NDUC - Northumberland House

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Northern Doctors Urgent Care on 2, 5, 7, 9 and 11 February 2015.

Overall, we rated the service as good. Specifically, we found the service to be good for providing well-led, effective, caring and responsive services.

Our key findings were as follows:

- Feedback from patients was positive; they told us staff treated them with respect and kindness;
- Patients generally reported good access to the service, with appointments available at a centre convenient to them;
- Patients we spoke with told us they felt they had sufficient time during their appointment.
- Patients' needs were assessed and care was planned and delivered following best practice guidance;
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, reviewed and addressed;
- There was a clear leadership structure and staff felt supported by the management team. The service actively sought feedback from patients
- A patient survey had been undertaken by the service in October 2014. The results were very positive, with 100% of patients rating their treatment on the phone as very good or excellent;
- The premises were clean and hygienic, although some curtains in the consultation rooms at the North Tyneside and Royal Victoria Infirmary sites were not clean;
- Staff received appropriate, role-specific training. The medical director produced a seasonal bulletin which included several 'learning points' and provided clinical updates for staff.

We saw an area of outstanding practice:

Summary of findings

- Two detailed reviews of the service were carried out each year. 'A day in the life of' sessions were attended by senior managers and team leaders. All activities (initial telephone calls, triage calls, home visits and centre consultations) from a particular day were reviewed in detail. Any learning was then shared with staff as appropriate.

However, there were also areas of practice where the provider needs to make improvements.

The provider should:

- Undertake a risk assessment and implement procedures for the management and testing of the water supply for the presence of legionella (a type of bacteria found in the environment which can contaminate water systems in buildings);
- Review arrangements for checking that medicines are in date;
- Implement a programme of appraisals for all non-clinical staff;
- Provide information at the six centres to inform patients of their right to request a chaperone;
- Improve arrangements for implementing actions following clinical audits.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The service is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep people safe; staff recruitment was well managed.

Medicines were generally well managed, although there was a box at one of the sites which contained out of date medicines. All sites were clean and well maintained, however, there were no arrangements in place to test for legionella and it was not clear when some of the privacy curtains had last been cleaned.

Are services effective?

Good

The service is rated as good for providing effective services. Care and treatment was being delivered considering current published best practice. Patients' needs were being met and referrals to other services were made in a timely manner. There was an effective system to ensure that patient information was promptly shared with each patient's own GP to ensure continuity of care. Staff had received training appropriate to their roles and arrangements had been made to support clinicians with their continuing professional development. Clinical staff received regular appraisals but these arrangements were not in place for non-clinical staff. The service worked with other healthcare professionals to share information, to promote better health outcomes for patients.

Are services caring?

Good

The service is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Patient's privacy and confidentiality was respected. Staff demonstrated they understood the support patients' needed to cope with their care and treatment. We saw that staff treated patients with kindness and respect.

Are services responsive to people's needs?

Good

The service is rated as good for providing responsive services. Services had been planned so they met the needs of the local Clinical Commissioning Group (CCG) areas. Patient feedback about the service was good. The service had consultation rooms at the headquarters site and six centres throughout Northumberland,

Summary of findings

Newcastle and North Tyneside where patients could access appointments with a GP. All of the centres had good facilities and were well equipped to treat patients and meet their needs. The management team worked closely with commissioners and had well established systems in place to monitor the service. There was an accessible complaints procedure, with evidence demonstrating the service made every effort to address any concerns raised with them.

Are services well-led?

Good

The service is rated as good for being well-led. The service had a clear vision which was shared by all staff. There was an effective governance framework in place, which focused on the delivery of high quality care. There was rigorous monitoring of performance to ensure patients received safe and effective care. We found there was a clear leadership structure and a high level of constructive staff engagement. Staff received regular training to equip them to carry out their roles effectively. The senior management team met with representatives of the Clinical Commissioning Groups (CCGs) regularly to discuss performance and capacity.

Summary of findings

What people who use the service say

During our inspection we spoke with seven patients who had accessed the service via the telephone triage system.

They told us the staff who worked there were very helpful and polite. They also told us they were treated with respect and dignity at all times and they found the premises to be clean and tidy. Patients generally reported good access to the service, with appointments available at a centre convenient for them.

We reviewed 10 CQC comment cards which had been completed by patients. The vast majority were complimentary about the service, staff who worked there and the quality of service and care provided.

The latest National GP Patient Survey completed in 2015 showed the large majority of patients were satisfied with the care and treatment the service offered, although there were some areas for improvement. The results were broadly in line with national averages:

- The proportion of patients who knew how to contact the service – 54% (national average 55%);
- Percentage of patients who said it was very or fairly easy to contact the service by telephone - 77% (national average 75%);
- The proportion of patients who felt care was provided on a timely basis – 58% (national average 60%);
- Percentage of patients saying they had confidence and trust in the out-of-hours clinician – 82% (national average 80%);
- Percentage of patients rating their overall experience as good or very good – 70% (national average 68%).

