Nestor Primecare Services Limited t/a Primecare Primary Care- Birmingham

Quality Report

Crystal Court
Aston Cross Business Village
Rocky Lane
Aston
Birmingham
B6 5RH
Tel: 01785 783311
Website: www.primecare.uk.net

Date of inspection visit: 14 April 2015
Date of publication: 10/09/2015

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

Ratings

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

Summary of findings

Contents

Summary of findings

Overall summary

We carried out an announced comprehensive inspection at Nestor Primecare Services Limited t/a Primecare Primary Care - Birmingham on 14 April 2015. The Birmingham branch operates it's out of hours service from a main office and across five sites referred to as primary care centres. Overall the service is rated as requires improvement.

Specifically, we found the service to require improvement for providing safe, caring and well led services. It was good for providing an effective and responsive service.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses that may have resulted in people being. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed at a corporate level. However, arrangements for identifying and managing local risks were not well defined.
- Data showed the organisation was mostly meeting performance standards on a regular basis and patients were seen according to priority. We saw evidence of an annual audit of the Birmingham branch of the out-of-hours service and this showed improvement.
- Feedback we received from patients about the service was positive. However, we identified concerns in relation to confidentiality during our inspection in which personal confidential information had been left visible in the back of a car used by the out-of-hours service.
- Information about services and how people could complain about services they received was inconsistent between the primary care centres.
- The service had a number of policies and procedures to govern activity. These had been regularly updated with reference to current best practice guidance. Regular governance meetings were held but were largely focused at an organisational level.
- The service sought feedback from staff and patients which was reviewed corporate staff rather than locally to identify any emerging themes.

The areas where the provider must make improvements are:

- Maintain an accurate audit trail for the location of medicines.
- Develop local arrangements and clear lines of accountability for the management of risks relating specifically to the Birmingham branch. For example local trends in relation to incidents, audits, patient feedback and complaints.
- Ensure consistent information is available and visible to patients who attend the primary care centres in relation to complaints.
- Ensure staff are aware of the importance of maintaining confidential patient information.

The areas where the provider should make improvements are:

- Ensure staff are aware who the safeguarding lead for the service is so that they know who contact for support and advice if needed.
- Implement systems to ensure all equipment requiring regular testing for electrical safety and calibration is not missed, including emergency equipment checks.
- Improve signage for patients who need to access the out-of-hours service located at Sandwell General Hospital.

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?

Requires improvement

The service is rated as requires improvement for providing safe services, as there are areas where improvements must be made. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons had been learnt and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Although risks to patients who used services were assessed and managed at a corporate level, the systems and processes to address local risks were limited. For example there were no robust systems for identifying and responding to local trends relating to incidents, patient feedback and complaints and for ensuring policies and procedures were locally implemented. We identified continuing concerns since our previous inspection with the management of medicines. Although some improvement in the management of medicines had been noted there was still a lack of local monitoring, policies and procedures were not consistently followed and audit trails were not always available to ensure the whereabouts of medicine boxes was known. There were enough staff available keep patients safe.

Are services effective?

Good

The service is rated as good for providing effective services. Best practice guidance such as those from the National Institute for Health and Care Excellence was referred to in policies and procedures and routinely shared with staff. Patients' needs had been assessed and care was planned and delivered in line with current legislation and guidelines for providing unscheduled (out-of-hours) care. Staff had received training appropriate to their roles and were supported and encouraged to continue their learning and development. Regular performance reviews took place for all staff through which any further training and development needs were identified and plans were put in place to meet these needs.

Are services caring?

Good

The service is rated as good for providing caring services. Feedback from patients about the service was mostly positive. We observed staff treating patients with dignity and respect. Information was available to support patients who were recently bereaved.

Are services responsive to people's needs?

Good

The service is rated as good for providing responsive services. It was aware of the needs of its local population and engaged with commissioners to deliver services to meet those needs. Feedback

Summary of findings

received from patients told us that they were happy with their experience of using the out-of-hours service and getting the support they needed. The service was equipped to meet patients' needs. Signage should be improved to assist patients finding services at the primary care centre in Sandwell. Information available on making a complaint was inconsistent across the primary care centres but when received complaints were appropriately managed and learning from complaints shared.

Are services well-led?

Requires improvement 

The service is rated as requires improvement for being well-led. The provider had clearly set out its vision and values for the service and staff we spoke with wanted to provide an excellent service but were not specifically aware of the vision and values. There was a documented leadership structure and most staff felt supported by management. Systems to monitor and improve quality and identify risk were well established at a corporate level. There were robust policies and procedures in place to govern activity and governance meetings held to discuss organisational risks. However, there was a disconnection between corporate and local management. Responsibility for ensuring policies and procedures were fully implemented at a local level were not always clear for example, in relation to medicines, safeguarding and identifying and acting on local issues. The provider sought feedback from patients but the provider was unable to produce evidence to show that this was used to review and improve the local service. Staff had received inductions, regular performance reviews and attended meetings on a regular basis to keep them informed.

