M-Doc Limited

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

M-Doc provides an evening and weekend out-of-hours primary care service for 10 practices and two Ministry of Defence establishments in East Mid Bedfordshire. The service is responsible for providing primary care when GP surgeries are closed. It covers a population of 88,000 and operates from a single location in Biggleswade Hospital.

All the patients we talked with were very positive about the care they received. We also found that all 49 patients who completed a comment card were very pleased with the service.

Staff told us that they enjoyed their work and liked their working environment. They told us there was a collegial atmosphere, with good working relationships at all levels.

The leadership team was very visible and staff found them very approachable. There was a low turnover of directors of the company as there was no maximum length of time for a director to serve. Directors who were required to resign by rotation were routinely immediately re-elected to the board.

The provider regularly met with the local clinical commissioning group (CCG) to discuss capacity issues and possible service improvements. There was generally a good relationship between the provider and the CCG.

There were problems with the management of medicines within the service. Staff had recorded temperatures in a fridge containing temperature-sensitive medicines that were outside of the safe range for those medicines, but no action had been taken to address the problem. When we pointed this out, the provider immediately took steps to identify patients who had been given medicines that may be less effective by being stored at an incorrect temperature.

The provider had not carried out appraisals on staff for at least two years. This resulted in a risk that poor performance was not being identified and addressed.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Parts of the service were potentially unsafe. The provider needs to ensure that when staff record the temperature in a fridge containing temperature-sensitive medicines, they alert an appropriate clinician about any out-of-range readings. The provider also needs to introduce more rigorous auditing of fridge temperature checks. Good systems were in place for the storage and tracking of non-temperature sensitive medicines. There was an open culture for reporting incidents and dealing with complaints.

Are services effective?

Overall the service was effective. Care and treatment was being delivered in line with current published best practice. Patients' needs were consistently met in a timely manner. The provider routinely investigated any breaches of the national quality requirements for out-of hours-services.

Are services caring?

Overall the service was very caring. Patients we spoke with were extremely complimentary about the level of care they received. All of the patients who used the service in the weeks before our inspection and who completed a comment card were entirely positive about the care they received.

Are services responsive to people's needs?

Overall the service was responsive to people's needs. There was an open culture within the organisation and a clear complaints policy. The service participated actively in discussions with commissioners about how to improve services for patients in the area. The provider varied the number of doctors on call to meet anticipated demand during the winter months.

Are services well-led?

Overall the service was well led. There was visible leadership with a clear organisational structure. There was a low turnover of company directors, as there was no maximum length of time any director could serve. Directors who were required to resign by rotation were routinely immediately re-elected to the board.

The provider had not given CQC a copy of its statement of purpose.

Summary of findings

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

All the people we spoke with during the inspection were very pleased with the service they received. We found that all the patients who used the service in the weeks before our inspection and who had completed a comment card were entirely positive about the care they received. We also saw the results of the provider's own monthly patient surveys. These were overwhelmingly positive.

Areas for improvement

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

- The provider must take action to improve the monitoring and auditing of its temperature checks on the fridge containing temperature-sensitive medicines.
- The provider must improve the supervision and appraisal process for administrative staff to ensure that underperformance is identified and managed.
- The provider must give CQC an up-to-date Statement of Purpose.

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

- Develop a formal business continuity plan.
- Develop a risk register for the service.

Good practice

Our inspection team highlighted the following areas of good practice:

- The service was very caring and was well regarded by people who used it.
- There was an open culture for reporting incidents and dealing with complaints.

M-Doc Limited

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC inspector and an Inspection Manager, who also attended part of the inspection. The inspectors were accompanied by three special advisers (two GPs and a nurse).

Background to M-Doc Limited

M-Doc provides an evening and weekend out-of-hours primary care service for 10 practices in East Mid Bedfordshire. It was created in 1997 as a GP owned co-operative, but in 2004 made the transition to being a commercial provider. It still provides out-of-hours cover for the same ten GP practices as it did when it was first formed.

The service is responsible for providing primary care when GP surgeries are closed. It covers a population of 88,000 and operates from a single location in Biggleswade Hospital. It claims to be Britain's smallest commercial out-of-hours provider.

