Glover Street

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

Birmingham and District GP Emergency Room Limited (Badger) provides out-of-hours services across seven primary care centres including Glover Street which is the administrative base and call handling centre.

During our inspection we visited two of the provider's primary care centres, Glover Street and a primary care centre at a local hospital. We spoke with 14 patients who were using the service and a range of clinical and administrative staff.

Most patients that we spoke with told us that they were happy with the treatment they received. Those that were not told us it was because they had felt rushed when they were seen. Most patients described a caring service and told us that they were involved in discussions about their health care and were treated with dignity and respect. We observed staff treating patients with sensitivity during telephone consultations.

We saw the service was provided in a clean and hygienic environment and there were systems in place to ensure the safety of patients such as safeguarding patients that may be at risk of harm and the safe use of medicines. Staff were aware of the systems in place for reporting incidents and untoward events and were involved in the investigations which enabled learning to take place.

We found the service was effective in meeting the wide range of needs of patients that presented to the service and dealing with the varying levels of demand that was placed on it. Staff had access to equipment and guidance needed to respond to patients. There were processes to ensure that those with urgent needs were seen as a priority.

The provider actively asked patients for their views and feedback and responded to information received to improve the service. Complaints were thoroughly investigated and responded to but not always in a timely way. Patients did not always have access to information needed to support them to raise a complaint.

We found the service was well-led and provided a supportive environment which empowered staff to flourish. Staff described an open culture and were supported through induction training, performance management and continuing professional development to provide a good service.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found good systems in place for reporting and investigating significant incidents that occurred. These systems ensured that action was taken where needed and staff learned from these events.

Recruitment processes ensured suitable staff were employed to work for the service. This included a comprehensive induction programme which checked the competency of staff before they worked unsupervised.

We found appropriate systems in place to protect patients from the risks associated with medicines and infection control practices in place helped to minimise the risk of cross infection. However, we did not see any action plans associated with the infection control audits which demonstrated how identified risks had been overcome.

Staff were aware of safeguarding policies and procedures and were able to demonstrate appropriate action taken in response to concerns about the safety of patients who used the service.

Are services effective?

The provider effectively managed demand for the service although a few patients described feeling a bit rushed through the service. Patients with urgent care needs were seen as a priority and arrangements in place helped to identify any changing needs.

Staff had access to current information and guidance to support them in their work and systems of regular audit helped to ensure the standards of service provided.

Information was routinely shared with patients usual GP to support a good continuation of patient care but this was not the case for patients that were not locally registered with a GP.

Are services caring?

Most patients we spoke with described being treated with respect and dignity and felt involved in decisions about their health care. Although some patients felt they were not given sufficient time with clinicians to discuss their health concerns.

We observed staff being helpful and sensitive towards patients' needs.

There was limited health information or information about the service for patients to read or take away from the waiting areas and none of the information displayed was available in a language other than English.

Are services responsive to people's needs?

The service had good arrangements in place to ensure that it could respond to patients with urgent needs with minimal delay. Staff had access to equipment to attend to patient needs and were aware of local services to contact should patients require specialist care.

The service was accessible to patients with mobility difficulties and translation services were available for patients who did not speak English.

Patient feedback was routinely sought through surveys and comments acted upon. Complaints were thoroughly investigated and patients responded to, although this was not always done in a timely manner.

Summary of findings

Are services well-led?

Staff who worked there described a supportive service which provided opportunities for continuous professional development and promoted a culture in which excellence could flourish.

There were arrangements in place to learn from incidents and complaints, and these were shared with staff.

Process were in place to ensure risks were managed and acted upon.

Summary of findings

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

We spoke to 14 patients who had used the out-of-hours service during our inspection. We also received eight comment cards from patients who had used the service.

Of the 22 comments received either face to face or by comment card most were positive about the service. However three patients commented that they felt rushed through the service and four patients commented that they had experienced a long wait to be seen.

All but one patient told us that they were treated with dignity and respect.

