Care UK – Surrey

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Care UK - Surrey on 22 to 24 November 2016 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.
- Patients' care needs were assessed and delivered in a timely way according to need. The service met the National Quality Requirements (NQRs).
- 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 some patient records, however, this depended on the ability of the patients' GP service to provide the access required.
- The out of hours staff shared relevant information about patients they had seen with their GP and the hospital, within the time frame set out in the national quality requirements.
- 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. Improvements were made to the quality of care as a result of complaints and concerns.
- The service worked proactively with other organisations and providers to develop services that supported alternatives to hospital admission where appropriate and improved the patient experience.
- The service had good facilities and was well equipped to treat patients and meet their needs. The vehicles used for home visits were clean, well maintained and well equipped.
- The GPs and Advanced Nurse Practitioners who staffed the bases were mostly recruited from local GP practices and were expected to supply their own fully calibrated personal equipment. However, they were

Summary of findings

not provided with a list of expected equipment and the provider did not undertake spot checks to ensure it was fit for purpose. A back up set of equipment was supplied at each base should it be required.
- 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.

The areas where the provider should make improvement are:

Provide all self-employed staff with a list of the personal equipment they are expected to supply. Undertake regular spot checks to ensure equipment is calibrated and fit for purpose.

To review online training including chaperone training to ensure that it complies with current guidelines.

To monitor the use of local operating procedures at primary care centres to ensure that staff are operating them as intended.

Ensure that all staff comply with the requirement to record the contents of medicines cassettes. Introduce guidelines as to when a cassette should be returned for refill.

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?

Good

The service is rated as good 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 systems and processes in place to keep patients safe and safeguarded from abuse. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- 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. For example all cars were fully equipped and maintained, with a backup mobile phone and easily accessible access to supervisory support from senior clinicians and managers.
- The GPs and Advanced Nurse Practitioners who staffed the bases were mostly recruited from local GP practices and were expected to supply their own fully calibrated personal equipment. There was no list of expected equipment and spot checks to ensure equipment was calibrated and fit for purpose were not carried out. A back up set of equipment was supplied at each base should it be required.
- Risks to patients were assessed and well managed.

Are services effective?

Good

The service is rated as good for providing effective services.

Summary of findings

- 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.
- 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.

Are services caring?

Good

The service is rated as good for providing caring services.

- Feedback from the majority of patients through our comment cards and those collected by the provider was 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. The organisation met with the commissioners on a regular basis to discuss their performance against several key performance indicators.
- 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. The service had strict national quality requirements that they needed to meet as to how quickly patients were seen. The service consistently met or exceeded the requirements.

Summary of findings

- Information about how to complain was available and easy to understand and evidence showed the service responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

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

Care UK conducted surveys of patients' experience on an ongoing basis. During the period October 2015 to September 2016 1179 patients had responded to surveys and 95% had had expressed overall satisfaction with the service they had received. The trend in satisfaction was generally upward from about 90% at the end of 2015 to about 98% by September 2016.

The national GP patient survey asks patients about their satisfaction with the out-of-hours service. There were three surveys, one for each of the three clinical commissioning groups that the OOH service covered. The results have been aggregated. The total number of surveys was 14148 of which 5049 were returned (44%). Patients were asked "how would you describe your last experience of NHS services when you wanted to see a GP but your GP surgery was closed" and 72% thought the service was either good or fairly good. The lowest response was 67% which is the same as the national average but the highest was 79% which is equal to the highest response in England.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 11 comment cards which were all positive about the standard of care received. The service was described as excellent and staff as helpful and caring.

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

Out of 1186 patients that filled in a friends and family test form between 1 October 2015 and 30 September 2016 94% would recommend the service to their friends and family.

Care UK – Surrey

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included three additional CQC inspectors, two GP specialist advisers, a member of the CQC medicines team, a nurse specialist adviser and a manager specialist adviser.

Background to Care UK – Surrey

Care UK – Surrey out of hours service provides out of hours services for the majority of Surrey.

Care UK – Surrey is part of the Care UK organisation and a subsidiary of Care UK (urgent care) limited.

The head office and despatch centre is based at:

Glassworks 2

Station Road

Dorking

Surrey

RH4 1HJ

The service is run from seven primary care centres across Surrey. All seven are open at weekends and four during the week. Seven fully equipped vehicles staffed by a GP and driver are based at the centres and patients may be seen at the primary care centres, at home or offered a telephone consultation with a clinician. The type of consultation depends on circumstances and following an initial triage call. In some instances appointments can be directly booked with the out of hours service by the NHS 111 service who are the first point of contact, without the need for triage.

