Wokingham Community Hospital – Westcall GP Out of Hours

Inspection report

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

Overall summary

This service is rated as Requires improvement overall. (Previous inspection December 2015 – Good with requires improvement for Safe. Follow up inspection in October 2016 - Good)

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at the registered location (Wokingham Community Hospital, locally known as Westcall) on 5, 12 & 20 July 2018. This inspection was planned to coincide with the provider Trust (Berkshire Healthcare NHS Foundation Trust) inspection as part of our inspection programme.

At this inspection we found:

- The service had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes. However, we found not all incidents or events had been reported in line with service policy.
- Evidence of safeguarding training had not been collected for all GPs and some staff had not received safeguarding children training to the appropriate level for their role.
- Infection control audits were not available for all service sites and we found dusty surfaces at two of the premises used by Westcall.
- Care and treatment was delivered according to evidence- based guidelines.
- Clinical audits were limited and did not drive quality improvement.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- Some governance processes were inconsistently applied and leaders did not have oversight of all the information required to safely deliver the service.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

The areas where the provider must make improvements as they are in breach of regulations are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.

The areas where the provider should make improvements are:

- Review and maintain oversight of emergency trolley checking procedures at all sites.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Our inspection team

The inspection team consisted of a lead CQC inspector, a GP Specialist Advisor with experience of Out of Hours, a CQC medicines team inspector and an additional CQC inspector.

Background to Wokingham Community Hospital

Wokingham Community Hospital is the registered location for Westcall GP Out of Hours (OOH) service. The service is provided by Berkshire Healthcare Foundation NHS Trust. The service provides OOH primary medical services to over 550,000 registered patients and those requiring immediate (but not emergency) treatment from the Berkshire West area when GP practices are closed. West Berkshire includes the towns and surrounding villages of Wargrave, Wokingham, Reading, Newbury and Hungerford. There are many rural areas within the catchment area.

Patients can access the Westcall service by calling NHS 111. An appointment is made directly with the service or patient details are added to a queue for GP triage. Following triage, the GP determines if a face-to-face assessment, home visit or remote home care advice is required and makes the appropriate arrangements. If patients require a more urgent outcome, the service can contact the ambulance service or direct patients to other local healthcare services, including the Emergency Department.

A dedicated operations hub is available to take calls from external providers requiring direct access to Westcall (for example, if looking after a patient with an advanced care plan or on the end of life register). The calls hub will also contact patients if there are delays to a GP making a home visit or return telephone call.

There are 79 GPs who provide clinical care to patients (12 salaried and 67 sessional GPs making a whole time equivalent (WTE) of 18.5 full time GPs). They are supported by Medical Directors at both service and trust level and the Head of Urgent Care. The trust operations manager for urgent care provides direct management support to the Westcall Matron and Westcall operations manager. There are nine Emergency Practitioners (WTE 4, from both nursing and paramedic backgrounds), ten Nurses (WTE 3.6) and eight healthcare assistants. The clinical team are further supported by 35 drivers, five receptionists, 20 operations room staff and four administration staff.

The service is registered to provider the following regulated activities:

- Treatment of disorder, disease or injury
- Diagnostic and screening procedures

The service operations centre and referral hub are based at:

The Old Forge

2nd Floor

45-47 Peach Street

Wokingham

RG40 1XJ

Details of the provider and services offered can be accessed through their website: www.berkshirehealthcare.nhs.uk

The service has two locations where GP OOH services are provided from:

Reading Primary Care Centre

Maternity block

Ground Floor

Royal Berkshire Hospital

Craven Road

Reading

RG1 5AN

and

Newbury Primary Care Centre

West Berkshire Community Hospital

Benham Hill

Thatcham

Berkshire

RG18 3AS

They also offer services to patients who have attended the Emergency Department but are assessed not to require emergency treatment:

Primary Care Unit

Royal Berkshire Hospital

Craven Road

Reading

RG1 5AN

We visited all three clinical sites and the operations hub as part of this inspection. The service has been inspected before in December 2015 and April 2016. All the previous inspection reports can be found by selecting the “all reports” link for “Wokingham Community Hospital – Westcall Out of Hours” on our website at www.cqc.org.uk.

Requires improvement

Are services safe?

We rated the service as requires improvement for providing safe services.