Why we carried out this inspection

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

How we carried out this inspection

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.

The inspection team spent eight hours inspecting the out-of-hours service and visited the provider's administrative offices and its primary care centre at Biggleswade Hospital. We spoke with six patients and six staff. We also reviewed 49 comment cards completed by patients who used the service in the weeks before our inspection.

We carried out an announced visit on 26 February 2014. We observed how M-Doc handled patient information received from the external call handling service. As part of the inspection we looked at the personal care or treatment records of patients, and we observed how staff cared for patients and talked with them. We also talked with carers and family members. We spoke with and interviewed a range of staff including the service manager, two directors of the company and two doctors. We also spoke with a visiting community pharmacist.

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

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

Detailed findings

- Is it well-led?

Are services safe?

Summary of findings

Some parts of this service were potentially unsafe. Staff had recorded the temperature of a fridge containing temperature-sensitive medicines as being below freezing for several days without taking any action. This could mean that medicines given to patients were ineffective or potentially dangerous. There was no formal business continuity plan in place. There was an open culture for reporting incidents and dealing with complaints.

Our findings

Significant adverse events

The provider had experienced a serious adverse event involving a patient with a learning disability last year. A thorough and rigorous internal investigation had identified some key learning points. However, at the time of our inspection, these had not been shared with other doctors working at the service because the directors wanted to wait for the outcome of the inquest into the patient's death.

Incident reporting

M-Doc also kept a log of less serious incidents that occurred at the service. There were 18 incidents between October and December 2013. Nearly half related to communication problems between the 111 service and M-Doc, with four calls despatched to the service before its opening time. All of the incidents were investigated and learning was shared with staff appropriately.

Management of medicines

A community pharmacist from the local clinical commissioning group (CCG) coincidentally arrived to undertake a regular audit of the provider's management of medicines during our inspection. The pharmacist told us that M-Doc followed the CCG's guidance on what drugs to stock and how to store them. We looked at how controlled drugs were managed. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. The records showed that the controlled drugs were stored, recorded and checked safely. M-Doc kept a separate supply of drugs intended for patients receiving palliative care. A safety chart was kept with the palliative care drugs to enable doctors to check the compatibility of patients' syringe drivers with the different drugs available.

We found that temperature-sensitive drugs were not stored safely. M-Doc kept temperature-sensitive drugs in a fridge and a member of staff recorded the temperature daily. The records showed the temperature in the fridge at the time of the check, together with the maximum and minimum temperature the fridge had reached in the previous 24 hours. The records appeared to show that the fridge had reached a maximum temperature of 26°C every day for several weeks. This showed a lack of training for the member of staff carrying out the daily check and that the records had not been monitored by a clinician. More worryingly, the records showed that the actual temperature of the fridge at the time of the daily checks had been significantly below freezing on several occasions. The fridge contained medicines clearly marked 'do not freeze'. Again, this had not been identified as a concern by the person carrying out the checks and had not been picked up by any audit of the process. When we alerted one of the directors of the service to the problem they immediately began the task of identifying which patients had been given medicines from the fridge and assessing the risk to their health. M-Doc told us that they would record this incident as a serious adverse event and learn lessons from it. We understand that a new fridge was obtained the day after our inspection.

Emergency equipment

There was a defibrillator and oxygen available for use in a medical emergency. The defibrillator was checked daily to ensure it was in working condition. There was no means of suction available to help clear secretions from a patient's airways and there was only a single oral airway device available to maintain a patient's airway in an emergency. The service's primary care centre was based in a community hospital and staff told us that in an emergency they could obtain a suction device and oral airways from a nearby ward if necessary.

Safeguarding

Staff we spoke with demonstrated an understanding of safeguarding patients from abuse and what they should do if they suspected anyone was at risk of harm. There were policies in place for safeguarding vulnerable adults and

Are services safe?

children from abuse. These contained information to support staff in recognising and reporting safeguarding concerns to the appropriate authority for investigation. Staff told us that they were aware of these policies.

Staff had access to online training in safeguarding children and vulnerable adults, which they were required to complete. Training records showed that the doctors were trained to an appropriate level for safeguarding children and young people.

