

Wokingham Community Hospital- Westcall Out of Hours

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Wokingham Community Hospital. This is the registered location of Westcall Out of hours on 9 and 10 December 2015. 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 reporting and recording significant events.
- Risks to patients were assessed and well managed. However, some systems to address these risks were not implemented well enough to ensure patients were kept safe. For example, infection control risks and prescription security.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The service had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by the management and Berkshire Healthcare NHS Foundation Trust leaders. 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.

We saw two areas of outstanding practice:

- The service had introduced two near patient testing kits for diagnosing deep vein thrombosis (a blood clot in one of the deep veins of the body) and sepsis (where the body's immune system triggers a series of reactions including widespread inflammation, swelling and blood clotting). Both kits provided

Summary of findings

clinicians with the tools to make an early diagnosis and provide early intervention to prevent the worsening of the condition or even death. The use of these kits had prevented unnecessary hospital admissions and provided better outcomes for patients.

- 17,000 patients had advanced care plans, which contained care and treatment information about the individual patient. The development, usage and completion of these care plans was driven by Westcall leaders and clinicians. The initial care plans were entered by individual surgeries and hosted on the Adastra system. This included medicines, end of life care, palliative care needs, allergies etc. With the individuals consent these records could be accessed and updated by Westcall clinicians and staff, emergency department staff in Berkshire, district nurses, palliative care nurses and other health professionals, so up to date care and treatment could be provided 24 hours per day.

The area where the provider must make improvement is:

- Printed prescription pads were securely stored, but there was no system in place to record the use of prescriptions to minimise misappropriation or misuse. The security of blank prescription forms required improvement as there was no system in place to monitor the use and movement of these.

The areas where the provider should make improvements are:

- Introduce a system of recording the cold chain for when medicines requiring refrigeration are transported between sites.
- Ensure all nursing staff have received chaperone training and the chaperone service is clearly advertised to patients in both primary care centres.
- Appoint a lead nurse to ensure appropriate support for nurses and, where appropriate, ensure appraisals are undertaken.
- Review the provision and utilisation of nursing staff to allow greater responsibility and support for the care and treatment of patients, reducing the impact on GPs.
- Review the infection control procedures to ensure a robust audit is undertaken, regular checks are implemented and actions taken.
- Improve patient communications about the service and how the appointment system works at the Reading primary care centre.

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?

The service is rated as requires improvement for providing safe services.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the service.
- When there are unintended or unexpected safety incidents, patients receive reasonable support, truthful information, a verbal and written apology and are told about any actions to improve processes to prevent the same thing happening again.
- The service had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Medicines were handled safely.

Risks to patients were assessed and well managed. However, some systems to address these risks were not implemented well enough to ensure patients were kept safe. For example, infection control risks and blank prescription security.

Requires improvement



Are services effective?

The service is rated as good for providing effective services.

- Data showed patient outcomes met National Quality Requirements. Benchmarking showed how Westcall was performing at a higher level than other out of hours providers nationally.
- 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.
- Review the provision and utilisation of nursing staff to allow greater responsibility and support for the care and treatment of patients, reducing the impact on GPs.
- There was evidence of appraisals and personal development plans for most staff. Some bank nursing staff had not had an appraisal or appropriate support in the preceding 12 months.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patient needs.

Good



Are services caring?

The service is rated as good for providing caring services.

Good



Summary of findings

- Data showed that patients rated the service highly for several aspects of care.
- 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. Although, this could be improved at the primary care centres.
- We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

The service is rated as good for providing responsive services.

Good



- It reviewed the needs of its local population and engaged with Berkshire Healthcare NHS Trust and the Clinical Commissioning Group to secure improvements to services where these were identified.
- Patients said they found it easy to get through to the OOH service and that there was continuity of care, with urgent appointments available the same day at the primary care centres.
- The primary care centres and mobile vehicles had good facilities and were well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed that the service responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

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

Good



- It 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 this.
- There was a clear leadership structure and staff felt supported by management and Berkshire Healthcare NHS Foundation Trust leaders. The service had a number of policies and procedures to govern activity and held regular governance meetings. However, nursing staff had been without a nurse lead for over 12 months. 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.