Areas for improvement

Action the service SHOULD take to improve

- Undertake a risk assessment and implement procedures for the management and testing of the water supply for the presence of legionella (a type of bacteria found in the environment which can contaminate water systems in buildings);
- Review arrangements for checking that medicines are in date;
- Implement a programme of appraisals for all non-clinical staff;
- Provide information at the six centres to inform patients of their right to request a chaperone;
- Improve arrangements for implementing actions following clinical audits.

Outstanding practice

Two detailed reviews of the service were carried out each year. 'A day in the life of' sessions were attended by senior managers and team leaders. All activities (initial telephone calls, triage calls, home visits and centre consultations) from a particular day were reviewed in detail. Any learning was then shared with staff as appropriate.

NDUC - Northumberland House

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team also included a GP specialist advisor, a practice manager specialist advisor and a CQC Inspection Manager.

Background to NDUC - Northumberland House

Northern Doctors Urgent Care (NDUC) provides out of hours general practitioner cover in the evenings, overnight, at weekends and on bank holidays. The service provides telephone contact and access to general practitioners at local centres and home visits. The service covers 954,000 patients throughout the Northumberland, Newcastle and North Tyneside areas.

Patients can access the service from 6.30pm to 8.00am Monday to Friday and 24 hours throughout Saturday, Sunday and Bank Holidays. Calls to the service are handled by North East Ambulance Service (NEAS) via the 111 telephone number. NDUC operates a triage model where all patients receive clinical telephone assessments. This prevents unnecessary journeys for patients and enables appropriate coordination of home visits and appointments according to clinical urgency and demand.

GPs from local practices provide the service patients can be seen in person by attending one of the service's six locations:

- North Tyneside General Hospital, Rake Lane, North Shields, Tyne and Wear, NE29 8NH
- Hexham General Hospital, Corbridge Road, Hexham, NE46 1QJ
- Wansbeck Hospital, Woodhorn Lane, Ashington, Northumberland, NE63 9JJ
- Royal Victoria Infirmary, Queen Victoria Road, Newcastle upon Tyne, Tyne and Wear NE1 4LP
- Alnwick Infirmary, Infirmary Drive, Alnwick, Northumberland, NE66 2NS
- Berwick Infirmary, Infirmary Square, Berwick-upon-Tweed, Northumberland, TD15 1LT.

These locations are open until approximately 11.30pm seven days a week. After that time, patients may also have an appointment with a GP at the organisation's headquarters; Northumberland House, Gosforth Park Avenue, Newcastle upon Tyne, NE12 8EG. We visited all seven locations throughout the inspection period.

There is a stable clinical staff team who work for NDUC regularly. The service employs a number of both male and female GPs from the local community. The clinicians are supported by an administration / call handling team, receptionists, drivers and a management team who are responsible for the day to day running of the service.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as

Detailed findings

part of our regulatory functions. This 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

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

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

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. This did not highlight any significant areas of risk across the five key question areas. As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us. This included the local Clinical Commissioning Groups (CCGs).

We carried out announced visits on 2, 5, 7, 9 and 11 February 2015. We visited the headquarters and all six of the sites which the service operated from. During our visit we spoke with a range of staff which included; GPs, receptionists, drivers, management team representatives and the Chief Executive. We spoke with seven patients who used the service and looked at records maintained in relation to the provision of service. We also spoke with some representatives from GP practices throughout the area about the service provided.

Good

Are services safe?

Our findings

Safe track record

The service had a good track record for maintaining patient safety.

When we first registered this service in April 2013, we did not identify any safety concerns that related to how the service operated. Patients we spoke with said they felt safe when they used the service.

The service used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibility to raise concerns, and how to report incidents and near misses. Staff said there was an individual and collective responsibility to report and record matters of safety.

We saw that records were kept of significant events and incidents. We reviewed a sample of the reports completed by staff during the previous 12 months, and the minutes of meetings where these were discussed. The records looked at showed the service had managed such events consistently and appropriately during the period concerned and this provided evidence of a safe track record for the service.

Learning and improvement from safety incidents

The service was open and transparent when there were near misses or when things went wrong. There was a comprehensive system in place for reporting, recording and monitoring significant events, incidents and accidents. The medical director had overall responsibility for significant events, supported by a member of staff from the governance team.

We saw records of significant events that had occurred during the past year. The head of governance told us all events were recorded and reviewed, to enable trends to be identified. We saw details of each event, steps taken, specific action required, learning outcomes and action points were recorded.

Significant events were discussed at dedicated monthly and quarterly meetings. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

We saw there had been a significant event in relation to some confidential information being misplaced. This had identified some key learning points, which had been shared with the relevant staff. The event had been discussed within the service and guidelines were revised to prevent this from happening in the future. The changes were implemented and the head of governance told us they would be reviewed at a later date to confirm they remained effective. Staff we spoke with were aware of the changes in procedures in relation to patient information.