Areas for improvement

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

- Improve systems for transferring information back to GP practices for patients seen who are not locally registered with a GP. This will ensure the patient's GP is aware of any care or treatment their patient has received from the service.
- All audits undertaken should complete the full cycle in order to demonstrate improvements or learning.
- Review the chaperone policy to include further clarity in the role of the chaperone to include the protection of patients as well as clinicians during sensitive examinations.
- Provide patient information relevant to the service provided in languages that reflect the diverse population using the service.
- Amend patient feedback forms to enable patients to provide anonymous feedback if they wish to. Ensure patients are aware as to what is being done with their information and assure patients that feedback will not affect access to services or treatment in the future.
- Review complaints process to ensure patients are supported to make a complaint and provide timely responses to complaints received.

Good practice

Our inspection team highlighted the following areas of good practice:

- There were processes in place to reduce the risk of clinical staff working excessive hours where they may have more than one job.
- Staff underwent a high quality induction programme before working unsupervised.
- Staff received regular clinical audits based on the quality of their consultations.
- Staff had access to in house continuous professional development which enabled them to keep up to date with mandatory training.
- Healthcare support workers were trained in undertaking patient observations prior to being seen by the clinician. The meant the GP had information about the patient to help assess their needs and reduce the patient waiting time.
- The service was accessible to patients with mobility difficulties and translation services were available for patients who did not speak English.

Glover Street

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP. The team also included a GP Practice Manager and an expert by experience (a person who has experience of using this particular type of service, or caring for somebody who has).

Background to Glover Street

Birmingham and District GP Emergency Room Limited (Badger) provides GP led out-of hours primary care services when GP surgeries are closed. Patients can access the service directly if their own GP surgery is one of the membership surgeries or via the NHS 111 telephone service. There are approximately 80 membership surgeries.

Glover Street is the head office and administrative base for Badger. It is also where triage and GP call handling takes place. Patients who need to be seen by a clinician are referred by appointment to one of Badger's primary care centres in Birmingham, Solihull, Sutton Coldfield, Stafford, Cannock and Walsall. The provider also caries out home visits as part of the out-of-hours service.

Information from the provider showed that they had managed the care of 11019 patients either by telephone consultation, face to face consulation or a home visit during February 2014.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we had received from the out-of-hours service and asked other organisations to share what they knew about the service.

We carried out an announced visit on 12 March 2014 between 14.30 and 23.30 and on the 13 March 2014 between 11.30 and 13.30. We visited Glover Street and the primary care centre based at Birmingham Heartlands Hospital.

During our visit we spoke with a range of clinical and administrative staff, including the medical director, five GPs, two GP registrars, the lead nurse, an advanced nurse practitioner, a healthcare support worker, three

Detailed findings

receptionists. We spoke with 14 patients who used the service and reviewed documents relating to the care of patients. We reviewed comment cards that eight patients had completed after using the service.

Are services safe?

Summary of findings

We found good systems in place for reporting and investigating significant incidents that occurred. These systems ensured that action was taken where needed and staff learned from these events.

Recruitment processes ensured suitable staff were employed to work for the service. This included a comprehensive induction programme which checked the competency of staff before they worked unsupervised.

We found appropriate systems in place to protect patients from the risks associated with medicines and infection control practices in place helped to minimise the risk of cross infection. However, we did not see any action plans associated with the infection control audits which demonstrated how identified risks had been overcome.

Staff were aware of safeguarding policies and procedures and were able to demonstrate appropriate action taken in response to concerns about the safety of patients who used the service.

Our findings

People's views

We spoke with 14 patients who were using the out-of-hours service on the day of our inspection and read the eight comment cards that had been completed by patients who had recently used the service. Most comments we received were positive and did not raise any concerns about patient safety.

Significant events

The provider had arrangements in place to report significant incidents that occurred during the provision of out of hours care. An adverse events policy supported staff in the reporting of incidents for investigation. Staff we spoke with confirmed that they were aware of these arrangements and we saw evidence of clinical staff having completed incident forms. The provider reported that 144 incidents had been recorded in the last year, although none of these were deemed servious adverse events. We looked in detail at the records for two of the incidents. These showed that the incidents had been investigated in a timely manner and feedback, including any learning, had been given to the clinician involved. This demonstrated a willingness of staff to report incidents which enabled the provider to use the learning from them to minimise the risks to patient safety in the future.