Summary of findings

- The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents
- 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.
- The provider had commissioned an independent review of Westcall out of hours in March 2015. Recommendations were made in relation to improvements of the following areas: clinical performance, access, service provision, leadership and management. An action plan had been developed and recommendations had been or were in the process of being implemented, demonstrating continuous improvement.

Summary of findings

What people who use the service say

A Westcall Out of hours (OOH) patient experience survey was completed between 1st July and 30th September 2015. The results showed the service was performing well. From 18581 calls 164 survey forms were returned. (0.88%).

- 96% of patients confirmed their call was returned without unreasonable delay.
- 95% expressed how well the GP established the patient's condition and symptoms.
- 95.9% felt the GPs advice was clear.
- 92% felt the GPs advice was useful.
- 83.3% of patients seen at home were satisfied with the length of time the GP took to arrive.
- 88% were satisfied with the way the GP talked to them and established their concerns.
- 92% were satisfied with how the GP explained their findings and treatment.
- 96.1% of patients seen at a primary care centre found it reasonable to be seen there.

- 97.1% of patients felt the nurses were courteous and helpful.
- 83.5% of patients were seen promptly at the centre.
- 99% of patients felt they were treated with respect and dignity.
- 96.5% of patients would recommend the service to friends and family.
- Overall, 96.9% of patients rated the care they received as satisfactory or higher. (62% rated care as excellent, 25.2% as good and 9.8% as satisfactory).
- 3.1% (5 patients) of patients rated the care as poor.

Westcall OOH also took part in the Friends and Family Test (FFT). Year to date totals showed 840 FFT cards returned with 88.7% of patients being likely or extremely likely to recommend the OOH service. Only 4.3% of patients stated they would be unlikely or extremely unlikely to recommend the service. Nineteen carers also completed the FFT forms and 89.5% were likely or extremely likely to recommend the service.

Areas for improvement

Action the service **MUST** take to improve

- Printed prescription pads were securely stored, but there was no system in place to record the use of prescriptions to minimise misappropriation or misuse. The security of blank prescription forms required improvement as there was no system in place to monitor the use and movement of these.

Action the service **SHOULD** take to improve

- Introduce a system of recording the cold chain for when medicines requiring refrigeration are transported between sites.
- Ensure all nursing staff have received chaperone training and the chaperone service is clearly advertised to patients in both primary care centres.

- Appoint a lead nurse to ensure appropriate support for nurses and, where appropriate, ensure appraisals are undertaken.
- Review the provision and utilisation of nursing staff to allow greater responsibility and support for the care and treatment of patients, reducing the impact on GPs.
- Review the infection control procedures to ensure a robust audit is undertaken, regular checks are implemented and actions taken.
- Ensure all staff received Mental Capacity Act training appropriate to their role.
- Improve patient communications about the service and how the appointment system works at the Reading primary care centre.

Summary of findings

Outstanding practice

- The service had introduced two near patient testing kits for diagnosing deep vein thrombosis (a blood clot in one of the deep veins of the body) and sepsis (where the body's immune system triggers a series of reactions including widespread inflammation, swelling and blood clotting). Both kits provided clinicians with the tools to make an early diagnosis and provide early intervention to prevent the worsening of the condition or even death. The use of these kits had prevented unnecessary hospital admissions and provided better outcomes for patients.
- 17,000 patients had advanced care plans, which contained care and treatment information about the

individual patient. The development, usage and completion of these care plans was driven by Westcall leaders and clinicians. The initial care plans were entered by individual surgeries and hosted on the Adastra system. This included medicines, end of life care, palliative care needs, allergies etc. With the individuals consent these records could be accessed and updated by Westcall clinicians and staff, emergency department staff in Berkshire, district nurses, palliative care nurses and other health professionals, so up to date care and treatment could be provided 24 hours per day.

Wokingham Community Hospital- Westcall Out of Hours

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist out of hours advisor and practice nurse out of hours specialist advisor. We were also joined by a practice manager specialist advisor.