Infection prevention and control

The service used consultation rooms and a waiting room that were used as a hospital outpatient clinic during the day. The rooms were generally clean and there was a good supply of personal protective equipment and hand cleaning gel. Before the service opened each evening, the duty driver was responsible for preparing the facilities for use. This included checking the cleanliness of the rooms and the supply of equipment required to protect people from the risk of infection. There were appropriate procedures in place for the disposal of clinical waste and sharps. A spillage kit and a spillage incident reporting form was available.

Business continuity

There was no formal business continuity plan in place to deal with any significant disruption to the service. This might mean that it could take longer than necessary for the service to recover from a significant disruptive event and get back to running a full service for patients.

Are services effective?

(for example, treatment is effective)

Summary of findings

Overall the service was effective. Care and treatment was being delivered in line with current published best practice. Patients' needs were consistently met in a timely manner. There was good auditing of telephone consultations, prescribing and patient notes. There was also good performance management of doctors. M-Doc was not consistently meeting all of the national quality requirements, but small patient numbers meant that percentage scores were distorted.

Our findings

Auditing and monitoring

We saw evidence of good auditing of telephone consultations by one of the provider's directors. All telephone consultations were recorded and a director audited 20 each quarter, ensuring that the sample included at least one for each doctor. The director audited the calls against set criteria, including whether or not the assessment was appropriate in the light of the eventual clinical outcome. About one in 20 calls audited were found to include at least one area for improvement that was fed back to the doctor concerned. Feedback on trends emerging from the audits was shared with all doctors by email. The system helped to identify any shortcomings in an individual doctor's performance and helped maintain a high standard of care for patients.

One doctor who received persistent adverse comments on patient surveys had improved their performance following feedback. We were told that another doctor with persistent conduct issues had been prevented from working for the provider and had been reported to the GMC following similar concerns from other employers.

We saw the results of a recent audit of patients' written records. Although M-Doc was not using the toolkit for urgent care audit from the Royal College of General Practitioners, the system in place was generally aligned to it. All of the records reviewed in the audit were deemed to be satisfactory and general learning from them was shared with all the doctors who worked at the service. We also looked at two recent audits of prescribing within the service. Again, general lessons from the audit were shared with all the doctors who worked at the service.

Directors attended a monthly meeting at which clinical governance was a standing agenda item. This ensured that all directors of the service were familiar with any emerging clinical issues or serious adverse events.

Call handling

Calls to M-Doc were handled by an external service operated by the East of England Ambulance Service. Life-threatening calls were identified by the call handlers and diverted to the relevant emergency service. All other calls were assessed for urgency by the external service before being transmitted electronically to M-Doc using the Adastra system. The calls were then dealt with by the on-call doctor. Patients could be given telephone advice, invited into the care centre or allocated a home visit. When a home visit was necessary, the patient's details could be transferred to a secure laptop computer and taken on the visit. Any new calls received by the service while the doctor was out on a home visit could also be sent directly to the laptop computer. All call details and doctors' notes were faxed to the patients' own GPs by 8am the following day.

Implementation of current guidance

Until recently, doctors had been using a paper copy of the British National Formulary. An electronic version was now available to doctors, which reduced the risk of working with out of date prescribing information.

Recruitment

M-Doc took steps to ensure that all the doctors it used were on the East of England NHS GP performers list and on the General Medical Council list. It also obtained disclosure and barring service (DBS) checks before employing new doctors and checked that doctors' safeguarding training was up to date.

Training

M-Doc provided doctors newly recruited to the service with a comprehensive induction booklet. Newly recruited doctors were also expected to attend a two-hour induction session with the service manager and one of M-Doc's directors. They also undertook several shifts alongside a more experienced out-of-hours doctor before working shifts alone. After the induction, M-Doc did not provide an organised programme of ongoing training for its doctors. Doctors were responsible for their own continuous professional development. The service manager kept copies of doctors' mandatory training certificates on file and was in the process of creating a computerised traffic light system to identify when update training was required.

Are services effective?