Staffing and staff recruitment

The out out-of-hours service was GP led but also engaged a range of nursing staff including advanced nurse practitioners (ANPs). Senior managers advised us that they did not use locum clinicians, staff were directly employed and engaged by the service and if they needed to cover shifts there was always a waiting list of staff willing to work. Staff were supported when on shift by a team leader who could help them with any queries they might have. This meant there was a consistency of staff who were familiar with the local working arrangments and services.

Senior staff advised us that clinical staff were required to let them know the hours they worked in other positions. This enabled them to allocate shifts in compliance with the european working time directive. This helped ensure staff were not working excessive hours which may impact on their clinical judgment and patient safety.

There were formal processes in place for the recruitment of new staff. The recruitment and selection policy set out the systems in place for checking the suitabity and character of new staff prior to their employment. We looked at the recruitment records for two GPs. We saw recruitment checks had been undertaken which included proof that the member of staff was on the GP performers list and registered with their professional body. This ensured that the member of staff met the requirement of their professional body and had the right to practice.

The provider also undertook character checks of new staff including obtaining personal references, identification and criminal records checks. Provision of this information enabled the provider to identify and take appropriate action on information that may inpact on the suitability of staff to work with patients. Recruitment checks were signed off by the medical director before clinical staff were accepted onto an induction programme which was completed before staff could work unsupervised.

Cleanliness and infection control

We looked around two of the seven primary care centres used by the out-of-hours service. This included the head office at Glover Street and the primary care centre at a local

hospital. The waiting areas and clinical treatment rooms were in good condition and supported infection control practices. We found work surfaces and seating free from damage and flooring with coved skirting which enabled them to be cleaned thoroughly. Sinks were operated by elbow taps to help prevent cross infection and guidance on effective hand washing techniques was displayed throughout the premises. Clinical rooms were well stocked with gloves and aprons and staff had access to appropriate cleaning equipment for clearing spills of bodily fluids. At Glover Street we also saw that disposable curtains were used around the couches and were clearly dated as to when they were last changed. These practices helped to protect patients from the risks of cross infection.

There were appropriate arrangements in place for the management and disposal of waste. We saw that there was a clear distinction between clinical and non-clinical waste, including any sharp instruments to ensure appropriate and safe disposal. We were advised that the removal of waste was managed by the hospitals in which most of the primary care centres were located. At the provider's head office at Glover Street there were separate arrangments in place. These arrangements helped to ensure the safe disposal of clinical waste and minimise the risks to patients using the service.

We found the clinical areas were kept clean and tidy. Many of the primary care centres used by the provider for the provision of out-of-hours services were shared with a hospital. Staff advised us that the hospitals maintained responsibility for the premises and cleaning. There was one exception where the provider contracted with hospital contractors to clean the clinical area. None of the patients we spoke with raised any concerns about the cleanliness of the premises. This provided some assurance that the cleanliness of clinical areas were being maintained.

We saw that infection prevention and control audits had been carried out to identify any risks associated cross infection across the primary care centres. The provider showed us a new infection control audit tool which they had recently developed and planned to implement in April 2014. However it was not clear what action had been taken from previous infection control audits in order to minimise identified risks.

Safeguarding patients from harm

Staff that we spoke with demonstrated an understanding of safeguarding patients from abuse and what they should do if they suspected anyone was at risk of harm. There were policies in place for safeguarding children and vulnerable adults from abuse. These contained information to support staff in recognising and reporting safeguarding concerns to the appropriate authorities for investigation. There was a safeguarding lead for the service and staff were able to tell us who the lead was. This meant staff had access to information and support to enable them to act appropriately if they believe a patient may be at risk of harm.

We saw that referrals had been made to the relevant local authority who investigate safeguarding concerns. One GP advised us that they had made a safeguarding referral in the past and one healthcare support worker advised us that they had escalated a safeguarding concern to more senior staff. This demonstrated that staff were prepared to report concerns to protect patients from harm.

We were advised that safeguarding children and vulnerable adults training was compulsory for clinical staff and needed to renewed every three years. Safeguarding children and vulnerable adults training was available to staff through the provider as part of the continuous professional development programme. New staff were required to have undertaken safeguarding training (within the previous three years) when they were recruited. From the two recruitment files we reviewed we saw that this was the case. This meant staff had the skills and training needed to recognise and act on safeguarding concerns.