Background to Wokingham Community Hospital- Westcall Out of Hours

Wokingham Community Hospital is the registered location and address for Westcall Out of hours. The service provides out of hours primary medical services to 550,000 registered patients and those requiring immediately necessary treatment across the Berkshire West area when GP practices are closed. The areas covered include the towns and surrounding villages of Wargrave, Wokingham, Reading, Newbury and Hungerford. The west of Berkshire has large areas of rurality.

In 1996, the out of hours (OOH) service was started by a group of local GPs from the Reading and Wokingham area.

It was initially called REDDOC. In 2004, the REDDOC and Newdocs OOH services merged to form Westcall out of hours and in 2011 the service was transferred to Berkshire Healthcare NHS Foundation Trust community services.

The out of hours service is provided across two primary care centre locations. In Reading at the Royal Berkshire Hospital and in Thatcham at the West Berkshire Community Hospital. The administrative base for Westcall Out of Hours is located at The Forge in Wokingham, Berkshire. 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 primary care centre locations as a walk-in patient at the West Berkshire Community Service or be referred from the hospital accident and emergency at the Royal Berkshire Community Hospital.

The service provides out of hours care between 6:30pm and 8am Monday to Friday, from 6.30pm Friday to 8am Monday and on bank holidays. The service also provides primary medical services for patients when their registered GP practice is closed for staff training. GPs provide phone assessments and may offer advice to patients about care and treatment. Home visits are provided when patients are too unwell to attend the primary care centres. Appointments are available at the two primary care centres between 6.30pm and 12.30am weekdays and from 8am to midnight on Saturday, Sundays and bank holidays.

Detailed findings

The OOH services are provided by mobile teams in appropriately equipped vehicles and from the primary care centre addresses. We reviewed one of the mobile vehicles and visited the call centre and two primary care centre locations during this inspection.

Westcall OOH Call Centre, The Old Forge, 45 – 47 Peach Street, Wokingham, Berkshire, RG40 1XJ.

Primary Care Centre, Ground floor of the maternity block, Royal Berkshire Hospital, Craven Road, Reading, Berkshire, RG1 5AN.

Primary Care Centre, Minor Injuries Unit, West Berkshire Community Hospital, London Road, Benham Hill, Thatcham, Berkshire, RG18 3AS.

The primary care centres were situated in rented spaces from the Royal Berkshire Hospital and the West Berkshire Community Hospital and the services and facilities were managed by the respective organisations.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This was part of a wider Berkshire Healthcare NHS Foundation Trust inspection.

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

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the service and asked local clinical commissioning groups, GP practices, nursing and care homes and the local ambulance service to share what they knew.

We contacted 60 local GP practices, 12 nursing and care homes, local Healthwatches and the local ambulance NHS trust about their interaction with the service. Twenty GP practices and care homes provided responses and they were highly complementary of the service. As was the local Ambulance NHS trust. Healthwatch provided us with information they had received from patients who had not always had a positive experience with the service and we followed these concerns up during the inspection.

We carried out an announced visit on 9 and 10 December 2015. During our visit we:

- Spoke with eight GPs, three nurses, two care assistants, call handlers, administrators, Westcall managers, the medical director, senior trust leaders and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Checked the mobile vehicles for transporting the GPs and equipment on home visits.

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 patients' needs?
- Is it well-led?

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 manager of any incidents and there was also a recording form available on the trust significant event reporting system.
- The service carried out a thorough analysis of all significant events.

We reviewed safety records, incident reports national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the service. For example, the care and treatment of patients with serious infections was reviewed following a significant event. The service developed a specialist care and treatment kit which allowed clinicians to make an early diagnosis of Sepsis (where the body's immune system triggers a series of reactions including widespread inflammation, swelling and blood clotting) and provide immediate intervention to prevent the patient becoming more acutely unwell and in some cases preventing death.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

Overview of safety systems and processes

The service had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The service received information from local authority safeguarding teams regarding patients at risk. Where appropriate this information was added to patient records to ensure all staff were aware of those at risk. Staff demonstrated they understood

their responsibilities and all had received training relevant to their role. GPs were trained in child safeguarding up to level three. All staff had received adult safeguarding training appropriate to their role.