Summary of findings

What people who use the service say

As part of our inspection we spoke with four patients who used the out-of-hours service. The patients we spoke with all told us that they were satisfied with the service they had received and had not had to wait too long to be seen.

Prior to our inspection we sent the provider comment cards to distribute at the five primary care centres inviting patients to tell us about their experience of using the service. We received 11 responses. Most of these were from the Broadway Primary Care Centre. The comments received were all positive. Patients described staff as helpful and were happy with the care they received.

We looked at the results of the patients' satisfaction survey for the Birmingham branch of Primecare. The survey asked patients to rate the service across areas such as parking, the location, their consultation, how they were greeted, waiting times and overall satisfaction. The service had not analysed the results of the Birmingham branch results, however, the results seen indicated that the majority of patients rated the service positively across these areas and there were no clear themes emerging.

Areas for improvement

Action the service MUST take to improve

- Maintain an accurate audit trail for the location of medicines.
- Develop local arrangements and clear lines of accountability for the management of risks relating specifically to the Birmingham branch. For example local trends in relation to incidents, audits, patient feedback and complaints.
- Ensure consistent information is available and visible to patients who attend the primary care centres in relation to complaints.
- Ensure staff are aware of the importance of maintaining confidential patient information.

Action the service COULD take to improve

- Ensure staff are aware who the safeguarding lead for the service is so that they know who contact for support and advice if needed.
- Implement systems to ensure all equipment requiring regular testing for electrical safety and calibration is not missed, including emergency equipment checks.
- Improve signage for patients who need to access the out-of-hours service located at Sandwell General Hospital.

Nestor Primecare Services Limited t/a Primecare Primary Care- Birmingham

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP Specialist Advisr, a practice manager, five CQC inspectors (including a CQC pharmacist inspector).

Background to Nestor Primecare Services Limited t/a Primecare Primary Care- Birmingham

Nestor Primecare Services Limited t/a Primecare Primary Care- Birmingham provides primary care medical services outside usual working hours (out-of-hours or OOH) when GP practices are closed. The service covers a population of approximately 1.5 million and holds contracts to provide out of hours services with a number of Clinical Commissioning Groups (CCGs). These are Birmingham Cross City CCG, South Birmingham CCG, Sandwell and West Birmingham CCG and Wolverhampton CCG. Patients access the out-of-hours services provided by Nestor Primecare via the NHS 111 service or directly if their GP service has subcontracted with them to provide primary medical services when they are closed.

Crystal Court is the main office for the Birmingham branch. This is where calls are received and triaged. Patients who need to be seen by a clinician are seen as a home visit or are referred by appointment to one of the five primary care centres located in Birmingham, Sandwell, Dudley and Wolverhampton. They include:

Broadway Health Centre, Cope Street, Birmingham, B18 7BASandwell General Hospital, All Saints Way, B71 1RU

Neptune Health Centre, Sedgley Road West, Tipton DY4 8PXSelly Oak Health Centre 15 Katie Road, Birmingham, B29 6JGPhoenix Health Centre, Parkfield Road Wolverhampton WV4 6ED

All the primary care centres are open in the evening Monday to Friday and four of the primary care centres are open at the weekend. Opening times vary slightly between the five primary care centres.

The service is predominantly GP led. There are approximately 108 clinicians contracted on a sessional basis or through an agency to provide the out of hours service.

The service was previously inspected as a pilot site for the new CQC inspection methodology in March 2014 where we identified concerns relating to medicines management and the management of complaints.

Detailed findings

Why we carried out this inspection

We inspected Nestor Primecare Services Limited t/a Primecare Primary Care - Birmingham as part of our new comprehensive inspection programme.

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

Please note that when referring to information throughout this report this relates to the most recent information available to the CQC at that time.

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 visiting, we reviewed a range of information that we hold about the service and asked other organisations to share what they knew. We also reviewed information we had requested from the provider.

We carried out an announced visit on 14 April 2015. During our inspection we visited the main office, central stores and three primary care centres in Dudley, Wolverhampton and Sandwell. We spoke with 16 members of staff including GPs, clinical and operational managers, administrative staff, receptionists and drivers.

We spoke with four patients who were attending the primary care centres we visited and reviewed the 11 comment cards where patients were able to share their views and experiences of the service received.

We reviewed the treatment areas and viewed the cars used to transport clinicians to consultations in patients' own homes.

Requires improvement

Are services safe?

Summary of findings

The service is rated as requires improvement for providing safe services, as there are areas where improvements must be made. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons had been learnt and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Although risks to patients who used services were assessed and managed at a corporate level, the systems and processes to address local risks were limited. For example there were no robust systems for identifying and responding to local trends relating to incidents, patient feedback and complaints and for ensuring policies and procedures were locally implemented. We identified continuing concerns since our previous inspection with the management of medicines. Although some improvement in the management of medicines had been noted there was still a lack of local monitoring, policies and procedures were not consistently followed and audit trails were not always available to ensure the whereabouts of medicine boxes was known. There were enough staff available keep patients safe.