We saw that the fire exits were kept clear and fire extinguishers checked regularly. Staff advised us that when they had carried out fire drills that they had doubled up on staff working to avoid disrupting the service. This demonstrated that the provider had considered the safety of patients if there was a fire at the premises.

Medicines

The provider held medicines on site for use in an emergency, to administer to patients during a consultation or as a prescription. We saw that the medicines were stored securely in tagged containers. Two staff were required to open these containers which were then re-tagged afterwards using a colour coded system with the earliest medicine expiry date recorded on them. This enabled staff to identify when medicines needed to be replenished or

Are services safe?

replaced. Records were kept of all medicines administered which enabled the medicine to be traced to the patient. These arrangements helped to safeguard patients from risks associated with medicines.

We looked at how controlled drugs were managed. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. The controlled drugs were accessible only by the on site team leader. We checked the controlled drugs available and saw that these were all present and in date and that the numbers available tallied with the controlled drugs register. We saw that any controlled drugs used had been signed for which enabled clear identification of the person responsible in the event of a system failure. The lead nurse told us that they could not recall any breaches of procedure since they had started working for the service in 2006. This provided assurance that controlled drugs were appropriately managed by the service.

Patient Environment

We saw that there was secure access into the premises at Glover Street. Patient waiting areas were monitored by CCTV which was installed to protect both patients and staff. These arrangements helped to maintain patient safety when using the service.

Are services effective?

(for example, treatment is effective)

Summary of findings

The provider effectively managed demand for the service although a few patients described feeling a bit rushed through the service. Patients with urgent care needs were seen as a priority and arrangements in place helped to identify any changing needs.

Staff had access to current information and guidance to support them in their work and systems of regular audit helped to ensure the standards of service provided.

Information was routinely shared with patients usual GP to support a good continuation of patient care but this was not the case for patients that were not locally registered with a GP.

Our findings

Outcomes for patients

We spoke with 14 patients who were using the out-of-hours service on the day of our inspection and read the eight comment cards that had been completed by patients who had recently used the service. Most of the patients we spoke with were satisfied with the service they had received. However, three patients described feeling rushed during their consultation and four patients told us they had experienced a long wait. Comments received from patients included, “I see doctor from here, very good service" ; "Excellent service, phoned Badger (the provider), was given an emergency appointment, seen almost immediately” and “Good today…doctors sometimes not as concerned, just feel like a number.”

We spoke with clinical staff about how they received updates relating to best practice or safety alerts they needed to be aware of. One GP showed us how they accessed links on the computer to obtain best practice information, clinical guidelines and other reference information such as the British National Formulary (information about medicines). The information available on the computer was the most up to date and accessible while clinicians were seeing patients. Staff also told us they received weekly newsletters which kept them informed about any changes to policies and procedures. This meant clinical staff had access to current information and guidance to support them to deliver good clinical care to patients.

The operations manager usually received safety alerts relating to medical equipment. They advised us that these were cross referenced against the medical equipment registers to see if there were any matches. This enabled the provider to take appropriate action if the safety alerts related to any equipment used by the service.

Access to the out-of-hours service

Patients accessed the out-of-hours service directly if their GP practice was one of the member practices or through the NHS 111 telephone service. Patients were prioritised and referred to one of the primary care centres for a consultation, received a home visit or advice and care from a clinician over the telephone. This process enabled patients to be appropriately managed according to their individual needs.

Patients were seen by a healthcare support workers when they arrived at the primary care centres for a consultation. This enabled the patients to be reassessed as some time may have elapsed since they were triaged. The healthcare support worker advised us that if they had any any concerns about a patient they could inform a clinician who would re-prioritise the patient if needed. This process ensured people were seen according to need.

Staffing

There was a rota for the deployment of staff to each primary care centre. This enabled the service to resource the primary care centres with an appropriate skill mix of staff. The medical director advised us that the skill mix would always include GPs and sometimes Advanced Nurse Practitioners. Healthcare support workers and reception staff also provided support at the primary care centres.

Staff worked flexibly across the primary care centres to meet changing demand. The team leader on duty had access to real time information about the demand for each primary care service and would re-deploy staff to work at other primay care centres if needed. The escalation plan detailed the criteria for re-deploying staff and we saw evidence of this happening during our visit. This helped to minimise any delays to patients waiting to be seen by a clinician.