The service employs 102 staff members, 88% of these have direct patient contact.

The service is open from 6.30pm to 8am Monday to Friday and all day at weekends and on bank holidays. Opening times at the primary care centres are variable. The service also provides cover when GP practices are closed for example during training afternoons.

The service covers 840 square miles, just under 1,146,000 patients and 96 GP practices. Surrey is one of the least deprived counties in the country. People tend to live longer than the national average. Only 2.5% of the population are deemed to be living in poor health and 19% of patients are over 65.

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew. We carried out an announced visit on 22 to 24 November 2016. During our visit we:

- Spoke with a range of staff, the service manager and regional medical director, senior administrative staff, GPs, nurses, a pharmacy technician, despatch staff, drivers and reception staff. We also spoke with patients who used the service.
- Observed how patients were provided with care and talked with carers and/or family members
- Inspected the out of hours premises, looked at cleanliness and the arrangements in place to manage the risks associated with healthcare related infections.
- Looked at the vehicles used to take clinicians to consultations in patients' homes.
- 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.

Good

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. All clinical events were reviewed by the medical director and notifications sent to relevant bodies such as the people involved, commissioners of the service and CQC. Incidents were also taken to regional and national panels. The provider ensured that learning from them was disseminated to staff and embedded in policy and processes. Data showed that all serious incidents were reported to the commissioner within the agreed timescales. All significant incidents were referred to clinical commissioning group significant incident panels.
- 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. The organisation sent out a national quarterly clinical newsletter in which several similar significant events were shared and discussed. For example we saw a newsletter in which, amongst several other significant event analyses, three different presentations of a pulmonary embolism (blood clot on the lungs), all of which had been raised as significant events from different services within the organisation, were described with questions posed to the reader. This was followed by several pages that described and discussed relevant NICE (National Institute of Health and Care Excellence) guidelines to help ensure staff kept up to date with best clinical practice.
- Medicines recalls were circulated to staff for action if required. The service provider kept records to demonstrate that all relevant alerts had been appropriately actioned.

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:

- There were arrangements to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. There were flowcharts and policies which outlined who to contact for further guidance. There was a nominated lead member of staff for safeguarding.
- Care UK had completed safeguarding audits, against Section 11 of the Children Act 2004. This was a self-assessment of the degree to which the organisation was meeting its obligation to safeguard and promote the welfare of children. The assessments were sent to the local safeguarding board which was under a duty to ensure the arrangements were robust. The board had accepted the audit and this provided a degree of independent scrutiny of the arrangements for safeguarding children.
- Staff we spoke with understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs and advanced nurse practitioners (ANPs) were trained to child safeguarding level three. Staff who had no direct contact with vulnerable people had safeguarding training if it was felt that this would enhance their role.
- The safeguarding records we looked at showed that alerts had been raised and handled in accordance with best practice and reflected current issues of concern, for example we saw that an alert was raised in relation to a potential case of female genital mutilation.
- 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 although

examination of the training and discussion with staff revealed that the training needed to be updated to fulfil current guidelines. We saw evidence that this was being put in place before the inspection had been completed. Staff trained as chaperones 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. Infection control audits were undertaken in a monthly rolling cycle 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 for example annual servicing of fridges including calibration where relevant. All clinical equipment owned by the organisation was calibrated yearly. GPs and Advanced Nurse Practitioners who staffed the bases were mostly recruited from local GP practices and worked as self-employed staff. They were expected to supply their own fully calibrated personal equipment. There was no list of which equipment that they were expected to supply. However a spot check of four GPs on the second day of inspection found three to be using recently calibrated equipment and the fourth was using Care UK calibrated equipment. We also saw that the clinical staff had to sign at induction that they would keep the calibration of equipment current. We also saw that they were reminded via email and newsletters (for example January 2016 clinical newsletter). A back up set of equipment was supplied at each base should it be required.
- We reviewed 12 personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body, appropriate indemnity and the appropriate checks through the Disclosure and Barring Service.

Medicines Management

- The arrangements for managing medicines at the service, including emergency medicines, kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). 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.
- 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. The provider held a Home Office licence to permit the possession of controlled drugs within the service. 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 bags for the out of hours vehicles.
- Arrangements were in place to ensure medicines and medical gas cylinders carried in the out of hours vehicles were stored appropriately.
- We saw that a local operating policy (LOP) relating to temperature recording in a room (not a fridge) where medicines were stored at room temperature had been misinterpreted by staff. This was pointed out and the policy was clarified immediately when we inspected another primary care centre the next day, staff we spoke with were aware of the revised system and were already adhering to it.