- Chaperone services were offered to patients. However, we did not see notices in the waiting rooms of the primary care centres to advise patients that nurses would act as chaperones. However, staff informed us that all patients requiring an intimate examination would, as a matter of course, be offered a chaperone. A chaperone policy was available and staff knew how to locate this. Mobile GPs who saw patients in their own homes also had access to the chaperone policy and consent forms for intimate examinations. Most staff, including the drivers, who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of patients barred from working in roles where they may have contact with children or adults who may be vulnerable). Some of the nursing staff we spoke with reported that they had not received chaperone training.
- The service maintained appropriate standards of cleanliness and hygiene. We observed the premises to be generally clean and tidy. The infection control lead within Berkshire Healthcare NHS Foundation Trust linked with the WestCall Manager who in turn liaised with the local prevention teams to ensure that best practice was followed. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- However, on inspection at the primary care centres, there were issues that the infection control audit had not identified. For example, at the primary care centre located at the Royal Berkshire Hospital in Reading we noted that the treatment room where samples were being tested required improvements in infection control. The mobile screen was visibly dirty and dusty. We also noted that the impermeable material on one chair and the treatment couch was perished in places.
- At the West Berkshire Community Hospital primary care centre the OOH area was shared with a minor injuries unit. We noted the dirty utility room was not locked which contained clinical waste and cleaning substances

Are services safe?

which should have been stored securely. In the cleaning storage area, we noted the cleaning materials and trolley to be particularly damp and dirty. Both of which could increase the risk and spread of infection.

- On speaking to staff, we were advised that the issues and concerns with cleanliness or maintenance of the premises would be reported to the building facilities management team.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the service kept patients safe (including obtaining, prescribing, recording, handling, storing and security). When medicines requiring refrigeration were transferred between sites there was no record of the cold chain. The service carried out regular medicines audits, with the support of the local pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Printed prescription pads were securely stored, but there was no system in place to record the use of prescriptions to minimise misappropriation or misuse. The security of blank prescription forms required improvement as there was no system in place to monitor the use and movement of these. There was a robust system in place for the handling of controlled drugs. All medicines were administered in accordance with a prescriber's instructions.
- We reviewed 20 personnel files and found that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

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. The service had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment

was checked to ensure it was working properly. The landlord of the call centre and primary care centres service had a variety of other risk assessments in place to monitor safety of the premises and building. Westcall managers reviewed these assessments to assure themselves of building safety. Other risk assessments such as control of substances hazardous to health and infection control and legionella were undertaken by the service.

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. We reviewed the rotas for December 2015 and found there were enough staff to cover the call centres, primary care centres and GP cover requirements. Where there were gaps GPs were offered an enhanced pay rate to cover the shifts. Home based GPs were also able to securely log on to the Adastra system and triage calls when the demand increased.

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 instant messaging system on the computer system which alerted staff to any emergency, urgent cases or issues.
- All staff received regular basic life support training and there were emergency medicines available in the mobile vehicles and primary care centres.
- The service had a defibrillator available at each primary care centre and on each vehicle, with oxygen and adult and children's masks. There was also a first aid kit and accident book available.
- Emergency medicines were easily accessible to staff and all staff knew of their location. All the medicines we checked were in date and fit for use.
- The service had a comprehensive business continuity plan in place for major incidents such as power failure, bad weather or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The service assessed needs and delivered care in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The service had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met needs.
- Senior leaders monitored the guidelines were followed through risk assessments, audits and random sample checks of patient records and through the clinical guardian system.
- 17,000 patients had care plans hosted on the Westcall Adastra system. These advanced care plans contained care and treatment information about the patient. This included medications, end of life care, palliative care needs, allergies etc. GP practices entered the information onto the Adastra system and with the individuals consent these records could be accessed and updated by other health professionals so up to date care and treatment could be provided 24 hours a day. These care plans were specifically helping palliative care patients to stay at home and also to die in the place of choice. Between July and September 2015, 260 patients died at home and 339 patients received palliative care at home as outlined on their care plan. We reviewed the data for these two areas over the previous two years and noted an increasing use of the care plans meant an increased number of palliative care patients receiving care and dying at home, reducing the need for unnecessary hospital admissions.