Information sharing

Staff told us that they did not usually have much information about a patient before they were seen. They explained that some information was available from any previous visits the patient had had to the service. Some GPs

Are services effective?

(for example, treatment is effective)

would also leave special notes about specific patients who may use the service but this depended on the GP practice. Healthcare support workers at primary care centres undertook tests such as blood pressure, temperature and urine testing prior to the patient seeing the doctor. This meant that when the doctor or nurse saw the patient, they had some information about them to help manage the patient's health needs effectively.

Information about patients who used the out-of-hours service was shared with their usual GP. This was an automated process. We were advised that the information was transferred by 8am the day after the patient had been seen. Staff told us that if there were any difficulties transferring information back to the GP they would be alerted by an error report which would prompt them to contact the GP practice directly and re-send the information. However, there was not a robust system in place for transferring information back to a patient's GP where the patient was not locally registered with a GP practice. Staff told us that this was because patients were not always able to provide accurate details about their usual GP and that they were complying with the commissioners requests not to send this information. This meant some GPs were not made aware of treatment given to their patient to support the good continuation of care.

Auditing and monitoring

We saw that quarterly clinical audits were carried out on consultations undertaken by clinical staff. The audits reviewed the quality of triage calls, telephone consultations and face to face consultations at primary care centres and on home visits. Staff were scored on the quality of their consultations and could earn audit free quarters for good performance or meetings with the medical director for poor performance. Information from these clinical audits were actively used to drive up standards of care.

We saw that there was a rolling programme of audits covering areas such as medicines management, clinical conditions and referral patterns. GPs told us that participation in these audits helped support their appraisals and re-validation. One GP told us that they had received feedback from clinical audits during continuing professional development modules they had attended. The provider was also a member of Urgent Health UK (UHUK) and participated in regular benchmarking audits with other out-of-hours providers. The UHUK gave the service an overall assurance of green in March 2014 following audits in areas such as patient surveys and complaints. The audit findings did not highlight any major concerns. Participation in regular audits demonstrated a commitment by the provider to continually improve the service provided.

The provider had carried out infection control audits in 2012 and 2013. However, it was not clear what action had been taken as a result of these audits. The lead nurse explained that the infection control lead who had undertaken the audits had left the service but assured us that action had been taken in response to the findings such as improvements to handwashing signage. Reporting of action taken in response to audits undertaken would provide assurance that issues raised had been acted upon.

Are services caring?

Summary of findings

Most patients we spoke with described being treated with respect and dignity and felt involved in decisions about their health care. Although some patients felt they were not given sufficient time with clinicians to discuss their health concerns.

We observed staff being helpful and sensitive towards patients' needs.

There was limited health information or information about the service for patients to read or take away from the waiting areas and none of the information displayed was available in a language other than English.

Our findings

Patient views

We spoke with fourteen patients who were using the out-of-hours service on the day of our inspection and read the eight comment cards that had been completed by patients who had recently used the service. Most comments received were positive and described a caring service although some patients did not feel they were given enough time to discuss their health concerns. One patient described staff as "Welcoming and approachable." Another patient told us, "I have visited the service many times over the past few years, the service has been very good throughout my visits, the staff always listen carefully and treat you with respect and are friendly."

The provider regularly sought feedback from patients who used the service. We saw patient feedback forms available at the two primary care centres we visited. In addition six per cent of patients seen from each case type (telephone and face to face consultations) were sent a survey in the post. Results from the patient experience survey for the period July to September 2013 showed 95.5% of patients rated the service as fair to excellent.

We were concerned that the patient feedback form sent by post did not allow patients to provided anonymous feedback. Patients could choose whether to provide details of their name and contact details however a patient reference number was recorded on the return form which meant the patient could be traced. We saw an example where a patient had been contacted but had provided no contact details. This did not respect the patients right to remain anonymous if they wished to do so.

Involving patients

Most patients we spoke with or provided feedback through the comment cards confirmed that they had been involved in decisions about their care and treatment. They told us that they were satisfied that information was given to them in a way they could understand. Feedback on one comment card explained, "They [the staff] respect opinions, treat you with respect too. As well as giving high level of care they make sure diagnosis and treatment is explained as much as possible." However, we also spoke with two patients who did not share this view. One patient explained, "Sometimes, not all times, questions are not answered and you are rushed through."