Our findings

Safe track record

The provider used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. Awareness of clinical incident reporting and reminding staff of the importance of reporting had been highlighted in the provider's patient safety newsletter which was distributed to all staff. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example an incident had occurred when a patient had gone against medical opinion and refused admission to hospital and subsequently died. This had led to raising awareness of consent and capacity among staff. Guidance on consent and capacity was discussed along with various case studies to help staff to better understand and support patients when making difficult decisions.

We saw summary reports of incidents and complaints reported during the last 12 months. There was evidence of regular monitoring and action taken in response to issues raised. This showed that safety information was consistently managed over time and could show a safe track record.

Learning and improvement from safety incidents

The out-of-hours service had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw records of significant events that had occurred during the last year and we were able to review these. Evidence seen showed that they were thoroughly investigated, with action taken as a result. Managers told us that any individual learning took place with staff involved and where appropriate wider learning was identified and shared with relevant staff through a series of case studies in the patient safety newsletter.

Staff had access to an incident reporting system through the out-of-hours service intranet site although they told us that they tended to notify the duty manager who would record the incident for them. One primary care centre we visited showed us a report they routinely completed at the

end of the shift on which they would report any breaches in performance and incidents that had occurred during the shift to raise with managers. However, we did not see this used at the other two primary care centres visited.

We saw that significant events (events from which staff may learn from to help improve the service) were managed at provider level and that one of the clinical services managers from the Birmingham branch of Primecare would attend the meetings in which they were discussed. Feedback and learning from significant events that had occurred across the organisation and not just the Birmingham branch was fed back through the patient safety newsletter. We asked about local arrangements for identifying and discussing incidents specific to the Birmingham branch but there were none. This would enable the local service to identify any themes or trends locally that needed to be addressed.

National patient safety alerts were disseminated and action monitored by the Clinical Services Managers to relevant staff and via email to those who worked remotely. Staff were able to provide an example of a safety alert that had recently been acted upon involving a defective defibrillator pad. Checks had been made to identify whether this particular pad was in use. Staff told us that relevant alerts were also included in the patient safety newsletter to ensure staff were made aware.

Reliable safety systems and processes including safeguarding

The out-of-hours service had systems to manage and review risks to vulnerable children, young people and adults. A recent audit of staff training in February 2015 showed that 100% of staff were up to date with safeguarding vulnerable adults and 98% with child protection. We saw records to show that safeguarding training was monitored and staff were sent reminders to update their training when it was due. Staff had access to safeguarding policies via the intranet which described signs and symptoms of abuse and what signs to look for when undertaking telephone as well as face to face consultations. Staff we spoke with demonstrated an understanding of their responsibilities in reporting safeguarding concerns to the appropriate authorities for investigation. We were given examples of situations where referrals had been made. Contact details for the local authority who investigate safeguarding concerns were available on the provider's intranet or through the duty manager. However, we found that staff were not clear who the safeguarding lead was for this service should they wish to discuss any safeguarding concerns or needed advice. We identified that this was the case at our previous inspection in March 2014.

There was a system to highlight vulnerable patients on the service's electronic record system. However, staff told us that this depended on other providers giving them this information. There were also processes in place for following up patients who could not be contacted after calling the NHS 111 service to ensure they were followed up.

There was a chaperone policy in place. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Chaperone duties were carried out by drivers and receptionists who had been trained to be a chaperone. Reception staff and drivers we spoke with confirmed they had received training and knew they needed to stand where they would be able to observe the examination. Information advising patients that they could request a chaperone if they wished was only seen displayed in one of the three primary care centres we visited.

Medicines management

At our previous inspection in March 2014 we found that the management of medicines was not robust. We had found a lack of clear audit trail for medicines used. Policies and procedures in relation to the receipt of controlled drugs, prescription pads and for securing medicine boxes after use to minimise the risks of unauthorised access were not being followed. At this inspection we found improvements had been implemented but there remained a lack of local accountability for ensuring improvements made were sustained.

We found the provider had appropriate policies and procedures in relation to the management, safe storage and checking of medicines used to treat patients. Staff were required to sign to say they had read and understood these policies however, we found that the provider was unable to evidence that these policies and procedures had been read and understood by appropriate staff members as systems in place were not sufficiently robust.

We visited two locations, which were the main areas where medicines were prepared and stored ready for use by GPs

working out of the primary care centres or carrying out home visits. Since the last inspection the service had made changes to the way the duty doctors' boxes were managed. We found that the colour coded tagging system that was used to identify whether medicines needed replenishing had been simplified. Records were maintained of medicines used from the boxes. Boxes with insufficient stock were replenished at a central location by a dedicated team who would audit medicines used against a computer prescribing system.

Restocked boxes were securely stored at the main office to await collection by GPs and drivers on duty for use on home visits and at the primary care centres. We found that the service had a system for recording which boxes were being used for home visits; however the provider did not maintain a system for recording which boxes were at one of the five primary care centres and so had no audit trail should a box of medicines go missing.