We discussed the process for dealing with safety alerts with the head of governance. Safety alerts inform the service of problems with equipment or medicines or give guidance on clinical practice. They told us alerts came into the service from a number of sources. The head of governance reviewed these and forwarded to the clinical director. Any information or new guidelines were then disseminated to relevant members of staff. The head of governance was able to give examples of recent alerts and how these had been responded to. A record had been kept to indicate when alerts had been reviewed. We saw examples of where safety alerts had been shared with staff; this was via an email and there was a notice put onto the front screen of the computer system.

Reliable safety systems and processes including safeguarding

The service had systems in place to manage and review risks to vulnerable children, young people and adults. Safeguarding policies and procedures were in place. These provided staff with information about safeguarding legislation and how to identify, report and deal with suspected abuse. Information about how to report safeguarding concerns and contact the relevant agencies was easily accessible.

There was an identified clinical member of staff with a clear role to oversee safeguarding within the service. Staff we spoke with were aware of who the lead was. The lead was responsible for ensuring staff were aware of any safeguarding cases or concerns.

Good

Are services safe?

All of the staff we spoke with had a good knowledge and understanding of the safeguarding procedures and what action should be taken if abuse was witnessed or suspected.

We saw records which confirmed all relevant staff had attended training on safeguarding children and adults. All of the GPs had completed child protection training to Level 3. This is the recommended level of training for GPs who may be involved in treating children or young people where there are safeguarding concerns. This was confirmed by the staff we spoke with.

The head of governance described arrangements for offering patients a chaperone. They told us the reception staff at each site would undertake this role. We spoke with reception staff based at all six hospital sites about chaperoning duties. Staff told us they had undertaken appropriate training but said patients very rarely asked for a chaperone. There was no information in either the waiting areas or consultation rooms to inform patients of their right to request a chaperone at any of the six centres. Both of the consultation rooms at the headquarters site had notices displayed.

A whistleblowing policy was in place. Staff we spoke with were all able to explain how, and to who, they would report any such concerns. They were all confident that concerns would be acted upon.

Medicines management

There were clear systems in place to manage medicines. The service had an up to date medicines management policy and detailed procedures were available for staff to refer to. Medicines were only given to patients when they could not access the local pharmacy. Staff were aware of opening times of pharmacies and were able to pass this information onto patients as necessary. Where medicines had been issued, prescriptions were issued and details were provided to the patient's own GP.

The service maintained an in-house pharmacy at the headquarters site, staffed by two pharmacy technicians. Medicines were stored securely at the site and issued as necessary to each of the six centres and to the GPs going out on home visits.

Medicines were packed into individually numbered boxes for use by the clinicians. The medicines were in line with those suggested in the National Formulary for out of hours' services. Each box was then sealed to show it was ready for use. Boxes were stored in a secure area and each one was signed out by the driver of the car being used for home visits or to transport the box to another site. Any medicines issued to patients were recorded and the records were returned with the used box. The process was then completed when the pharmacy technicians checked stocks and restocked any medicines.

The service held stocks of controlled drugs at the headquarters site (controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the staff. For example, they were stored in a controlled drugs cupboard, access to them was restricted and the keys held securely. There were arrangements in place for the safe destruction of controlled drugs.

Processes were in place to check medicines were within their expiry date and suitable for use but these were not always followed.

The medicines we checked at all but one site were within their expiry dates. The medicines in the palliative care box at the Ashington centre were nearly all out of date. The box was held within the centre in case a GP had to visit a patient requiring palliative care out-of-hours. Staff told us the box had not been used for a long time, we saw records confirming this. We asked about arrangements for checking the medicines and saw the last check had been carried out in November 2014. Some of the medicines were dated June 2013 and October 2013 but were not identified during this stock take. All out of date medicines were disposed of during the inspection.

We saw records of blank prescription form serial numbers were made on receipt into the service and when the forms were issued to GPs carrying out home visits and at the six centres. Blank prescriptions were securely stored.

Cleanliness and infection control

We looked around each of the centres and saw they were clean, tidy and well maintained. Patients we spoke with told us they were happy with the cleanliness of the facilities.

The clinical development manager was the nominated infection control lead. We saw there was an up to date infection control policy and detailed guidance for staff about specific issues. For example, hand hygiene and use

of protective clothing. All of the staff we spoke with about infection control said they knew how to access the service's infection control policies. Infection control training was provided for all clinical and site based staff annually.

The risk of the spread of infection was reduced as all instruments used to examine or treat patients were single use, and personal protective equipment (PPE) such as aprons and gloves were available for staff to use. The treatment rooms had flooring that was impermeable, and easy to clean. Hand washing instructions were also displayed by hand basins and there was a supply of liquid soap and paper hand towels. The privacy curtains in the consultation rooms were cleaned (or changed if they were the disposable type) every six months or more frequent if necessary. We saw the curtains in most rooms were clearly labelled to show when they were due to be cleaned or replaced. However, the curtains in the rooms at the North Tyneside and RVI sites were stained and there was no indication of when they had last been cleaned. There were spillage kits (these are specialist kits to clear any spillages of blood or other bodily fluid) located throughout each of the sites.