Patients were offered a chaperone service if they needed an examination, the chaperone acts as support and accompanies the patient during a medical examination. We saw information relating to the chaperone service displayed in one of primary care centres we visited (but not both) so that patients could request a chaperone if they wanted one. A chaperone policy provided clear guidance to staff about the role of the chaperone. We noticed that in the chaperone policy that the role of chaperone was seen to provide protection to the healthcare professional but did not mention protection for the patient. Provision of a chaperone helps to provide some protection to patients and clinicians during sensitive examinations.

We spoke to three staff who told us that they sometimes acted as a chaperone. This included the healthcare support worker and two receptionists. Staff spoken with confirmed that they had received training in chaperoning and demonstrated an understanding of the role and what they would do if they had any concerns about a patient. This provided assurance that staff were aware of their role when chaperoning and knew what they should do to act in the patients best interest.

Patient information

We looked at the provision of information to patients that used two of the primary care centres and found this variable. One of the primary care centres which was also the provider's head office contained very little information for patients about the service while the primary care centre visited at a local hospital held some patient information

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including leaflets explaining the waits and how to complain. We did not see any health information for patients to take away and none of the health or other information available to patients was in languages other than English. Staff advised that health information could be printed off for patients if required. Health information helps to support patients to understand and cooperate with their treatment.

Respect and dignity

All but one patient described being treated with respect and dignity when using the service. The one patient who did not feel they were treated with respect told us that they felt the member of staff who saw them had "No patience or time." They went on to tell us, "I could hear people next door so I don't feel it was very private."

We heard clinicians interacting over the telephone with patients and found they exhibited empathetic, clear and knowledgable consulting manner and skills. The quality of consultations undertaken were regularly monitored. This provided some assurance that patients who used the service were being treated with dignity and respect.

We saw that consulting rooms were lockable and there was appropriate screening to maintain patient's dignity and privacy while they were undergoing an examination or treatment. We saw that doors to the consulting rooms were kept closed during consultations.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The service had good arrangements in place to ensure that it could respond to patients with urgent needs with minimal delay. Staff had access to equipment so that they could attend to patient needs and were aware of local services should patients require specialist care.

The service was accessible to patients with mobility difficulties and translation services were available for patients who did not speak English.

Patient feedback was routinely sought through surveys and comments acted upon. Complaints were thoroughly investigated and patients responded to, although this was not always done in a timely manner.

Our findings

Patient feedback

Patients were asked for their feedback about the service on an ongoing basis. We saw that patients were asked to rate the service they received and were given opportunities to comment on the areas they felt were good or could be improved. Information received from the surveys was analysed and individual feedback given to patients about any action they had taken. We also saw feedback had been given to staff where comments received from patient surveys directly applied to them. Providing opportunities for patients to report on their experiences helps to ensure that the service continues to be responsive to the needs of patients.

The patient survey that was posted to patients included a leaflet in nine different languages which offered to provide the survey in a different language or format. This helped to ensure any feedback received would be representative of the whole local community.

We saw evidence of changes implemented as a result of patient feedback. This included the development of a leaflet which explained to patients why they had to wait and why patients may not been seen in order of arrival. We saw the leaflet displayed at reception in one of the primary care centres we visited. This demonstrated that the service was receptive to the views of patients and helped manage patient expectations of the service.

Access to services

The two primary care centres we visited were accessible to patients who may have mobility difficulties. Patients could easily access the primary care centres by ramp and automatic doors. Toilets facilities were available for disabled patients and consultation rooms were on the ground floor. At both primary care centres there was patient parking available close by which included parking spaces for disabled patients. At one primary care centre we saw a large number of young children in pushchairs, the carers appeared to be accessing the service without difficulty. This meant patients with mobility difficulties were able to access the service to get the support they required.

Staff we spoke with told us that there was information available that they could access on their computer if they needed an interpreter for patients but had never used it. Staff told us that there were usually staff on duty who could speak some of the languages spoken in the local community or the patient usually came with someone who could translate for them. Use of interpreter and translation services helps to ensure all patients can access the service, communicate their needs and understand information that is given to them.