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. We saw home office licenses were in place for the possession of these drugs. The drugs were appropriately stored in a cabinet accessed by a key code. The code was changed and the drugs were checked each time the controlled drugs cabinet was opened. The provider's standard operating procedures stated that the controlled drugs register must be completed by a doctor and countersigned by a witness. The issue of the process not being carried out under the supervision of a witness had been raised at the last inspection and we saw this had not been resolved. We spoke with the Head of Medicines Management for the provider who told us that a witness was not required. This identified that the provider was not following its own policies and procedures and best practice. We also found that several pages in the controlled drugs register were loose and there was therefore the risk that information about controlled drugs could be lost if the information needed to be referred to at a later date.

We looked at how prescription pads were issued to duty doctors. Prescription pads are controlled stationary because stolen prescriptions may be used to unlawfully obtain prescription only medicines. We found that the prescription pads were being kept securely and the provider had improved their systems for recording when and who the prescription pads had been assigned to and when they were returned. This record also kept track of the prescription serial numbers so that used prescription could be traced if required.

Cleanliness and infection control

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. They included policies relating to hand washing; use of personal protective equipment; spillages of bodily fluids and safe handling of sharps.

We observed the premises visited during our inspection to be visibly clean and tidy. The primary care centres were located in shared accommodation (hospitals and GP practices). We asked about the cleaning arrangements and were advised by operational managers that this was included in the contractual arrangements which were held by the provider's central management team. Although we asked to see these arrangements they were not made available to us. Feedback we received from patients did not raise any concerns about cleanliness or infection control.

New staff received infection control training as part of their induction. This information was also included in the induction manual which made reference to issues such as hand washing techniques and safe handling of sharps. We saw that staff records contained information about staff immunity. This information is important for staff who are likely to come into contact with blood and other bodily fluids and can help minimise the risk of blood borne infections to patients and themselves.

Staff working at the primary care centres had access to appropriate hand washing facilities and personal protective equipment. Spill kits were also available for safely cleaning away spills including blood or bodily fluids. Staff undertaking home visits who may not have access to hand washing facilities were provided with gloves and hand gels as part of their kit.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Medical equipment included blood pressure monitoring devices, pulse oximeters, stethoscopes and emergency equipment such as an automatic external defibrillator (used to restart a person's

heart in a cardiac emergency). The equipment was checked at the start of the shift to ensure all equipment items were available and we observed a driver undertaking those checks. Staff told us that once each week the equipment was returned to central stores for checks and calibration. We saw that daily checks were also undertaken for the vehicles used to take GPs on home visits. We saw 10 vehicles and saw that these were in good condition.

We saw evidence that relevant equipment testing and maintenance took place. However, the provider did not maintain a register of relevant equipment to ensure items which required electrical safety checks and calibration were not missed. Equipment seen at the primary care centres did not display any up to date information to verify when they were last checked.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The service had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staffing levels and skill mix were based on contractual agreements with the Clinical Commissioning Groups. The service was predominantly delivered by GPs, although some nurses were employed mainly at the Phoenix Health Centre in Wolverhampton. There were dedicated staff that were responsible for managing the rota and ensuring shifts were appropriately staffed. There were systems in place to minimise the risks of clinical staff with work commitments outside the out-of-hours service working excessive hours.

The service relied on the use of locum GPs through an agency to staff the shifts. Data available to us showed that agency use in the last two months of 2014 was consistently over 30%. Managers told us that the agency staff used regularly worked for them and received the same induction as the sessional GPs. We saw evidence of an effective induction plan in place. We were shown a breakdown of the hours worked by individual agency staff in the last three months which showed 65% of the agency staff regularly worked for the service. The provider assured us that they would not use an agency member of staff that had not worked for them before without having received an induction and would reconfigure staffing for that shift if an unexpected absence occurred.

Monitoring safety and responding to risk

Face to face consultations with patients were provided at one of the five primary care centres. These were locations owned and shared with other providers. Managers told us that there were contractual arrangements in place to cover risks such as fire, legionella and cleaning which were held centrally. Although we asked to see these arrangements they were not made available to us and so could not be verified. A health and safety audit had been carried out within the last 12 months at the main office only and this had not raised any major concerns.

The out-of-hours service had a health and safety policy in place and staff received health and safety training and fire training as part of their induction programme. Health and safety information was displayed for staff to see in the main office of the Birmingham branch and there was an identified health and safety representative. There were systems in place to monitor risks to patients which included annual checks of the primary care locations to ensure they met requirements.

There were processes in place for responding to risks relating to patients. Patients who required support from the out-of-hours service were prioritised by the NHS 111 service and seen according to priority. Clinical staff we spoke with were aware of referral processes if patients needed to be referred to hospital. They were also supported by a duty manager throughout the shift who was able to provide details if required. There were processes in place to follow up patients who could not be contacted after their initial call to NHS 111 call and if home visits were likely to be delayed a comfort call was made which enabled the patient's situation to be assessed.

Arrangements to deal with emergencies and major incidents

The out-of-hours service had arrangements in place to manage emergencies. Records seen showed that the majority of staff had received training in basic life support. We saw that basic life support training was a mandatory requirement for all staff and monitoring arrangements were

Requires improvement

Are services safe?

in place to remind staff when refresher training was due. The Clinical Services Managers told us that staff that were not up to date would be flagged and not allowed to work until training was completed.