We saw there were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We looked at some of the clinical waste and sharps bins located in the consultation rooms across the seven sites. All of the clinical waste bins we saw had the appropriately coloured bin liners in place and all of the sharps bins we saw had been signed and dated as required.

The service had not carried out a risk assessment and did not have procedures in place for the management and testing of the water supply for the presence of legionella (a type of bacteria found in the environment which can contaminate water systems in buildings) at the headquarters site.

Equipment

Staff had access to appropriate equipment to safely meet patients' needs. There was a range of appropriate equipment in place. This included patient couches, access to a defibrillator and oxygen, sharps boxes (for the safe disposal of needles), electrocardiogram (ECG) machines (equipment to record electrical activity of the heart to detect abnormal rhythms and the cause of chest pain) and fire extinguishers. We looked at a sample of medical and electrical equipment. We saw regular checks took place to ensure the equipment was in working condition. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of calibration of relevant equipment; for example, blood pressure monitoring equipment.

The service leased 10 vehicles for use on home visits. Two of these were 4 x 4 type cars to enable staff to travel during severe weather conditions. The vehicles were regularly serviced and checks on the condition of the cars were carried out by the drivers at the start and end of each shift. We saw documents confirming these checks and services had been carried out.

Staffing and recruitment

We saw the service had an up to date recruitment policy in place that outlined the process for appointing staff. These included processes to follow before and after a member of staff was appointed. We looked at a sample of personnel files. We found the appropriate recruitment checks had been completed. For instance, written references had been obtained from previous employers, and employment history information had been provided.

All staff that were in contact with patients had been subject to Disclosure and Barring Service (DBS) checks, in line with the recruitment policy. All of the GPs had undergone DBS checks as part of their application to be included on the National Medical Performers' List. All performers are required to register for the online DBS update service which enables NHS England to can carry out status checks on their certificate.

We were told the GPs working within the service were mainly practicing GPs from the local area. This meant patients were seen by experienced GPs who were familiar with the local health and social care services. GPs working at the six centres were able to seek support from senior staff at all times. The computer systems and telephones were linked to the headquarters and a team leader was on duty to ensure the smooth running of the shift.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Weekly meetings were held for line managers to review staffing levels and identify any gaps. The service had a dedicated 'rota team' and used a computerised system to plan staffing levels. We saw there was a rota system in place for all the different staffing groups to ensure there were enough staff on duty. A

Good

Are services safe?

forecast model was used to assess the number of staff required, this took into account the number and type of calls made during previous similar time periods. Staff felt this system worked well. There was also an arrangement in place for members of staff to cover each other's annual leave.

We asked the head of governance how they assured themselves that GPs employed by the service continued to be registered to practice with the General Medical Council (GMC). They told us they regularly checked staff's registration status. Regular checks were also carried out on GP's professional indemnity insurance, to ensure this was in place and covered the GPs for working in the out-of-hours service. We saw records which confirmed these checks had been carried out.

Monitoring safety and responding to risk

The service had developed clear lines of accountability for all aspects of patient care and treatment. There were designated leads for areas such as safeguarding and infection control. Each clinical lead had systems for monitoring their areas of responsibility, including routine checks to ensure staff were using the latest guidance and protocols.

The service had well established risk management systems in place and had been accredited with the International Standard ISO 31000 (Risk Management).

The head of governance showed us a number of risk assessments which had been developed and undertaken; including a fire and a health and safety risk assessment. Risk assessments of this type helped to ensure the service was aware of any potential risks to patients, staff and visitors and planned mitigating action to reduce the probability of harm. As part of the ISO 31000, regular external audits were carried out before the service could be reaccredited with the Standard.

There were systems in place to manage and monitor health and safety. There was an up to date policy; this was on display in the headquarters, was available on the computer system and hard copies were held at each of the six centres. Staff received regular training on health and safety, including fire safety awareness.

The service had arrangements in place for reporting and reviewing any significant events which occurred. A policy was available for staff to refer to, so they knew how to report incidents for investigation. All of the staff we spoke with were aware of these arrangements.

Arrangements to deal with emergencies and major incidents

The service had arrangements in place to manage emergencies. We saw records showing relevant staff had received training in basic life support.

Emergency equipment was available including access to oxygen and a defibrillator (used to attempt to restart a person's heart in an emergency). Specific equipment was held at the headquarters location. All of the other sites were within hospital sites and close to either accident and emergency departments or minor injuries units, which held the necessary equipment and medicines. Staff at all sites knew the location of this equipment.

Emergency medicines were available in a secure area of the headquarters and all staff knew of their location. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked at the headquarters site were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the service, such as power cuts and adverse weather conditions. Risks were identified and mitigating actions recorded to reduce and manage the risk. For example, the computer system could be accessed from various sites and calls could be taken from other services within the company if ever necessary. The service had an arrangement with a voluntary organisation which would provide heavy vehicles in the event of extreme weather, so staff could still visit patients in remote or hard to reach areas.