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 areas accessible to all staff that identified local health and safety representatives. In one primary care centre not owned by the service there was no poster, but all staff knew who their representatives were. The service had

up to date fire risk assessments and fire alarms were tested monthly. The provider carried out fire drills every six months and we saw that learning points were identified and shared after the event. 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. The service had a variety of other risk assessments in place to monitor safety of the premises such as infection control and legionella (Legionella is a term for a bacterium which can contaminate water systems in buildings).

- There were systems in place to ensure the safety of the out of hours vehicles. Extensive checks were undertaken at the beginning of each shift. These checks included administration materials, hand gel, sharps bins, clinical waste bags and oxygen. A consumable box containing a nebuliser, face masks, gloves and a defibrillator were also checked. Finally equipment related to the maintenance and safety of the vehicle was checked. This included the fuel level, fluorescent jackets, tyre gauge, jump leads, torch, maps, tablets, phones, chargers and insurance details. Interior and exterior vehicle checks were carried out and recorded. Records were kept of ministry of transport test (MOT) and servicing requirements, however all the current vehicles had been recently bought from new and were not yet due an MOT or service.
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota for all the different staff groups to help ensure enough staff were on duty. There was a core rota and each week managers reviewed and adjusted it to meet national or local demands. For example the total rota hours worked per month rose from about 2300 during the summer to about 2900 during the winter. On average the rota hours were worked as planned 99% of the time. This fulfilled the standards expected for National Quality Requirements.

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 a defibrillator on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available. The service also had access to a defibrillator and oxygen with the appropriate masks at each of the primary care centres that we inspected and in each vehicle.
- Emergency medicines were easily accessible and all staff knew of their location. All the medicines we checked were in date and stored securely.
- Stock medicines were provided in cassettes by a third party pharmaceutical company and were administered by them. They were run on a traffic light system, green being unused and red needing return for refill. When medicines were dispensed a record was kept of the use of the medicine. We looked at a large number of open cassettes; all except one had the use of medicines correctly logged. One cassette however had a disparity between the number of nebules (inhaled medicines) signed out and those remaining and also between the number of a non-medicine consumable signed out and remaining. We reported this to the service who immediately took the cassette away for investigation.
- The assessment as to when a cassette was marked red and returned for refill was the individual clinician's, there were no written guidelines as to when they should be returned to be refilled.
- 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. Each base had a site specific business continuity kit box which contained, amongst other items, evacuation procedures, a site plan and head office plan. Head office also had copies of all site plans. For example the service used some four wheel drive vehicles and in severe weather the contingency was that where necessary the vehicles would pick the GPs up from their homes and take them back after the shift.

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.

- All alerts were emailed to the service manager and governance lead and disseminated to relevant parties. Alerts were also added to monthly minuted Quality Assurance (QA) meetings and QA register and actioned as appropriate.
- The service had systems in place to keep all clinical staff up to date by emailing monthly updates to clinicians. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. They also had access to the Prescribing Advisory Database (PAD) online.
- The service monitored that these guidelines were followed as part of the audits that they carried out of the activities of all clinical staff.

Management, monitoring and improving outcomes for people

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

The National Quality Requirements (NQR) is a set of data designed to measure, in part, the timeliness of a provider's response to patient demand. The relevant requirements measure the critical areas of the timeliness of clinical assessment of the patient, whether by telephone or face to face and timeliness of face to face consultations at primary care centres or at the patients home. We looked at the NQRs in detail from October 2015 to September 2016.

- The performance of the service met the NQR standards. For example patients categorised as "urgent" should be seen within two hours. This was achieved 98% of the time whether the patient was at a primary care centre (PCC) or at home. Patients categorised as "non-urgent" should be seen within six hours. This was achieved 100% of the time when the patient was at a PCC and 96% when at home. There are three timescales for speaking to a GP on the telephone, 60 minutes, two hours and six hours. The average performance for the year was 95%, 96% and 100% respectively.
- The NHS 111 service was able to book patients directly into the Care UK system whether for telephone, PCC or home consultations. This provided a more seamless experience for patients as they were not called back by the OOH service simply to make an appointment.
- Performance was maintained through a flexible approach with skilled co-ordinators managing demand. For example at PCCs one appointment slot at the end of each hour was kept free for urgent matters. Co-ordinators could contact the GPs and ask them to use this slot for telephone consultations if demand for such consultations was rising. Similar flexibility was used in managing the PCCs. If waiting times at a particular PPC were rising staff would ring patients and offer them appointments at other PCCs which might be more distant but where the waiting time was shorter. Staff reported that most patients took advantage of and appreciated the choice.