Responding to need

Calls that came into the service were handled at the provider's head office by clinicians who decided on the most appropriate pathway for the patient. This would be a telephone consultations, face to face consultation (at one of the primary care centres or a home visit) or a referral to 999 in the case of an emergency. Each shift had a team leader who monitored the service demand in real time. The team leader was able to see which primary care centres were busy and re-deploy staff to support those areas. We saw that there was an escalation plan in place which described action needed to manage activity levels and increased pressure on the service. These arrangements helped to ensure that when there was a high demand for the service, people were seen with minimal delay.

We spoke with the receptionists at one primary care centre to ask what they would do if they were concerned about a patient in the waiting room. They told us that they would call the healthcare support worker to review the patient who in turn would contact the clinician. We saw that the healthcare support workers were given training and competency assessments in aspects of nursing care such

Are services responsive to people's needs?

(for example, to feedback?)

as patient observations. These arrangements ensured any concerns about patients were appropriately escalated to the relevant staff on duty who were most able to act on them.

Performance data for February 2014 showed that the service was meeting the national quality requirements (NQRs) for waiting times. NQRs are a set of standards specific to the delivery of out-of-hours services. This meant patients were in most cases being seen within the waiting time standards for the service.

Availability of equipment

Most of the primary care centres used by the out-of-hours service were shared with other providers. We spoke with a healthcare support worker who was responsible for setting up and putting away equipment in the consulting rooms at the beginning and end of the shift. We saw that equipment looked clean and in good condition. We also saw evidence that equipment had been checked for electrical safety. Staff advised us that the equipment was maintained yearly and any equipment found defective would be recorded in the team leaders shift report and returned to the head office for replacement and repair. When not in use equipment was stored tidily in clearly marked containers and in locked cupboards. These arrangements meant equipment needed for clinical staff to carry out their job and respond to patient need were available when needed.

There were arrangements in place to deal with foreseeable emergencies. Arrangements for emergency equipment varied at the two sites we visited. One of the primary care centres we visited was based next to the A&E department at the hospital. The healthcare support worker advised us that in an emergency they would receive support from the hospital resuscitation team and use their emergency equipment which was situated close by. Emergency equipment was also available at the provider's head office site and was in date. We saw that emergency equipment included a defibrillator and oxygen. Each room had a sealed emergency medicine pack with the earliest expiry date written on them. We were advised that these were also used for home visits. This meant staff had access to equipment or support needed to enable them to respond to a medical emergency if one arose.

Basic life support was part of the mandatory training that all staff were required to undertake. We saw that this training was listed as part of the continuing professional development (CPD) programme offered to staff. The CPD programme for 2014 was displayed on the noticeboard at the providers head office so that staff could sign up to it. Staff that we spoke with confirmed that they were up to date with their training in basic life support. This helped to ensure that staff were equipped to assess and respond to the needs of patients in a medical emergency.

Medicines

Some medicines were available on site to administer to patients immediately. We saw examples of patient records where medicines had been administered and recorded. This meant clinicians were able to respond promptly to patient symptoms that they were presented with.

The provider also held a small stock of prescription medicines if people were not able to get to a pharmacy. This meant patients were able to start their treatment in a timely way

Vulnerable patients

We spoke to one GP about how they managed patients who may, due to their health conditions, be likely to use the out of hours service. The GP explained that they received special notes through their computer about patients who may be on palliative care. However, not all GP's provided this information. We also spoke about the management of mental health patients who may be at their most vulnerable when attending the service. The GP showed us protocols in place for assessing the potential risks of mental health patients and were able to describe the referral pathways for patients in a mental health crisis. This provided some assurance that the service would be able to respond appropriately to support vulnerable patients.

Referrals

Staff advised us that there was a single access point for hospital referrals in Birmingham. Staff also had access to the contact details for specisalist doctors at the hospital where one of the primary care centres was located. This meant clinical staff had information needed to ensure that referrals were made without delay.

Complaints

There were arrangements in place for the management of complaints received about the service although these were not always consistently applied. We saw information to support patients to make a complaint available and on display at one of the primary care centres visited but not the other. We looked at four complaints received within the

Are services responsive to people's needs?