Staff knew what to do in the event of an emergency evacuation. All fire equipment was tested and maintained in line with manufacturers' guidelines. Fire alarms tests and checks were carried out regularly at each of the sites.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered considering recognised best practice standards and guidelines. GPs demonstrated an up to date knowledge of clinical guidelines for caring for patients. There was a strong emphasis on keeping up to date with clinical guidelines, including guidance published by professional and expert bodies. The service undertook regular reviews of clinicians' calls and any referrals to other services to ensure current guidance was being followed.

All clinicians we interviewed were able to describe and demonstrate how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local health commissioners. New guidelines and the implications for the service's performance and patients were discussed at the monthly clinical management team meetings. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

We found from our discussions with the GPs that staff completed, in line with NICE guidelines, thorough assessments of patients' needs, often with limited information available to them. Patients we spoke with said they felt well supported by the GPs with regards to decision making and choices about their treatment.

Interviews with seven GPs demonstrated that the culture within the service was to refer patients onto other services on the basis of their assessed needs, and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The service had arrangements in place to monitor performance; audits of clinical and non-clinical practice took place throughout the year. The head of governance told us a clinical audit policy was currently being prepared, although this was still at a draft stage.

Audits covered areas including call handling, response times, prescribing, use of controlled drugs, health and safety and infection control. The results of the audits were reported back to management team meetings.

There was a system in place for completing clinical audit cycles, which generally led to improvements in clinical care. We saw a number of clinical audits had recently been carried out. The results and any necessary actions were discussed at the clinical team meetings.

An audit of prescribing in patients diagnosed with urinary tract had been completed. An initial audit was carried out in January 2014. This demonstrated that 30% of patients were prescribed medicines other than those recommended in the first instance. Measures were put into place to improve prescribing, although these were not shared with staff. The second cycle of the audit in May 2014 demonstrated that performance had not improved. Staff told us the recommendations had since been shared and a further re-audit would take place to measure performance.

The service used data from the National Quality Requirements (NQRs) for out-of-hours services to compare outcomes for patients. NQR performance reports were prepared and shared with relevant stakeholders. We looked at a sample of reports and they showed performance was in line with other out-of-hours providers nationally.

Effective staffing

Service staffing included medical, managerial, administrative staff and drivers. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as basic life support.

The continuing development of staff skills and competence was recognised as integral to ensuring high quality care. Role specific training was provided. Monthly training sessions were provided for all clinical staff and they were provided with a seasonal clinical bulletin which included several 'learning points'. The service provided staff with equality and diversity training. Staff were proactively supported to acquire new skills and share best practice. For example, one of the pharmacy team members was being supported to undertake a professional pharmacy technician qualification. A member of staff from the finance department was in the process of studying for an accountancy qualification. Staff told us they had sufficient access to training and were able to request further training where relevant to their roles.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation (in order to be eligible for revalidation all GPs must take part in annual

Good

Are services effective?

(for example, treatment is effective)

appraisal over a five year period and satisfy the criteria set by the General Medical Council (GMC), only when the GMC have agreed that these criteria have been satisfied is a doctor revalidated and their licence to practice renewed. GPs who have a valid licence to practice can remain on the Performers List held by NHS England).

All other staff had regular 'one to one' meetings with their line manager. Staff told us they felt supported. We looked at a sample of staff files and saw that annual appraisals took place for clinical staff. However, non-clinical staff did not have formal appraisals where for example, training needs were identified. We raised this with the head of governance. They were aware that this was an area for development and had begun to take steps to ensure staff received annual appraisals.

The service had a comprehensive approach to the induction of new staff. We saw all new staff were provided with an induction pack and received a comprehensive, formal induction to the service. This was monitored by the human resources team and provided new staff with opportunities to learn about the service and their own specific role. Staff were encouraged to take the time reflect on what they had learned and regular reviews took place throughout the induction period.

The patients we spoke with were complimentary about the staff. Staff we spoke with and observed were knowledgeable about the role they undertook.

Working with colleagues and other services

The service worked closely with other health and social care providers, to co-ordinate care and meet people's needs.

There were six centres where patients could attend to see a GP. All of these were located within local NHS hospitals, this facilitated good working relationships between the services. We spoke with staff based at each centre and they confirmed that staff worked well together.

In addition to the routine out-of-hours cover, the service supported local GP practices during times when they were closed for staff training or development. This working relationship had been extended in the North Tyneside area, the service had a contract to provide support to GP practices during normal opening hours (Acute Visiting Service). NDUC GPs carried out home visits on behalf of practices which were either experiencing high demand or unplanned staff shortages.

We spoke with representatives from several GP practices and they all commented on the positive working relationship with the service.

Staff across the service had established links with social workers and local mental health teams to enable them to fully address the needs of patients.

We found appropriate end of life care arrangements were in place. We saw there were procedures in place to record information from other services about any patients on a palliative care pathway.

Information sharing

The service had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. This software enabled information about patients to be shared with their own GP. We saw that such information was shared promptly to enable continuity of care.