Emergency equipment was available at the primary care centres and as part of the home visit kit. The emergency equipment included access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart). When we asked members of staff, they knew the location of this equipment. However, there were no records available at the primary care centres to show that the emergency equipment was routinely checked. Staff told us that equipment was returned to the central stores weekly for checks.

Emergency medicines were available for clinicians undertaking home visits and in all the primary care centres. These were kept securely when not in use. Emergency medicines included treatment of anaphylaxis, hypoglycaemia, respiratory and heart emergencies. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. Staff told us that this was carried out by central stores on a weekly basis who would check expiry dates and replenish medicine stocks. Medicine boxes would be tagged to show they were complete.

The provider had business continuity plans in place to deal with a range of emergencies that may impact on the daily operation of the service. There were business continuity plans in place for each of the primary care centres and for the main office where telephone calls were handled. These reflected the different risks relevant to each site. For example, if telephone systems failed the Birmingham branch had a shared agreement with the Cardiff branch to manage calls. We saw contact details were included in the plans for utilities such as gas and electrics and for IT or communication failure.

Good

Are services effective?

(for example, treatment is effective)

Summary of findings

The service is rated as good for providing effective services. Best practice guidance such as those from the National Institute for Health and Care Excellence was referred to in policies and procedures and routinely shared with staff. Patients' needs had been assessed and care was planned and delivered in line with current legislation and guidelines for providing unscheduled (out-of-hours) care. Staff had received training appropriate to their roles and were supported and encouraged to continue their learning and development. Regular performance reviews took place for all staff through which any further training and development needs were identified and plans were put in place to meet these needs.

Our findings

Effective needs assessment

Staff working for the out-of-hours service were provided with information about best practice guidance to support them in their work. We saw that policies and procedures were kept up to date and made reference to various best practice guidance. Clinical staff received patient safety newsletters which presented case studies that referred to guidance. For example, in a recent case study on the management of diabetes reference was made to specific guidance from the National Institute for Health and Care Excellence (NICE). All staff (sessional and agency) were provided with an induction manual which included information about conditions which they might be faced with during the out-of-hours period such as meningitis and diabetes and how to manage these conditions. Information provided included sources of reference that outlined the rationale for the care and treatment cited and for further reading.

Management, monitoring and improving outcomes for people

We found no evidence of clinical audits being undertaken which demonstrated improvements to the service. However, data available from February 2015 showed that the service was meeting the National Quality Requirements (NQRs) relating to the undertaking of audits on a random sample of patient contacts. NQRs are quality standards set out for GP out-of-hours services. There were systems in place for auditing the performance of individual staff. All clinical staff (GPs and nurses) working for the service were audited. This was usually six monthly but varied depending on the outcomes of previous audits and how new they were to the service. The audit tool used was based on an urgent and emergency clinical audit tool. Consultations with patients (face to face and telephone) were audited in areas which included history taking, clinical assessment, and management of the patient's needs. Clinicians received a copy of their audit report with an action plan for improvement. If a clinician failed to meet the required standards they were placed on the risk register and managed more closely and we saw examples of this.

Good

Are services effective?

(for example, treatment is effective)

The provider had also sought to follow up actions following the previous CQC inspection at this service. The provider's action plan had identified that they were making good progress with this, however we found further work was needed as a result of this inspection.

Effective staffing

The out-of-hours service employed staff who had the appropriate skills and training to perform their required duties. This included medical, nursing, managerial and administrative staff. Staff were required by the provider to have up to date training in basic life support, child and adult safeguarding and mental capacity. Compliance with the provider's mandatory training was monitored and we saw emails that had been sent out to staff to remind them when their training needed updating. Staff training records showed high levels of compliance with the provider's mandatory training.

Qualifications and registration with professional bodies such as the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) were monitored to ensure they were kept up to date and that staff met the criteria for their professional body to work in their capacity as a GP or nurse.

New staff, including agency staff, were given induction training which consisted of training in the use of IT systems, policies and procedures, shadowing and mentoring from other clinical staff. We saw that training opportunities were provided; for example telephone triage training was advertised in the patient safety newsletter for staff to sign up to. Staff we spoke with confirmed that training opportunities were made available to them.

There were systems in place to monitor and assess individual staff performance. Clinical staff were monitored against a range of performance measures including reliability, clinical quality, effective use of technology and clinical audit of their consultations. Reports from the performance reviews were shared with the staff member including a development plan identifying any actions needed to improve their performance. We saw the processes were in place to manage poor performance. The rota staff were notified of any restrictions that had been placed on a clinician preventing them from taking a shift.

Working with colleagues and other services

The out-of-hours service worked with other healthcare organisations. This included the NHS 111 service, local GP practices and commissioners. The service used IT systems which were compatible with the NHS 111 services. This enabled the NHS 111 service to make appointments for patients at the primary care centres and reduced the need for patients to wait for a call back from the out-of-hours service. The service also worked with the NHS 111 service if they were unable to contact patients to check recorded details

The service held monthly performance meetings with the four clinical commissioning groups that commissioned services from them. Feedback from the commissioners was positive. They told us that they received good engagement from the service and that they were always amenable to their requests.