(for example, treatment is effective)

Doctors told us that although M-Doc did not provide specific training, there were good learning opportunities from the information about incidents and audits that was shared with them. Doctors also received regular feedback, both positive and negative, from patient surveys.

M-Doc provided more comprehensive training for its administrative staff. Staff completed online courses in a variety of subjects appropriate to their role. Completion of the courses was recorded in their personal file. There was no system in place to ensure that administrative staff received regular supervision or appraisal. Some staff told us that they had not received appraisals for more than two years. This meant that M-Doc did not have a system in place to identify and act upon underperformance by staff.

National quality requirements

Out-of-hours providers are required to regularly report on their performance against a series of national quality requirements (NQR). These requirements are designed to ensure that the service is safe, clinically effective and delivered in a way that gives the patient a positive experience. M-Doc was not consistently meeting all of the national quality requirements, but small patient numbers meant that percentage scores were distorted. Extra and extended GP shifts were added to the rota from December to meet winter demand. NQR targets were met during the time the extra sessions have been added.

Are services caring?

Summary of findings

Overall the service was very caring. Patients we spoke with were extremely complimentary about the level of care they received. All the patients who used the service in the weeks before our inspection who completed a comment card were entirely positive about the care they received.

Our findings

Patient survey

We looked at the results of a monthly survey that collected the views of patients who used the service. Patients were overwhelmingly positive about the service they received. Patients scored call handlers and doctors very highly for professionalism. They said that doctors were good at listening to them and 100% of patients completing the survey felt the doctor treating them listened to them. In January and February 2014, 100% of patients said they were happy with the service they received. We also reviewed 49 comment cards completed by patients who used the service in the weeks before our inspection. The comments on the cards were unanimously positive.

Staff attitude

Staff told us that they enjoyed their work and liked their working environment. They told us there was a collegial atmosphere, with good working relationships at all levels. We observed staff talking to patients in a calm, respectful and reassuring manner. We also saw staff welcoming patients at the out-of-hours primary care centre in a polite and professional way. Patients we spoke with were very happy with the way they had been dealt with by staff. They told us that they were never made to feel as if they were wasting the doctor's time.

Involving patients in their treatment

M-Doc did not operate a patient participation group or have patient representation at its service meetings. However, individual patients told us they felt that they had been involved in decisions about their own treatment and that the doctor gave them plenty of time to ask questions. They were satisfied with the level of information they had been given and said that any next steps in their treatment plan had been explained to them.

Patient consultations

A member of our inspection team accompanied a doctor on a home visit with the patient's permission. The doctor was polite and respectful throughout the consultation and made great efforts to ensure that the patient understood what was being said. In addition to prescribing appropriate medication, the doctor gave good advice to the patient and their family about how to minimise the risk of the patient's condition spreading to other people. We also sat in on two consultations between doctors and patients. We were impressed by both the clinical and service quality of the consultations.

Privacy and dignity

The service had a patient dignity policy in place. Staff were familiar with the steps they needed to take to protect people's dignity. Consultations took place in purpose designed consultation rooms with an appropriate couch for examinations and curtains to protect privacy and dignity. Patients told us that they felt that staff and doctors had effectively protected their privacy and dignity.

Interpreter services

There was a service handbook available in each consulting room. The handbook contained details of how staff could obtain interpretation services to assist patients who did not speak English if required.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Overall the service was responsive to people's needs. There was an open culture within the organisation and a clear complaints policy. The service participated actively in discussions with commissioners about how to improve services for patients in the area. The provider varied the number of doctors on call to meet anticipated demand during the winter months.

Our findings

Patient feedback

M-Doc did not operate a patient participation group or have patient representation at its service meetings. However, the service conducted regular patient surveys and responded to the issues raised, where appropriate. For instance, several patients commented that the entrance to the M-Doc service was hard to find. In response, M-Doc had improved external signage and the issue was not raised again at the next patient survey.

Meeting people's needs

Directors of M-Doc met with representatives of the clinical commissioning group (CCG) regularly to discuss performance and capacity. In response to demand, M-Doc had introduced a second doctor at its primary care centre during the early evening to cope with increased patient numbers during the winter months. Up to four doctors worked during the day at weekends and a nurse was also available. A single driver/ administrator worked overnight, but an additional receptionist was on duty at weekends and bank holidays.