There was evidence of quality improvement including clinical audit.

- National monthly 'core' audits were carried out on a rolling schedule. Approximately 30 audits were ongoing and completed yearly. Responsive audits were also carried out where appropriate. Where indicated improvements made were implemented and monitored.
- The service participated in local audits, national benchmarking, accreditation, peer review and research.
- All clinicians (GPs and ANPs) had one percent of their consultations audited. This included face to face and telephone consultations. If the audits results fell below set levels then enhanced audits were carried out. All clinicians received written feedback with respect to their audit results at least every three months. Outcomes were rated on a traffic light system of red amber and green and where areas for improvement were identified

then a remedial action plan would be put in place in partnership with the regional medical director. Any complaints and incidents would be included in the discussions.

Effective staffing

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

- The service had an induction programme for all newly appointed staff. 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.
- Clinical staff also underwent an induction which was completed signed off and stored in their records.
- The service could demonstrate how they ensured role-specific training and updating for relevant staff. For example, training for telephone consultations included theory and practical training. GP trainees underwent a comprehensive graded induction in both triage and consultations and were only allowed to treat patients on their own once they were experienced enough to do so. They had access to a supervisor, who had undergone deanery training, at all times. Feedback from registrars regarding induction and supervision was consistently very good.
- Advanced Nurse Practitioners (ANP) who undertook this role were signed off as competent and had received appropriate training in clinical assessment. This included shadowing and a check of all the necessary competencies and discussion with the senior ANP as to which patient groups they could and could not treat. ANPs were not left to work alone and there was always a GP on site. Additionally they could contact any doctor via the computer system or the senior ANP. The regional medical director could log in to the system from home to discuss issues if required. ANPs received regular appraisals from the nurse clinical director and had one per cent of their consultations audited. They received feedback and if necessary an action plan following audits.
- The service did not employ health care assistants.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of service development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, and clinical supervision. All staff had received an appraisal within the last 12 months and had started to receive interim appraisals every six months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. Staff had access to a training application for phones and tablets that allowed them access to online training, recorded their online training activity and informed the service management as to their training status. When a member of staff required a training update and had not initiated it themselves, their line manager was informed and would prompt the staff member to undertake the training.
- Any clinical staff that had not completed mandatory training within the required time frame were stood down until the training was completed.
- Training needs were monitored monthly by the quality assurance group and formed part of their report to senior management.
- All staff had completed customer service training within the timescales demanded by the national quality requirements.
- Staff involved in handling medicines received training appropriate to their role.

Additional NQRs that were all adhered to for the year October 2015 to September 2016 were :

- Staff sickness levels were less than 5% (12 month cumulative service figure 2.6%).
- Staff turnover rates were less than 10% (12 month cumulative service figure 0.4%).
- The percentage of clinical shifts covered by agency or locum clinicians was less than 20% (12 month cumulative service figure 9.6%).

Good

Are services effective?

(for example, treatment is effective)

- The rota fill levels minimum should be 95% of the interim bid rota (those described at the time the service bid for the contract was made). The 12 month cumulative service figure was 99%.

Coordinating patient care and information sharing

The provider sent details of all Out Of Hours consultations (including appropriate clinical information) to the practice where the patient is registered by 8am the next working day. This occurred over 99% of the time for ten months of the year and 98.9% of the time for one month. In January 2016 a short term information technology system failure following routine maintenance on one weekend led to the patient updates to the GP practices not arriving until 12am on Monday morning (four hours late). This reduced this figure to 82% for the month which reduced the annual average monthly figure to 98%. (NQR 2). In response to the Information Technology failure the service have built in changes to their monitoring of the IT system, so that similar potential incidents can be identified early and prevented in future.

The providers had systems in place to support and encourage the regular exchange of up-to-date and comprehensive information (including, where appropriate, an anticipatory care plan) between all those who may be providing care to patients with predefined needs. They regularly met with communicated with practices to encourage the exchange of information and to discuss patients that were regular users of the out of hours service. (national quality requirements three).