The service worked with clinical colleagues working remotely. Those working remotely, including GPs on home visits, had access to computers or laptops and mobile phones which enabled them to maintain contact with the main office and receive information needed to provide patient care. It also enabled them to record patient information about the care and treatment provided which would be transferred to the patients usual GP. A duty manager was on duty during the out-of-hours period to provide support and information needed to clinicians throughout the shift.

Information sharing

The out-of-hours service used an electronic patient record system. Information provided through the NHS 111 service and from local GPs about patients was accessible to the clinicians through this system. The system was also used to document, record and manage care patients received. GPs working for the service were assessed as part of their performance monitoring on their ability to use this system to appropriately record information from patient consultations. NQR data for February 2015 showed the service was meeting requirements for having systems in place to support and encourage the exchange of up to date information between those providing care to patients.

Hospital admittance forms were completed for patients who were referred to hospital during the out-of-hours period. This provided information about the patient's medical history, details of medication and clinical findings from the consultation to assist with the continuity of care.

Good

Are services effective?

(for example, treatment is effective)

Information relating to patient consultations carried out in the out-of-hours period was transferred electronically to patients' GPs by 8am the next day in line with national quality requirements (NQRs). NQRs are quality standards set out for GP out-of-hours services. Any failed transfers of information were the responsibility of the duty manager to follow up to ensure GPs received information about their patients. NQR data for February 2015 showed that the service was meeting requirements for sending details of consultations (including appropriate clinical information) to the practice where the patient is registered by 8.00 a.m. the next working day.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. The Mental Capacity Act provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make their own decisions. The clinical staff we spoke with understood the key parts of the legislation and had all received training in this area. They were also required as part of the recruitment knowledge to demonstrate an understanding of mental capacity. Mental capacity was part of the provider's mandatory training for staff working for the out-of-hours service. An audit of staff training in February 2015 showed that 95% of staff had received mental capacity training.

There was a consent policy in place which provided guidance to staff. We saw that the policy was kept up to date and made reference to the Mental Capacity Act. It also made reference to Gillick competencies, used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. We saw that a recent patient safety newsletter which was circulated to all clinical staff also contained a case study on consent and provided useful information about supporting patients to make decisions, assessing capacity and making decisions when a patient is assessed as lacking capacity. Legal cases around consent had been provided staff to support staff understanding.

Good

Are services caring?

Summary of findings

The service is rated as good for providing caring services. Feedback from patients about the service was mostly positive. We observed staff treating patients with dignity and respect. Information was available to support patients who were recently bereaved.

Our findings

Respect, dignity, compassion and empathy

We obtained the views of patients who used the out-of-hours service through the CQC comment cards patients had completed and from the four patients we spoke with. The feedback received from patients was complimentary about the service. Patients described the service as 'good' and staff as 'helpful' and that they were treated with dignity and respect. The provider also collected feedback about the service on an ongoing basis. We looked at some of the feedback that had been left at two of the primary care centres we visited. There were 11 completed feedback forms, although these were mostly positive five commented on long waiting times.

As part of the NQRs, out-of-hours services are required to regularly seek feedback from people that have used the service and report any action taken to improve quality to commissioners. NQR data from February 2015 showed the practice was meeting this requirement. We looked at the results from patient feedback received by the out-of-hours during 2014. The data was presented for each primary care centre on a monthly basis and presented to commissioners as part of the performance review meetings. These asked patients to rate the parking facilities, location, the consultation with the clinician, how they were greeted by staff, waiting times and overall satisfaction. The results showed that patients were generally satisfied with the service although some had raised parking facilities and waiting times as the main concerns. We asked but did not see any specific discussions or action plans in place locally in response to patient feedback received. There was some feedback on patient satisfaction in the patient safety newsletter but this related to the provider as a whole.

During our inspection we visited three of the five primary care centres. We noted that consultations took place in private behind closed doors and that conversations taking place in these rooms could not be overheard. Reception staff told us that if patients wished to speak in confidence they would take them somewhere private to speak. At the Phoenix Health Centre we saw that the receptionist was careful to lower their voice when speaking with patients to minimise the risk of conversations being overheard.

Care planning and involvement in decisions about care and treatment

Good

Are services caring?

Patients that we spoke with as part of the inspection were satisfied with their involvement in decisions about their care and treatment. Clinicians were alerted to special notes from the patient's usual GP if these were available. Special notes are a way in which the patient's usual GP can raise awareness about their patients who might need to access the out-of-hours service, such as those nearing end of life and their wishes in relation to care and treatment.

Staff had a good understanding of consent and involving patients in decision making. A range of information was made available to clinical staff around capacity and decision making to support them in their work. This included up to date policies, case studies and training.

For patients who did not have English as a first language, a translation service was available if required. We saw the number was listed at the main office.