The surgery was accessible to patients with mobility difficulties. The consulting rooms were large with easy access for patients with mobility difficulties. There was also a toilet for disabled patients. Staff said they had access to interpreter or translation services for patients who needed it, and there was guidance about using interpreter services and contact details. They said that although they asked patients who their normal GP was, they did not refuse to see anybody if they were not registered with a GP.

The service covered two nearby military bases. The staff had identified the possibility of an increased demand from patients with mental health problems once military personnel returned from active overseas service. The doctor's handbook included a section on liaising with the military health service when treating such patients.

Information about patients receiving palliative care was shared between the patient's GP, M-Doc and a local coordination service run by the Sue Ryder charity. This ensured that doctors working for the service had all the information they needed to treat and support people receiving end of life care. M-Doc kept a separate supply of drugs intended for use with patients receiving palliative care. A safety chart was kept with the palliative care drugs to enable doctors to check the compatibility of patients' syringe drivers with the different drugs available.

Learning from experiences, concerns and complaints

The service had an open culture policy in place and staff told us that there was a 'no blame' culture in the service. We saw that there was a robust complaints procedure in place. M-Doc regularly audited the performance of doctors. Any specific issues were raised directly with the doctor concerned. General learning points were shared with the whole team by email.

Are services well-led?

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

Summary of findings

Overall the service was well led. There was visible leadership with a clear organisational structure. There was a low turnover of company directors, as there was no maximum length of time any director could serve. Directors who were required to resign by rotation were routinely immediately re-elected to the board. The provider had not given CQC a copy of its statement of purpose.

Our findings

Structure

M-Doc was created in 1997 as a GP owned co-operative, but in 2004 made the transition to being a commercial provider. It still provides out-of-hours cover for the same 10 GP practices as it did when it was first formed. When M-Doc became a commercial organisation in 2004 it was hoped that a representative of each GP practice covered by the service would sit on its management board. However, only four doctors were willing to become directors of the new commercial organisation. The company's constitution requires one director to resign each year but there are no rules limiting directors to any maximum period of office. Directors resigning by rotation have always been immediately re-elected if they were willing to remain in office. Two new doctors were appointed to the board in 2011 following the resignation of two directors who did not wish to be re-elected. M-Doc has had the same person chairing the board since 1997.

Each director had clear responsibilities and the board met monthly with the service manager. There were good systems in place to ensure that the service delivered on quality and safety.

Risk management

The provider had not produced a register of risks to the service. A recent meeting with the local CCG had also identified this, and we were told that there was work in progress to produce one. We also identified that there was no formal business continuity plan in place to deal with any significant disruption to the service. This might mean that it could take longer than necessary for the service to recover from a significant disruptive event and get back to running a full service for patients.

Statement of Purpose

Regulation 12 of the Care Quality Commission (Registration) Regulations 2009 requires providers to give CQC a 'statement of purpose' that must include a set of basic information about their service. The provider has not supplied a Statement of Purpose.

Strategy

There was no published strategy or vision for the provider. A director told us that there was no ambition to expand services by bidding for contracts in neighbouring areas. M-Doc's prime concern was to provide a good quality service to its own existing group of patients. The lack of vision and strategy could potentially raise issues about the longer term sustainability of the service.

Culture

There was a good relationship between clinical and non-clinical staff. There were clear job descriptions for non-clinical staff. The staff we spoke to were clear about their roles and responsibilities. They described the culture within the organisation as supportive and inclusive with a focus on patient care. Staff also told us that the leadership was visible and accessible.

Quality indicators

M-Doc was regularly held to account by the local CCG using the national quality requirements for out-of-hours services. M-Doc could account for instances where the requirements had been missed and had adjusted its services to improve performance when appropriate. There were no locally produced indicators of quality.

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.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider was not protecting service users against the risks associated with the unsafe use and management of medicines.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 23 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider did not have suitable arrangements in place to support staff by means of appropriate supervision and appraisal.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 of the Care Quality Commission (Registration) Regulations 2009. The provider had not supplied CQC with a copy of its statement of purpose.