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 patient notes which detailed information provided by the person's GP. These were relayed to the service via fax, online and by email. This helped the out of hours staff in understanding a person's need. The service's patient experience lead had been working with the local practices to increase the number of special patient notes that the service had access to. The local hospice faxed a list of patients receiving end of life care weekly.
- 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, for example the NH 111 service was able to book patients directly into the Care UK system whether for telephone, PCC or home consultations.
- 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 were working with one clinical commissioning group (CCG) and the local mental health trust to base a crisis team at the call centre, so that a call regarding a patient with mental health concerns could receive direct advice.
- The provider also provided GP sessional services to local sheltered housing for mental health patients, a local specialist children's service, and local community hospitals.
- The provider also met with GP surgeries to discuss patients that were frequent attenders at Out of Hours (OOH) services and with the local deanery to discuss GP trainee training. The regional medical director also attended CCG local prescribing and medicine project meetings.

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

Care UK carried out a rolling survey of patients' experience. During the period October 2015 to September 2016 1179 patients had responded to surveys and 95% had had expressed overall satisfaction with the service they had received. The trend in satisfaction was generally upward from about 90% at the end of 2015 to about 98% by September 2016.

The national GP patient survey asks patients about their satisfaction with the Out-of-Hours service. There were three surveys, one for each of the three clinical commissioning groups that the OOH service covered and we have aggregated the results. The total number of surveys was 14148 of which 5049 were returned (44%).Patients were asked "how would you describe your last experience of NHS services when you wanted to see a GP but your GP surgery was closed" and 72% thought the service was either good or fairly good. The lowest response was 67% which is the same as the national average but the highest was 79% which is equal to the highest response in England.

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 the 11 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the provider offered an excellent service and described staff as brilliant, helpful, pleasant and caring.

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

Care planning and involvement in decisions about care and treatment

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

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. A clinician's handbook was available in each room with clear instructions on how to obtain an interpreter.
- A communication book for patients containing pictorial representations of pain levels, parts of the body and ailments was available for staff to use to help explain things to patients including children, those who may not have English as their first language or who had learning difficulties.
- Information leaflets were available in easy read format.
- There were facilities for people with hearing impairment including a hearing aid loop.

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 was taking part in a pilot in conjunction with a local accident and emergency department (A&E) whereby patients were triaged in A&E and if appropriate referred to the out of hours team for treatment of conditions suitable for management by primary care clinicians.

- Home visits were available for patients whose clinical needs resulted in difficulty attending the service.
- There were accessible facilities, a hearing loop and translation services available. Staff had fast access to a telephone interpreter service whereby a teleconference could be set up to include the patient, interpreter and clinician.
- The provider supported other services at times of increased pressure. For example the provider provided out of hours cover for five local prisons, a dental help line, mental health sheltered housing and carried out ward rounds at a local children's specialist hospital.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.

Several innovations had been introduced by the service:

- A test for deep vein thrombosis (a clot in the veins in the leg) was available on site, to allow early of treatment and prevent an urgent hospital referral. The clinician could also initiate a follow up ultrasound test to confirm the diagnosis.
- A clinical navigator role had been initiated for weekends. This was a lead clinician who had oversight of the whole service and could make decisions regarding the re-direction of resources if necessary to cope with demand.
- New audit templates had been introduced which included additional criteria (in particular extra social factors) in the consultation audit.
- Urgent care practitioners (paramedic practitioners) had been added to the work force and were due to start shortly.

Access to the service

The service was open between 6.30pm and 8am Monday to Friday, and during weekends and bank holidays. The service also provided cover when GP practices were closed for example during training afternoons.

Patients could access the service via NHS 111. The service saw 'walk in' patients and saw, on average, 99% of them within one hour. There were arrangements for health care professionals to bypass the 111 service and contact the out of hours service directly.

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.
- The patient experience lead co-ordinated the handling of all complaints in the service.
- We saw that information was available to help patients understand the complaints system For example posters were displayed in primary care centres and the patient information leaflets also contained the relevant information.

We looked at the 25 complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way with openness and transparency. All complaints were logged on the system including verbal complaints that were resolved at the time. Patients received a letter of acknowledgement within three days and the service aimed to resolve the complaint within 20

Good

Are services responsive to people's needs?

(for example, to feedback?)

days. If there was to be a delay, the complainant was sent a letter with an explanation. All complaints were discussed at monthly quality assurance meetings. Current complaints were reviewed and closed ones were discussed to look for learning points and assess action that was taken to improve the quality of care. Every three months the figures were sent to the governance lead and details of the complaint including the clinician involved were logged. There were annual quality assurance reviews to analyse trends and ensure service improvement. For example a complaint about a prescription was reviewed by the clinical lead and passed to the consulting clinician who responded in writing and acknowledged the error. An apology was offered and letter containing an outline of the appeal process was sent.