Patient/carer support to cope emotionally with care and treatment

A bereavement pack was available for clinicians to give to families when they attended a death. The pack contained information about registering the death and practical advice as well as information about support available including contact details to services such as Cruse bereavement care, and other helplines.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The service is rated as good for providing responsive services. It was aware of the needs of its local population and engaged with commissioners to deliver services to meet those needs. Feedback received from patients told us that they were happy with their experience of using the out-of-hours service and getting the support they needed. The service was equipped to meet patients' needs. Signage should be improved to assist patients finding services at the primary care centre in Sandwell. Information available on making a complaint was inconsistent across the primary care centres but when received complaints were appropriately managed and learning from complaints shared.

Our findings

Responding to and meeting people's needs

Patients referred to the out-of-hours service were prioritised triaged by the NHS 111 service who handled the initial call and were seen according to priory by the NHS 111 service. GPs undertaking telephone triage had systems and care pathways which they used to carry out clinical assessment and telephone advice. If necessary they would arrange a further face to face consultation at a primary care centre or through a home visit. Comfort telephone calls were made to patients allocated home visits if waiting times were likely to be longer than expected. This enabled the service to inform the patient of the delay and check their current situation.

Nestor Primecare Birmingham branch was commissioned by four CCGs to provide out-of-hours primary care services to the local population. Quarterly meetings were held with commissioners to discuss the level of service provided against the National Quality Requirements (NQRs) for out-of-hours providers.

We looked at the NQR data available for February 2015. This showed that the service was mostly meeting requirements. However, there were some variations in relation to the timeliness of face to face consultations . We asked about the areas where performance had dipped and managers were able to explain why these had occurred. For example, delays in the transfer of information to the GP practices. These were reported to commissioners as part of the quarterly review meetings. Managers told us that areas identified had been beyond their control.

Tackling inequity and promoting equality

The out-of-hours service understood and responded to patients with diverse needs and those from different ethnic backgrounds. For patients who did not have English as a first language, a translation service was available. We visited three of the five primary care centres and found they were accessible to patients who used a wheelchair and for pushchairs. We found the primary care centre located in Sandwell General Hospital difficult to find as there was limited signage available to advise patients where the out-of-hours service was. Staff were not wearing any form of identification to assist patients. There was also a risk that patient would divert to A&E as they passed this prior to reaching the out-of-hours clinic.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Staff told us that they would see patients who walked in without an appointment but would ask them to call the NHS111 service so that their call could be registered.

Access to the service

Patients who called the NHS 111 telephone service were referred for a telephone or face to face consultation at one of the five primary care centres located in Birmingham, Sandwell and Wolverhampton or for a home visit. The primary care centres were open in the evening Monday to Friday and four of the primary care centres were open at the weekend. Opening times varied between the five primary care centres. Patients were allocated an appointment time for the primary care centres and feedback we received indicated that patients were seen according to priority and in a timely manner.

The provider was aware that some patients may need additional time to discuss their concerns. For, example we saw in a recent patient safety newsletter a reminder to clinicians undertaking triage to book extra time for patients with mental health concerns.

Listening and learning from concerns and complaints

At our previous inspection in March 2014 we found that the patients were not made aware of the complaints policy and systems in place to raise their concerns. At this inspection we found that there had been some improvement in this area although further improvements could be made.

The service is required to operate a complaints procedure that is consistent with the principles of the NHS complaints procedure and report any action taken to improve quality. Data from the NQR for February 2015 showed the service had reported that it was meeting this requirement.

Complaints were handled at an organisation level. We looked at complaints received in the last 12 months. There were 86 in total relating to the Birmingham branch. These showed that that complaints received were well managed, complaints were thoroughly investigated and involved staff concerned. Learning was also identified. We looked at the management of three complaints in detail and these showed that they were handled in line with the provider's complaints policy. Learning from complaints was fed back to individual members of staff involved and at provider level through the patient safety newsletter where case studies from complaints were discussed. At a local level complaints were shared with commissioners but no analysis of local complaints to identify any trends which may require action was undertaken.

During our visits to three of the primary care centres we found that information to help patients understand the complaints system was only on display at the Phoenix Health Centre. Information available at this location was available for patients to take away and explained the complaints process and how to complain, details of expected timescales for acknowledgement and response and where patients may escalate their complaint if not satisfied with the response. At the other two primary care centres we visited a verbal complaints form was held behind reception which may deter some patients from making a formal complaint particularly if the complaint was in relation to reception staff. There was no specific information on view or for patients to take away at these two centres to help understand the process.

Are services well-led?

Requires improvement

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

Summary of findings

The service is rated as requires improvement for being well-led. The provider had clearly set out its vision and values for the service and staff we spoke with wanted to provide an excellent service but were not specifically aware of the vision and values. There was a documented leadership structure and most staff felt supported by management. Systems to monitor and improve quality and identify risk were well established at a corporate level. There were robust policies and procedures in place to govern activity and governance meetings held to discuss organisational risks. However, there was a disconnection between corporate and local management. Responsibility for ensuring policies and procedures were fully implemented at a local level were not always clear for example, in relation to medicines, safeguarding and identifying and acting on local issues. The provider sought feedback from patients but the provider was unable to produce evidence to show that this was used to review and improve the local service. Staff had received inductions, regular performance reviews and attended meetings on a regular basis to keep them informed.