In addition to the patient notes, if a GP felt there was a need to highlight an issue to a patient's own GP, there was a system to facilitate this. The 'Post Event Messaging Service' (PEMS) had been set up to ensure this information was shared.

Regular staff meetings were held. These included team meetings, clinical meetings and multi-disciplinary team meetings. Information about risks and significant events were shared openly at meetings. Information was shared with clinical staff via email if urgent or within the seasonal clinical bulletins. The service had an intranet system which contained a wealth of information for staff.

Consent to care and treatment

Before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. There was a policy on consent, this provided guidance for staff on when to document consent.

Staff were all able to give examples of how they obtained verbal or implied consent.

GPs we spoke with showed they were knowledgeable about how and when to carry out Gillick competency assessments of children and young people. Gillick

Good

Are services effective?

(for example, treatment is effective)

competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

We found that staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. Some staff had received specific training on consent and the MCA. Decisions about or on behalf of people who lacked mental capacity to consent to what was proposed were made in line with the MCA. The GPs described the procedures they would follow where people lacked capacity to make an informed decision about their treatment.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with seven patients during our inspection. They were all happy with the care they received. People told us they were treated with respect and were very positive about the staff.

Staff were familiar with the steps they needed to take to protect people's dignity. Consultations took place in purpose designed consultation rooms with appropriate couches for examinations and curtains to maintain privacy and dignity. We noted that consultation and treatment room doors were closed during consultations and conversations taking place in those rooms could not be overheard.

We saw the reception staff treated people with respect and ensured conversations were conducted in a confidential manner. Staff spoke quietly so their conversations could not be overhead. Staff were aware of how to protect patients' confidential information. There were rooms available if patients wanted to speak to the receptionist privately. Staff were very knowledgeable about the service and recognised when an issue raised by a patient was an emergency.

Staff were aware of the need to keep records secure. We saw patient records were all computerised and systems were in place to keep them safe in line with data protection legislation.

The service had policies in place to ensure patients and other people were protected from disrespectful, discriminatory or abusive behaviour. The staff we spoke with were able to describe how they put this into practice.

Care planning and involvement in decisions about care and treatment

Patients told us they felt they had been involved in decisions about their care and treatment. They said the clinical staff gave them plenty of time to ask questions and responded in a way they could understand. They were satisfied with the level of information they had been given.

We saw that access to interpreting services was available to patients, should they require it. Staff said when a patient requested the use of an interpreter, they would contact the team leader at the headquarters site. The team leader would then arrange for an interpreter to speak with the patient and clinician on the telephone.

Male and female GPs were available and patients were offered a choice of locations to attend. GPs described how they recorded a summary of their consultation with the patient. This included past medical history and details of current medication being taken. They involved patients in the decisions about the next steps and discussed any relevant treatment options with them.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with during our inspection told us staff responded compassionately when they needed help and provided support.

We saw that the vehicles used by GPs for home visits contained bereavement literature for carers and families, with contact details for other support organisations. GPs could also access the service computer system from the laptop computers they carried with them if they needed any further details. Information about opening hours of local pharmacies was available to give to patients where necessary.

Patients we spoke with said they were appropriately supported and offered information about what they should do should their condition change or worsen, as well as information about how to support their recovery. Patients said they were very clear when they needed to see their own GP and that when they attended their own practice for a follow up it was clear the out of hours service had communicated the care and treatment they had received.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The service was responsive to the needs of the local population. Patients we spoke with said they felt the service met their needs. For example, patients could either receive a telephone call back from a clinician, be visited at their home or were offered an appointment with a GP at a local centre.

There were six centres based at hospital sites throughout the Northumberland, Newcastle and North Tyneside areas. In addition, the headquarters site in Newcastle was used as a further centre during the night and during times of high demand. Patients could choose which centre to attend up until 11.30pm. All centres had sufficient car parking which was close to the service. Patients we spoke with said the sites were conveniently located.

Patients we spoke with told us the service met their needs and they felt they had sufficient time during their appointment.

The service engaged regularly with the local Clinical Commissioning Groups (CCGs) across the area to discuss local needs and service improvements that needed to be prioritised. Managers told us they had a close working relationship with the local CCGs and took part in many initiatives. For example, the service had a contract with the North Tyneside CCG to provide support to GP practices during normal opening hours (Acute Visiting Service). The service's GPs carried out home visits on behalf of practices which were either experiencing high demand or unplanned staff shortages.

The service worked collaboratively with other agencies, regularly updating shared information to ensure good, timely communication regarding patients seen and any treatment or medicines given. The Department of Health published a set of National Quality Requirements (NQRs) for out of hours service providers (under the primary medical care contracts introduced in April 2004, all those who provide out of hours services have to meet the NQRs). NQR Two relates to sending details of all consultations to the practice where the patient was registered by 8.00am the following morning. We saw performance reports which showed the service met this target. We also spoke with some GPs from the local area; they all confirmed that information about their patients who had accessed the service was provided on a timely basis.