The Westcall out of hours (OOH) offered walk-in appointments at the primary care centre based at West Berkshire Community Hospital. Main access to the service was via the national NHS111 service. In Berkshire, this service is provided by South Central Ambulance Service (SCAS) from their base in Bicester, Oxfordshire.

- Following a telephone triage (clinical assessment) completed by NHS 111 patients may be referred to the Westcall OOH GP service.

- Referred patients received a telephone call from one of the Out of hours GPs who undertook a further assessment of their needs. From the outcome of this assessment, the GP would make a decision for the patient to receive telephone advice with no onward referral, attend an appointment at one of the primary care centres, visited at their place of residence or a referral to an alternative provider (e.g. the emergency services or Emergency Department). Decisions made depended on the patients' needs.

In October 2015, the Westcall service dealt with 6,415 cases. We were shown information that 32 cases (0.49%) were considered a life threatening condition. 544 cases were sent to an emergency department or admitted including 999. 907 cases (14.13%) had a home visit by one of the services GPs, 2899 cases (45.9%) had an appointment at a primary care centre and 2464 cases (38.40%) received telephone advice including a clear set of worsening instructions (a set of instructions should their condition worsen/deteriorate). The low level of referrals to emergency department and emergency services by the out of hours service reduced pressures across the urgent and emergency care system in Berkshire. The service confirmed that patients were managed appropriately by clinical audit and sampling of patient records.

The Department of Health has set standards, known as National Quality Requirements (NQRs) for all out of hours GP services to meet.

Data we received prior to the inspection indicated that the provider was meeting the NQRs.

Specifically:

- In October 2015, 97% of urgent cases had a face-to-face consultation within 120 minutes and 99% of less urgent cases had a face-to-face consultation within 360 minutes.
- 83% of cases requiring a one hour triage received this in less than 60 minutes. 98% of calls that required a triage within two hours were triaged within 120 Minutes

Management, monitoring and improving outcomes for people

Clinical audits demonstrated quality improvement.

Are services effective?

(for example, treatment is effective)

- We reviewed five clinical audits completed in the last two years; two of these were completed audits where the improvements made were implemented and monitored.
- The service participated in applicable local audits, national benchmarking, accreditation, peer review.
- An external review had been commissioned in March 2015 which outlined improvements to the services which would improve outcomes for patients.
- Findings were used by the service to improve services and effectiveness of care and treatment. For example, the service audited their antibiotic prescribing and actions were taken to reduce their usage by 10%. In December 2015, the average prescribing rate was 8.3%.

We found evidence of clinical audits being undertaken in order to demonstrate improvements to the service and so ensure the best outcomes for patients.

- One of the NQRs for all Out of hours GP services to meet is the requirement of regular audit of a random sample of patient contacts. The audit process must be led by a clinician, appropriate action must be taken on the results of those audits and regular reports of these audits should be made available to the Clinical Commissioning Groups (CCGs).
- The service implemented a clinical guardian system where staged reviews are undertaken for each clinician. A traffic light system identifies the quality of each clinician's work and the level of quality reviews are determined by this. For example, those clinicians with a green rating will have 5% of their call records reviewed. Those with amber rating (those identified with areas of concern) will have 100% of their call records reviewed.

These audits were undertaken by the medical director and/or staff peers using the clinical guardian system and feedback was provided to clinicians via email or during meetings. In October 2015, 508 cases were reviewed. 46(8.43%) from 58 clinicians were reviewed in the month. The audit outcomes showed 43 cases were considered to be Excellent, 452 to be satisfactory, 12 required reflection and one case was considered of concern. The results were shared with the GPs and additional training and support was offered where required.

Effective staffing

Westcall employed mostly bank and self-employed staff. This included the majority of GPs, most of the nursing staff and some call handling staff. There were 15 salaried GPs, a number of drivers and call handlers, administration and management team who were permanently employed.

Staff had the skills, knowledge and experience to deliver effective care and treatment. The learning and development of staff was managed and provided by Berkshire Healthcare Foundation Trust. Local training was also provided by the medical director and managers.