(for example, to feedback?)

last year. We found the complaints had been thoroughly investigated and responded to including details about what the patient should do if they are still not satisfied with the response given. However the quality and the timeliness of the responses to the patient varied. With two out of the three complaints the timescales set by the provider exceeded the 28 working days cited in the information provided to patients. There was also no evidence that the patient had been informed of any delays in responding where the 28 working days had been exceeded. This meant the provider did not always follow it's own guidance to ensure patients received a timely response to their concerns.

Are services well-led?

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

Summary of findings

Staff who worked there described a supportive service which provided opportunities for continuous professional development and promoted a culture of excellence.

There were arrangements in place to learn from incidents and complaints, and these were shared with staff.

Process were in place to ensure risks were managed and acted upon.

Our findings

Leadership and culture

There were strong governance arrangements in place for the management of the service. With clear lines of leadership. Staff described the culture of the organisation as supportive. They spoke positively about the induction training, opportunities for continuing professional development and performance management of staff. The service provided an out-of-hours GP training scheme for GP registrars. We met two of the GP registrars during our visit who praised the scheme provided. This demonstrated a commitment to developing a culture of excellence within the service.

Staff were kept informed about the service. Weekly newsletters were sent out to all staff informing them of any changes or new policies that they needed to be aware of. A staff noticeboard at the head office also provided useful information about training and service performance to staff. These arrangemements helped to support staff and helped the smooth running of the service.

Management of staff

New staff received a comprehensive induction programme in order to familiarise themselves with the service. GP's were allocated a mentor and gained practical experience in the three aspects of the out-of-hours service (telephone and face to face consultations at the primary care centre and the patients home. They also undertook scenario based assessments of anonymised past cases. All GPs were signed off as competent by the medical director before they could work unsupervised. Clinical staff that have not worked for the service for more than six months were required to retake some of the induction programme. Provision of induction training helps ensure staff receive consistent information in relation to the day to day running of the service.

Staff had access to a range of policies and procedures, which were kept up to date. The policies and procedures were accessible to staff when needed. This meant staff had access to current guidance to support them in their work.

Performance monitoring was carried out on all clinical staff on a quarterly basis. A sample of consultations were randomly picked and the quality of the consultation scored against set criteria. Clincians that scored over 80 per cent on two occasions could earn an audit free quarter. Clinicians that scored less than 50 per cent would be interviewed by the medical director athough we were advised that this was a rare occurrence. We saw evidence that the results of these audits were given back to individual clinicians . This provided assurance that clinical performance was kept under review and action would be taken as necessary to improve the service patients received.

Staff were given access to regular training. A Continuing Professional Development (CPD) programme was available to all staff for a nominal membership fee. This including compulsory training modules that staff needed to complete. Staff that were compliant with their mandatory training and clinical audit were given preference for their choices on the out-of-hours rota. These arrangements helped to maintain and improve standards of clinical practice.

Learning from complaints and incidents

There were arrangements in place for staff to discuss and learn from complaints and incidents. Incidents and complaints were thoroughly investigated and any learning was fed back to staff involved. Staff we spoke with confirmed this happened. Incidents and complaints were also discussed at the montly Clinical Management Group whose membership included the medical director and associate medical directors. This meant that any issues arising were discussed by staff who were able to act on the information received in order to improve the service. We were advised that the complaints and incidents were discussed on an individual basiss but did not undertake any trends analysis which would assist in identifying any common themes.

Are services well-led?

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

Performance against the national quality requirements for (NQR) out-of-hours services were reported to the clinical commissioning group (CCG) that contracted with the service. Performance against the NQRs were analysed monthly which enabled the service to identify any areas or times where the service might be falling short of the standards. NQRs were discussed at meetings with senior staff who were able to act on information received.

Minimising Risk

We saw that there was a corporate risk register for the management of identified risks to the service. Individual staff had the responsibility for carrying out risk assessments and reporting back to the executive team. This helped to ensure risks to the service were identified and acted upon to minimise the risks of them occurring.

The provider had a business continuity plan which was reviewed by the CCG as part of winter planning. Staff advised us that in order to test out their business continuity plans they would double up on their staff rota to avoid disrupting the service to patients.

As we looked around the premises at the provider's head office we saw that an electric generator had been installed as a back up to protect the computer systems needed to run the out-of-hours service.