NQR Three relates to the need to have systems in place to support and encourage the regular exchange of up to date and comprehensive information between those providing care to patients with predefined needs (including, for example, patients with a terminal illness). The service operated a 'special patient register' (SPR). Forms with the relevant information were completed by the patient's own practice and shared with NDUC. This meant the information was available if a patient or carer contacted the service. The service had taken additional steps to enhance the system; an online tool, containing the SPRs was developed which out of hours staff could access via the service's computer system.

The head of governance told us there were some limitations with linking the service's computer system to the GP practice systems. The service was therefore developing their own system which would link directly into the GP practice systems. This had been successfully trialled and was to be rolled out by the end of 2015.

Tackling inequity and promoting equality

Each site was accessible to all patients, for example, doors were automatic and we saw the consulting rooms were large with easy access for all patients. There were toilets that were accessible to disabled patients and baby changing facilities for use at each site.

Only a small minority of patients did not speak English as their first language. Staff told us that usually the patient was accompanied by a family member or friend who would translate for them. There were arrangements in place to access telephone interpretation services if patients were not accompanied.

The service treated any patient who lived within the area served, irrespective of ethnicity, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met. Staff told us they had undertaken equality and diversity training, we saw records confirming this.

Access to the service

Patients could access the service between 6.30pm and 8.00am Monday to Friday and 24 hours throughout Saturday, Sunday and Bank Holidays. Calls to the service

Good

Are services responsive to people's needs?

(for example, to feedback?)

were handled by North East Ambulance Service (NEAS) via the 111 telephone number. The service operated a triage model where all patients had clinical telephone assessments.

Calls to the service were continuously monitored. There was a large electronic board in the operations room which detailed the numbers of calls coming in and how many were being dealt with at any one time. Calls could not be missed as the computer system and electronic board were synchronised.

If a patient needed to see a GP then an appointment would be made for them to attend one of the six centres. The centres were open between 6.30pm and 11.30pm. After this time patients could see a GP at the headquarters site in Newcastle. Home visits were also available where necessary.

NQR 12 states that 'Face-to-face consultations (whether in a centre or in the patient's place of residence) must be started within the following timescales, after the definitive clinical assessment has been completed:

- Emergency: Within 1 hour
- Urgent: Within 2 hours
- Less urgent: Within 6 hours

We looked at the performance data for the service for 2014 and saw targets were achieved in all months except December. We spoke with staff about this. They told us this was due to unprecedented high demand on two days during the month. Contingency plans were put into place during these days, this included 'comfort calls' to patients.

The most recent National GP Patient Survey (2015) showed the percentage of patients who said it was very or fairly easy to contact the service by telephone was 77% (above the national average of 75%).The proportion of patients who felt care was provided on a timely basis was 58%, which was slightly below the national average (60%).

Listening and learning from concerns and complaints

The service had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and there was a designated responsible person who handled all complaints in the service

None of the seven patients we spoke with during the inspection said they had felt the need to complain or raise concerns with the service.

Staff we spoke with were aware of the complaints policy. They told us they would deal with minor matters straight away, but would inform the team leader of any complaints made to them. Patients could therefore be supported to make a complaint or comment if they wanted to.

Complaints received had been reviewed as part of the service's formal annual review of complaints. Where mistakes had been made, it was noted the service had apologised formally to patients and taken action to ensure they were not repeated. Complaints and lessons to be learned from them were discussed at staff meetings. Staff we spoke with felt involved in the process.

We looked at some of the complaints the service had received. We saw these had all been thoroughly investigated. The complainant had been communicated with throughout the process and the service apologised when they did not do as well as they should have done. We saw the clinicians involved had reviewed what had happened and what could be learnt to prevent a reoccurrence. For example, further training had been provided following a complaint about a GP's attitude. When complaints were received the telephone calls to and from the service were reviewed to ascertain whether there were any learning points. Some of these calls were then recorded and used for training purposes.

Are services well-led?

Good

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

Our findings

Vision and strategy

The service had a clear vision to provide clinically safe and timely medical advice for the population of Northumberland, North Tyneside and Newcastle. The mission statement was outlined on the service's website and was on display in the headquarters reception area. This referred to providing 'Right Care, Right Time, Right Place.

Staff told us they knew and understood what the service was committed to providing and what their responsibilities were in relation to these aims. They all told us they put the patients first and aimed to provide person-centred care. We saw that the regular staff meetings helped to ensure the vision and values were being upheld within the service.

Quarterly strategic planning meetings were attended by the Chief Executive and the head of governance. These meetings were also used to reaffirm what the service did well, what its priorities were for the year ahead, and what changes needed to be made to make further improvements to patient outcomes.

Governance arrangements

The service had a well-established governance framework. There were a number of policies and procedures in place to govern activity. These were available to staff via the shared drive on any computer within the service, whether based at the headquarters or one of the six centres. All of the policies and procedures we looked at had been reviewed regularly and were up-to-date. The service's computer system enabled the governance team to verify that staff had read any new policies or procedures.