- The service had an induction programme for newly appointed members of staff that covered topics such as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. All the members of staff we spoke with had received an induction, period of shadowing and assessment before they were able to work unsupervised.
- The service could demonstrate how they ensured role-specific training and updating for relevant staff e.g. safeguarding, basic life support, information governance and fire safety. Staff had access to and made use of e-learning training modules and in-house training. Where we identified gaps in training records the service was able to describe why staff had not received the training.
- The learning needs of permanent staff were identified through a system of appraisals, meetings and reviews of service development needs. GPs and non-clinical staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All permanent staff had received an appraisal within the last 12 months or had been revalidated within the appropriate timescales.
- Bank staff received training and appraisal at their first place of work and the Berkshire Healthcare Foundation NHS Trust (BHFT) learning and development team collated this information. Where the training did not meet the required levels all staff were booked on the equivalent BHFT training. Appraisals were offered to bank staff who had not received an appraisal from their main employer.
- Three of the nursing staff we spoke with had not received an appraisal or adequate support in the

Are services effective?

(for example, treatment is effective)

preceding 12 months. One had not received an appraisal as BHFT was their only employer. They also explained that they felt underutilised and would like to take on additional responsibility in the care and treatment of patients.

Coordinating patient care and information sharing

Westcall uses an electronic patient record system called Adastra. Information provided from GP practices was entered onto the system and these records could be accessed and updated by Westcall clinicians and staff, emergency department staff in Berkshire, district nurses, palliative care nurses and other health professionals about patients, with the consent of the individual concerned. The system was also used to document, record and manage care patients received.

- Information relating to patient consultations carried out during the out of hours period was transferred electronically to a patient's GP by 8am the next day in line with National Quality Requirements (NQR). Any failed transfers of information were the responsibility of the duty manager to follow up to ensure GPs received information about their patients.
- NQR data showed the service was meeting this requirement in the previous 12 months. For example, in October 2015, 95% of patient records (5702) with details of consultations were sent before 8am. All reports were sent before surgeries opened the next day.
- The service worked closely with the local ambulance staff, emergency departments, palliative care nurse and community teams to provide joined up care. For

example, all staff across these teams had access to the care plans of patients on the Adastra system. Westcall facilitated the coordinated care of patients in the community, which meant they could also receive care and treatment outside of normal GP practice hours.

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. All staff who required MCA training for their role had received this and there was an understanding of the Mental Capacity Act 2005. Staff also described how they seek consent in an emergency situation in line with the services consent policy. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. For example, a clear understanding of the Gillick competency test. (These were used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).
- Where a patient's mental capacity to consent to care or treatment was unclear the GPs assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

Where clinicians were required to give intimate examinations (particularly for patients in their own homes) specific consent forms were completed and chaperones were offered to patients.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that 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 and that conversations taking place in these rooms could not be overheard.
- Staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- However, we noted patient initial observations were sometimes completed on young patients and children in the waiting rooms. Staff told us that initial observations on young patients and children were sometimes completed in waiting rooms, with their parents consent, in order to limit disruption to them prior to their consultation with a GP, and as part of the care system to reduce the risk of a more unwell child not being seen promptly. On the day of inspection we spent time in the waiting room of both primary care centres. We noted from the majority of observations seen that consent was not requested from the parent before these were taken.

All of the 64 patient CQC comment cards we received were positive about the service experienced. Patients said they felt the service offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

Results from Westcall out of hours (OOH) patient experience survey was taken between 1st July and 30th September 2015. The results showed Westcall was performing well and patients were satisfied with the service.

- 97.1% of patients felt the nurses were courteous and helpful.
- 99% of patients felt they were treated with respect and dignity.

- 96.5% of patients would recommend the service to friends and family.
- Overall, 96.9% of patients rated the care they received as satisfactory or higher. (62% rated care as excellent, 25.2% as good and 9.8% as satisfactory).
- 3.1% (5 patients) of patients rated the care as poor.

Westcall OOH also took part in the Friends and Family Test (FFT). Year to date totals showed 840 FFT cards returned with 88.7% of patient being likely or extremely likely to recommend the OOH service. Only 4.3% of patients stating they would be unlikely or extremely unlikely to recommend the service. Nineteen carers also completed the FFT forms and 89.5% were likely or extremely likely to recommend the service.

