good for providing a well-led service.**

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

- During the inspection at PC24 and the headquarters (NEMS Community Benefit Services Limited, 484 Derby Road, Nottingham), leaders of the service demonstrated that they had the experience, capacity and skills to deliver the service strategy and address risks to it. They discussed the actions they were taking to improve and the plans they had to further improve services.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. During our discussions with staff they told us that a number of improvements had been made; a number of policies had been reviewed, the safeguarding process had been strengthened. The service had strengthened its medicines management process including development of an effective audit process.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- Senior staff, including an on-call manager and on-call director were accessible throughout the operational period.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

### Vision and strategy

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

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- The service developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The provider planned the service to meet the needs of the local population. It met with commissioners to discuss how it could met the needs of the population.
- The provider monitored progress against delivery of the strategy.
- The provider ensured that staff who worked away from the main base felt engaged in the delivery of the provider's vision and values. Some staff members we spoke with told us that they did not feel senior management were not always visible at this site. We spoke with the senior leaders who told us that they were working to ensure better integration of all sites.

### Culture

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

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance consistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. We looked at a response following a complaint; the response was a self-reflection of the clinician's consultation and demonstrated openness, honesty and transparency. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. The service acknowledged difficulty in recruiting some staff, particularly some nursing roles and was currently supporting two nurses to become advanced nurse practitioners.
- Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional time for professional development and evaluation of their clinical work.

# Are services well-led?

Good

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

- There was a strong emphasis on the safety and well-being of all staff.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

**Governance arrangements**

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

- Structures, processes and systems to support good governance and management were clearly set out as standard operating procedures. These were accessible to staff through their intranet system, along with other guidance.
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- There was a clear leadership structure and staff were aware of who to escalate concerns to.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control. There were local leads who monitored and supported their specialties such as safeguarding and engaged with the local system to ensure a joined-up approach to patient care with local agencies and providers such as GPs and secondary care.
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. Staff members we spoke with confirmed that polices had been reviewed and processes such as for medicine management had been improved. The provider told us that they were working to improve the service and had employed a quality and governance lead in November 2017. The quality and governance lead was able to demonstrate their approach to improving quality and governance for the service.

**Managing risks, issues and performance**

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

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.

The provider had processes to manage current and future performance of the service. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Staff at all levels were clearer in relation to their roles in managing safety alerts, incidents and complaints.

- Leaders had oversight of MHRA alerts, incidents, and complaints. Leaders also had a good understanding of service performance against the national and local key performance indicators. Performance was regularly discussed at senior management and board level. Performance was shared with staff and the local CCG as part of contract monitoring arrangements.
- Governance meetings were held at a provider level, these were attended by the heads of services, governance lead and clinicians. From the minutes seen, issues discussed included an overview of incidents and complaints, patient pathways, safety alerts among other issues.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality.
- The providers had plans in place and had trained staff for major incidents. There was a business continuity plan in place in the event of a major incident such as power failure, telephone loss or building damage.

**Appropriate and accurate information**

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.

# Are services well-led?

Good

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

- The service used information technology systems to monitor and improve the quality of care. GPs were provided with laptop computers that allowed them to work from home and alleviate pressures in the primary care centres by undertaking telephone triage and call-backs to patients. The provider had taken steps to hire an additional ten lap-tops to further enhance their capacity to meet the anticipated additional demands of winter pressures.
- The service submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Staff received data protection training.

**Engagement with patients, the public, staff and external partners**

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. The provider had undertaken a staff survey within the last 12 months and had analysed the responses. There were a number of findings and the provider was taking action to respond. For example, better feedback in response to near misses and incidents; more effective communication from senior management. The findings of the survey were fed back to staff.
- Staff members told us that they had suggested posters to be displayed in the waiting area regarding waiting times and this was actioned.
- Staff were able to describe to us the systems in place to give feedback. Staff were encouraged to provide feedback through the monthly meetings with their line managers. The service was transparent, collaborative and open with stakeholders about performance.
- Some staff members had raised issues about being isolated in the reception area away from the main consultation corridor. A risk assessment had been carried out and the service was considering the introduction of a personal alarm system for staff. We saw the quotation for this had been received to organise installation of this system.

**Continuous improvement and innovation**

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

- There was a focus on continuous learning and improvement at all levels within the service. Quarterly audits of telephone and face to face consultations were carried out and learning communicated to relevant staff members. The provider was working with the CCG to continually improve the services provided.
- Staff knew about improvement methods and had the skills to use them.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance. Clinical staff members we spoke with told us that the provider supported reflective learning through email of top-tips and therapeutic guidelines.