There was a management team in place to oversee the service. They held regular governance meetings where matters such as performance, quality and risks were discussed. There were arrangements in place for ongoing reviews of all functions. This included a 'telephone triage review', where calls by doctors to patients were randomly selected for review. Each new doctor had five calls reviewed during their first three months working for the service. Four calls throughout the year were reviewed for all other doctors. Results and any learning points were then shared with the doctors.

The North East Ambulance Service was the host organisation for the 111 service. Their staff triaged calls and referred patients to NDUC as necessary. The organisations had an agreement in place for reviewing performance. A 'Health Professional Feedback Form' was completed if there were any issues of concern identified. The head of governance then held monthly meetings to share information and review any areas for improvement.

The leadership team actively encouraged staff to be involved in development of guidelines and practice procedures. This was confirmed when we spoke with staff, they were able to give examples of where they had made suggestions and these had been acted upon. This included the development of a new policy on safe driving by the lead driver. We found that staff felt comfortable to challenge existing arrangements and looked to continuously improve the service being offered.

The service participated in external peer review with other out of hours providers, in order to compare data and identify areas for improvement (peer review enables services to access feedback from colleagues about how well they are performing against each other and national standards).

There was a system in place for completing clinical audit cycles, although this was not always followed. Examples of clinical audits included; a review of medication prescribed to patients with urinary tract infections and an audit of palliative care. The palliative care audit resulted in changes in practice by clinical staff. However, the findings and recommendations of the medication audit had not been shared with staff and performance had not therefore improved. A number of internal reviews had been completed, including regular infection control and prescribing audits.

Staff told us they were aware of the decision making process. Their roles were discussed during appraisals and staff were clear what they were accountable for. For example, staff who worked within reception demonstrated to us they were aware of what they could and couldn't do with regards to cancelling appointments.

Leadership, openness and transparency

The service had a clear leadership structure designed to support transparency and openness. There was a well-established management team with clear allocation of responsibilities. We spoke with staff from different teams;

Are services well-led?

Good

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

they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the service with any concerns.

Staff told us that the service was well led. We saw that there was strong leadership within the service and the managers were visible and accessible. Managers had a good understanding of, and were sensitive to, the issues which affected patients and staff.

The senior management team met representatives of the local clinical commissioning groups (CCGs) regularly to discuss performance and capacity. Monthly performance reports were provided for each CCG, these showed whether the service had performed in line with contractual obligations. The service was open and transparent when targets had not been achieved. We reviewed a sample of the monthly reports; they highlighted areas where standards had not been met, and outlined any corrective action taken.

Records showed that regular meetings took place for all staff groups. Staff told us that the departmental managers and team leaders were very supportive. We saw examples where staff had been supported and encouraged to develop their skills through discussions at team meetings.

We found the service learned from incidents and near misses. Significant events meetings were held where such issues were discussed. Lessons learned from these discussions were shared with the relevant team members.

Service seeks and acts on feedback from its patients, the public and staff

The service had made arrangements to seek and act on feedback from patients and staff. The head of governance told us they had been proactive in seeking feedback. There was a section on the website where patients could submit comments or suggestions and suggestion boxes in the waiting rooms. Information from patient complaints was reviewed and changes made to processes where necessary.

A patient survey had been undertaken by the service in October 2014. The results were very positive, with 100% of patients rating their treatment on the phone as very good or excellent.

The service gathered feedback from staff through staff meetings, appraisals and informal discussions. An 'Employee Consultative Committee' had been established; this group was chaired by the Chief Executive and members of staff from each team were elected to represent their colleagues. The committee met quarterly and minutes were shared with all staff.

Staff we spoke with told us their regular team meetings also provided them with an opportunity to share information, changes or action points. They confirmed they felt involved and engaged in the running of the service.

The service had whistleblowing procedures and a detailed policy in place. Staff we spoke with were all able to explain how they would report any such concerns. They were all confident that concerns would be acted upon.

Management lead through learning and improvement

The service had management systems in place which enabled learning and improved performance.

The service demonstrated its strong commitment to learning by providing various opportunities; including monthly educational sessions and seasonal clinical bulletins for the GPs. This provided the clinical team with dedicated time for learning and development. The GPs we spoke with during the inspection all told us they felt supported in terms of training.

Staff told us that the service supported them to maintain their professional (clinical and other professions such as pharmacy technicians) development through training and mentoring.

The management team met monthly to discuss any significant incidents that had occurred. Reviews of significant events and other incidents had been completed and shared these with staff. Staff meeting minutes showed these events and any actions taken to reduce the risk of them happening again were discussed.

Two detailed reviews of the service were carried out each year. 'A day in the life of' sessions were attended by various managers and team leaders, including operations staff, clinicians, the head of governance and the local clinical director. All activities (initial telephone calls, triage calls, home visits and centre consultations) from a particular day were reviewed in detail. The team considered whether the advice given and patient pathways were appropriate. Any learning points were disseminated to staff, usually within the seasonal clinical bulletin.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.