Care planning and involvement in decisions about care and treatment

Patients told us that they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the Westcall out of hours (OOH) patient experience survey showed:

- 95% expressed how well the GP established the patient's condition and symptoms.
- 95.9% felt the GPs advice was clear.
- 92% felt the GPs advice was useful.
- 88% were satisfied with the way the GP talked to them and listened to their concerns.
- 92% were satisfied with how the GP explained their findings and treatment.

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.

Patient and carer support to cope emotionally with care and treatment

Are services caring?

Notices and a TV screen in the patient waiting room of West Berkshire Community Hospital told patients how to access a number of support groups and organisations.

Patients that we spoke with and comments on cards indicated that patients were satisfied with their involvement in decisions about their care and treatment. Clinicians were alerted to special patient notes (on the

Adastras system) from the patients usual GP if these were available. Special notes are a way in which the patient's usual GP can raise awareness about their patients who might need to access the out of hours service, such as those nearing end of life and their wishes in relation to care and treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- The service saw walk in patients at West Berkshire Community Hospital (WBCH), who had not called the NHS 111 service first.
- Longer appointments were available for patients at the primary care centres.
- There were disabled facilities and a hearing loop at the primary care centres. A translation service was available at the primary care centres and to the mobile teams.
- Palliative care or end of life patients were able to contact the Westcall OOH service directly if they had a health concern out of hours.
- Patients at local community or mental health hospitals were also supported by Westcall clinicians during out of hours periods.

Access to the service

The service operated from 6.30pm to 8.00am Monday to Thursday and from 6.30pm until 8am Friday to Monday inclusive. The service also operated on all bank holidays.

Access to the service was via patients calling NHS 111. Those patients who required out of hours support were forwarded onto the Westcall OOH service. Patients were visited at home, offered telephone advice, referred to the emergency service or offered an appointment at one of two primary care centres. Royal Berkshire Hospital emergency department patients who required primary care services were referred to the primary care centre based there. Patients living in West Berkshire were offered appointments at the centre situated within the WBCH. This centre also accepted patients who walked in or were attending the neighbouring minor injuries unit and required primary care treatment.

Patients we spoke with were satisfied with the appointments system and said it was easy to use despite several telephone discussions taking place before any appointment was given. Patients told us they would speak with NHS111 and then later receive a call from a GP from the out of hour's service to arrange a visit, for telephone advice or to arrange an appointment.

We noted that patients were prioritised appropriately at the primary care centres whether they arrived for an

appointment, were referred from an emergency department or walked in themselves. Patients who were triaged as less urgent cases were offered the next available appointment after patients with more urgent needs were seen first. However, we noted that patients were not always advised of how the system worked and during the inspection some of these patients became frustrated at the wait times. The centre at WBCH had a notice which explained the waiting area was shared with the minor injuries unit and patients were called in order of priority and their medical concern. We did not see the same information displayed at the centre based within the Royal Berkshire Hospital.

Listening and learning from concerns and complaints

The service had an effective system in place for handling complaints and concerns.

- We found the service had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England and the NQR standard.
- There was a designated responsible person who handled all complaints in the service.
- We looked at all 17 complaints received in the last 12 months and found they were all handled appropriately and in line with the service complaints procedure. We noted that the responses were offered an apology, were empathetic to the patients and explanations clear. Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care.
- The service reviewed each complaint and could identify any patterns and shared the learning with the full team. Staff we spoke with confirmed this.
- We saw minutes of these meetings which demonstrated a discussion of the complaints, identified the relevant learning points and action taken to as a result to improve the quality of care.
- We saw that information was available to help patients understand the complaints system. A summary leaflet was available in the primary care centres and all staff were aware of the complaints process and how to explain this to patients.

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 senior Berkshire Healthcare NHS Foundation Trust (BHFT) team recognised the value and high performance of the Westcall OOH. The BHFT area lead had worked with the medical director to commission an external review of the OOH service in March 2015.

This review identified several areas where the service could improve or consider reviewing for the future success, including succession planning and staff retention. The trust and OOH service were working together to appoint a deputy medical director and had also recently agreed a change in the pay structure for GPs to secure a longer term workforce. Further changes were being implemented or had been made to improve the service for patients and become more efficient.