The clinicians involved were sent copies of the response and a summary discussed in the quarterly clinical newsletter.

Non clinical complaints would be discussed with the staff member face to face or by telephone.

Learning points were communicated to all staff via email, staff council meetings and via a change in policy as appropriate.

We saw that the complaints procedure was consistent with the principles of the NHS complaints procedure. Anonymised details of each complaint and the manner in which it has been dealt with, was reported to the contracting clinical commissioning group. We saw that all complaints were audited in relation to individual staff so that, where necessary, appropriate action was taken. This was in line with the national quality requirements (NQR6).

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 organisation had a clear vision to, amongst other aspects, differentiate themselves by the quality of their services, ensuring that they were innovative and customer focused.

The service had a mission statement and staff knew and understood the values and aims.

The service carried out an annual staff survey which included questions on how their values drove their behaviours. The results of the 2016 survey showed significant improvements in how staff viewed the service and their role within it since 2015. For example when faced with the statement 'where I work, we go the extra mile to provide quality care to our patients and customers' in 2015 59% of staff agreed, in 2016 this figure was 93%.

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. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Service specific policies were implemented and were available to all staff. Hard copies of local operating procedures had recently been updated and head office informed, but the online versions were awaiting the latest update from head office.
- The provider had a good understanding of their performance against National Quality Requirements (NQRs). These were constantly monitored,discussed at monthly local quality assurance (QA) meetings and then at senior management and board level. Performance data is considered monthly by the regional management team and a report prepared for the board. This included any NQRs that were not meeting the upper requirement level. The report included the reasons that the targets were not met and an action plan to resolve the issue. Local and national performance was shared with staff and the local clinical commissioning group as part of contract monitoring arrangements. Innovations and learning were fed back to staff via emails, newsletters and face to face discussion.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. There was a clear ethos of analysis, change, improvement and learning throughout the organisation.
- There were sound arrangements for identifying, recording and managing risks, issues and implementing mitigating actions via the monthly QA meetings. Where necessary, more immediate processes could be implemented and immediate action taken. We saw an incidence where a perceived risk was escalated to senior management for potential action at very short notice although ultimately action was not required.

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. Staff told us the management were approachable and always took the time to listen to all members of staff.

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 management 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.

Are services well-led?

Good

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

- There were arrangements in place to ensure the staff were kept informed and up-to-date. This included visits to staff at primary care centres by supervisory and senior staff, 'open door' sessions with the service manager on a regular basis. Newsletters and email communication. For example, on the first day we saw that in one primary care centre (pcc) there had been a misinterpretation of a local operating policy (LOP) relating to temperature recording in a room (not a fridge) where medicines were stored at room temperature had not been interpreted by staff as intended. This was pointed out and the policy clarified. When we inspected another primary care centre the next day, staff we spoke with were aware of the revised system and were already adhering to it.
- 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.
- When the service was operating there was always a supervisor, senior manager, director and medical director available on call

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

The service encouraged and valued feedback from patients, the public and staff. It proactively sought patients' and staff feedback and engaged patients in the delivery of the service. For example in the primary care centres there was a poster in the waiting area that encouraged patients to comment on the services provided.

- The service had gathered feedback from patients through surveys and complaints received. For example, out of 1186 patients that filled in a friends and family test form between 1 October 2015 and 30 September 2016 94% would recommend the service to their friends and family. Patients were encouraged to fill in a survey form or contact the service via their website. The patient information sheet also contained the contact details for the patient experience lead so that complaints, concerns or compliments could be relayed directly to them.
- The service had gathered feedback from staff through: suggestion boxes, through 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 as a result of staff feedback the head office had introduced a vegan only microwave in to its dining area. The provider had also responded to feedback from staff about the difficulties they had operating the tablets they used in cars by replacing them with a different make. At the request of staff the service manager ran a 'drop in' clinic every six weeks where staff could turn up and talk to them. Service managers visited staff at the pccs every six weeks. Staff told us they felt involved and engaged to improve how the service was run.
- The regional medical director did a clinical session at weekends so that they could meet staff and keep in touch with the issues that clinicians and other staff were facing.

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 provided training for GP registrars and were planning to introduce paramedic practitioners in to the workforce.