Our findings

Vision and strategy

The out of hours service had clear vision and values for the service which were cited on its website. This was to deliver high quality, innovative and cost-effective services, to meet the needs of all their patients and customers and to become the most successful commercial provider of primary health care services in the UK. Both clinical and non clinical staff we spoke with confirmed they wanted to provide excellent patient care but were not all aware of the vision and values

Governance arrangements

The provider had a range of policies and procedures in place to govern activity and these were available to staff on the provider's intranet. We found that these were well maintained and regularly updated. We saw that policies reflected and made reference to current guidance.

Performance and risks were mainly managed at a corporate level with management representation from each of the five Primecare branches. These included the monthly accountability meetings which were used to discuss performance against the National Quality Requirements and the clinical governance meetings in which the clinical risk register was discussed. The clinical risk register was used to manage clinical staff where performance issues had been identified. At a local level meetings were held with commissioners to discuss performance against the contracts.

We saw that there had been undertaken a review of the out-of-hours services provided from the Birmingham branch. This looked at progress against the previous CQC inspection and included a reflective view of performance against CQC outcomes. Unannounced visits had also been made to two of the primary care centres included in the previous CQC inspections where issues had been raised. Actions in relation to this review had been monitored and were showing overall improvement. However, there had been no visits to the three other primary care centres to ensure the standard and consistency of services provided.

When we visited the main office we noticed that confidential patient information had been left on the back seat of one of the cars used for home visits. We alerted

Are services well-led?

Requires improvement

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

managers and the information was removed We notified the staff that this should be recorded as an incident and a form was completed in order to investigate and take any necessary action to mitigate the risk of this reoccurring.

Leadership, openness and transparency

There was a local leadership structure with both operational and clinical managers within the Birmingham branch. However, some of the responsibilities for the service were managed at a corporate level. There was a gap in local leadership and responsibility for ensuring policies and procedures were being followed locally and performance issues which were specific to the service were picked up. For example, medicines, complaints, incidents, patient feedback and contractual arrangements for the premises used were managed and reported at a provider level. This made it difficult for local management to have an overview of any local trends or areas for action which might be specific to the services provided by the Birmingham branch.

As most clinical staff worked remotely the main forum for disseminating information was via email and through the patient safety newsletters. Clinical staff told us that they felt supported by managers and a duty manager was always available for information and support when working a shift.

Seeking and acting on feedback from patients, public and staff

The out-of-hours service obtained patient feedback on an on-going basis. Patient were asked to rate the service at each of the primary care centres. Questions were asked about the parking, location, consultation, courtesy of staff and waiting times. This information was included in the reports sent to commissioners. Information on patient satisfaction was included in the monthly reports to commissioners. Patient satisfaction data seen for 2014 was presented as raw data so it was difficult to clearly identify any trends. Most patients appeared satisfied with the service. Although we asked, no evidence was made available to show how patient feedback was specifically used to improve the service provided by the Birmingham branch.

We saw that reports were compiled at the end of each shift by staff working at one of the primary care centres but not at all. This enabled staff to raise any issues that had occurred with managers but not consistently. We saw that a clinical staff meeting had been arranged to bring together clinical staff who worked remotely. The meeting and agenda had been advertised in the patient safety newsletter. However managers told us that the response so far from clinicians was low.

The service had a whistleblowing policy which was available to all staff in the staff induction manual and on the service's intranet. Staff we spoke with told us that they were aware of the whistleblowing policy. The provider had also raised awareness of the policy in a recent patient safety newsletter.

Management lead through learning and improvement

The out of hours service had systems in place to support learning and improvement among staff. All staff (including agency) received induction training and a comprehensive induction manual. Opportunities for additional training were provided which staff could sign up to. Staff confirmed they received regular performance reviews from which any development needs were identified and followed up. Staff were positive about the training and support they were given and confirmed that they received regular feedback on their performance. This helped to drive standards in patient care.

Staff told us that the service supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the service was very supportive of training and that they had staff away days where guest speakers and trainers attended.

A patient safety newsletter was issued to staff every three months which provided detailed case studies and learning in relation to incidents, complaints and safety alerts that had occurred within the organisation. These helped contribute to staff learning.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use the service were not protected against the risks of unsafe care and treatment because the system for managing medicines was not safe. The provider could not account for the location of all medicines boxes allocated for use in the primary care centres and would not easily be able to identify if a box of medicines had gone missing. There were no records to ensure an audit trail was maintained. Regulation 12(1)(2)(g)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have clear lines of accountability and systems in place for monitoring and managing risks specifically relating to the Birmingham branch, to minimise those risks and ensure the quality of services provided locally. We identified concerns with the management of medicines, confidentiality and inconsistencies in the provision of services at the primary care sites. There was no evidence that audits, patient feedback and complaints specifically relating to the Birmingham branch had been analysed to identify trends and areas for action in order to minimise local risks and ensure the consistency and quality of the services provided. Information on the complaints process was not easily or consistently accessible to all patients who used the service which would enable them to raise a complaint if they wished to do so. Regulation 17 (1)(2)(a)(b)(c)