The service had a clear vision to deliver high quality care and promote good outcomes for patients and all staff were clear about demonstrating this through their work. The service had a robust strategy and supporting business plans which reflected the vision and were regularly monitored.

Governance arrangements

The service had an overarching governance framework which 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 on the trust's intranet system.
- A comprehensive understanding of the performance of the service. The performance manager closely reviewed the data and performance of the organisation and actions were taken to address concerns when they arose.
- A programme of continuous clinical and internal audit which is used to monitor quality and to make improvements. For example, the appropriateness of antibiotic prescribing audit and the subsequent antibiotic prescribing reduction plan.

- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, risks relating to infection control and prescription security required improvement.

Leadership, openness and transparency

There was a clear leadership structure in place and staff felt supported by the management team and trust leaders.

- Staff told us that they attended regular team meetings. Senior managers attended regular performance and governance meetings within the service and with the trust leadership team.
- Staff told us that there was an open culture within the service and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. We also noted that team away days were held.
- The majority of staff said they felt respected, valued and supported, particularly by the management team. All staff were involved in discussions about how to run and develop the service, and the managers encouraged all members of staff to identify opportunities to improve the service delivered. However, three of the nursing staff we spoke with did not always feel supported.

The Westcall senior management and BHFT management team ensured the service provided high quality and accessible care in the out of hours environment across Berkshire. They prioritised safe, high quality care and were visible within the service. Staff told us morale was high and staff felt supported. They spoke respectfully and highly of their immediate line managers and of the senior management team.

Some of the nursing staff we spoke with felt their skills were often underutilised. We noted on inspection that the service had not had a nurse lead for around 12 months, despite a rigorous recruitment campaign. We noted that nursing staff did not take leadership roles with this the primary care centres. There was however an Advance Nurse Practitioner who worked alternate weekend, who could relieve the pressure on GPs and support them with patient care and treatment.

The BHFT human resources team was responsible for human resource policies and procedures. We reviewed a number of policies, for example, the recruitment and

Are services well-led?

Good 

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

qualification checking procedure. We were shown the staff handbook which was available to all staff. This included sections on equality, health and safety and pensions. Staff we spoke with knew where to find these policies if required.

The service was aware of and complied with the requirements of the Duty of Candour. The senior management team encouraged a culture of openness and honesty. There was a system in place for notifying safety incidents.

When there were unexpected or unintended safety incidents:

- The service gives affected patients reasonable support, truthful information and a verbal and written apology.
- They kept written records of verbal interactions as well as written correspondence.

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' feedback.

- The service had also gathered feedback from staff 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. Staff told us they felt involved and engaged to improve how the service was run.

Continuous improvement and Innovation

There was a strong 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. For example, the early bird service. Where OOH GPs joined ambulance crews and provided care and treatment to patients, preventing unscheduled hospital admissions releasing ambulance crews for more urgent calls.

Westcall had identified areas where near patient testing could be improved. Following a significant event the service developed a Sepsis (a life threatening infection) kit which provided GPs with a care pathway, testing kits and medication for patients who demonstrated signs of Sepsis. The trust has identified that they should be seeing approximately 200 OOH cases of Sepsis per year. Since April 2015, the testing kit has been used on 125 patients potentially preventing more serious illness or loss of life.

The service has also identified that the number of patients with deep vein thrombosis (DVT) seen out of hours was increasing. They had introduced a D-dimer machine which detects whether a patient had a DVT and allowed for the early intervention of blood thinning injections to prevent a blood clot. Since April 2015, Westcall has seen 554 patients with this condition and has prevented hospital admissions and potential further complications or illness for these patients.

An external review had been commissioned in March 2015 which outlined improvements to leadership, governance and the services to patients. Changes were implemented which increased the effectiveness of care and treatment and improved outcomes for patients.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment. How the regulation was not being met: 12.— 1. Care and treatment must be provided in a safe way for service users. 2. (g) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— a. the proper and safe management of medicines; Specifically, the provider was not ensuring that blank prescription pads were securely stored and their movement monitored. There was no system in place to record the use of prescriptions to minimise misappropriation or misuse. Regulation 12 (1) (2) (g)