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- The provider conducted safety risk assessments. It had safety policies, including Control of Substances Hazardous to Health and Health & Safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction and refresher training.
- The provider had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- Not all staff could access adult and child safeguarding training to the appropriate level for their role. We found many of the GPs had not received level three child safeguarding training and the provider had not sought clarification of their knowledge or training from other employment. Most staff knew how to identify concerns although many we spoke with were unable to locate the safeguarding reporting form on the provider intranet. We also noted there had been one child safeguarding referral made by Westcall staff in the preceding 12 months.
- The service worked with other agencies to support patients and protect them from neglect and abuse. For example, we saw a spreadsheet of known GP child safeguarding cases which was shared with the service weekly from the local authority. Alerts identified at risk patients on the service computer system. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider had a human resources (HR) department who carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- We were shown a list of staff who had been trained to act as chaperones. The provider HR team undertook all pre-employment checks including a DBS check. At the time of the inspection we were unable to confirm all staff who may be asked to undertake chaperoning had also received a DBS check. We did see evidence where alerts were sent to the management team to identify when a DBS check was due to be renewed or had not been completed. The trust was able to confirm the HR process and reassure us systems were in place and fully embedded.
- There were limited systems in place to manage infection prevention and control. We asked to see the infection control audits for the three sites where patients were seen, as part of the services provided by Westcall. We were shown hand hygiene audits, sharps bins audits and an audit of the Newbury base. No other infection control audits were available after 2016 and we were shown an audit of one clinical room (unidentified site) dated May 2017. We were told there was a discussion between the estates department and the infection control team to determine responsibility for this. The clinical matron for Westcall had not carried out any interim infection control audits.
- We visited two Out of Hours (OOH) bases and the Primary Care Unit. The provider was unable to show us the cleaning logs for any of the units we visited. We found dust on some equipment at the OOH base in Newbury and the Primary Care Unit (PCU) in Reading. We also found there were no spill kits available in the PCU. At the OOH base in Reading we found a sharps bin had not been signed or dated to show when it had been assembled.
- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. Staff rotas were reviewed regularly to ensure any outstanding gaps were filled appropriately. Staff could be moved across sites to accommodate a different skill mix which enabled cover for shifts.
- We viewed the GP rotas and found 13 occasions in June 2018 where GPs had worked back to back shifts resulting in up to 17 hours of continuous work. We were told GPs could choose their working hours and

determine their own working practice. The provider had not considered the risks associated with long working hours and had not carried out checks to determine if the GPs were safe to work. We were told there was an informal policy of not working beyond 12 hours and 20 minute breaks were taken every six hours.

- There was an effective system in place for dealing with surges in demand. The service had collaborated with the NHS 111 service, reviewed the times and days when demand peaked during December 2017 and had created a "heat map" to demonstrate when more staff were required to cover. This had allowed the provider to start planning staff rotas for winter 2018.
- There was an effective induction system for temporary staff tailored to their role. All temporary staff were required to go through the same induction and shadow shift sign off as sessional and salaried staff.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis. In line with available guidance, patients were prioritised appropriately for care and treatment, in accordance with their clinical need. Systems were in place to manage people who experienced long waits or delays.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse. We saw information notices and leaflets describing the service and appointment system.
- When there were changes to services or staff the service assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Most staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way. However, at one of the OOH bases we saw a clinical member of staff who did not have access to the summary care records system. We also observed where information about patients was not always available at other sites due to reduced information technology systems.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. For example, the service sent care summaries to GP services to inform them when a registered patient had accessed OOH care. The provider had a system of telephoning through any high risk or priority issues to ensure GP services were aware of them.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Appropriate and safe use of medicines

The service had reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, including medical gases, emergency medicines and equipment, and controlled drugs and vaccines, minimised risks. At the Newbury base, the emergency trolley was shared with another service located in the adjoining area. We noted some dust on the surface of the trolley and irregular checking frequency. We were told the emergency trolley was the responsibility of the other service (part of the same trust) and they would raise this with them after the inspection. In addition, we found the emergency trolley at the Reading Primary Care Unit was also irregularly checked and was dusty on top.
- The service kept prescription stationery securely and monitored its use. Arrangements were also in place to ensure medicines and medical gas cylinders carried in vehicles were stored appropriately.
- The service carried out reviews of medicines prescribed and used by the service, although there were limited audits to ensure prescribing was in line with best practice guidelines for safe prescribing or to identify any quality improvement activity.
- The service had reviewed their monthly antimicrobial and antibiotic prescribing through an online application which gives authorised users access to prescription data. The service had achieved 12% for antibiotic prescribing for the year July 2017 to June 2018 against a target of 10% nationally for Out of Hours services. The service had not undertaken an audit of antimicrobial prescribing to identify learning outcomes or improve quality of patient care. However, we saw evidence of monitoring of Nurse and Paramedic Practitioner

antimicrobial and antibiotic prescribing through Patient Group Directions and GP prescribing through Clinical Guardian. (Clinical guardian is a system for monitoring safety, quality and productivity in GPs Out of Hours).

- From the records we viewed, we found most staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. However, there was one noted occasion when a prescription was requested to be raised by a non-prescribing clinician where the GP had not evidenced their review in the patient record. We also found an example where prescriptions were being used by a GP on behalf of another community service for chronic disease management, and there was no electronic record of what was being prescribed or a system to monitor use.
- Processes were in place for checking medicines and staff kept accurate records of medicines.
- Palliative care patients were able to receive prompt access to pain relief and other medication required to control their symptoms.
- The provider kept a stock of controlled drugs (CDs) for use at the bases and for GPs to take out on home visits where appropriate. (CDs are a group of medicines that require additional checks and special storage arrangements). We viewed the processes for storing, recording, reviewing and managing CDs and found most processes followed guidelines for use. GPs occasionally issued a CD from provider stock and did not raise the appropriate prescription in line with guidance. The provider told us they added the prescribed CD to the patient record and absorbed the cost through the provider. They did not feel they needed to raise a prescription called an FP10 Rec as they had other ways of recording and monitoring the use of CDs. (An FP10 Rec is a prescription used by GPs and other prescribing healthcare professionals for specific medicines).

Track record on safety

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- There was a system for receiving and acting on safety alerts. We looked at some examples of recent alerts and found actions had been taken and documented accordingly.
- Joint reviews of incidents were carried out with partner organisations, where necessary, including the local A&E department, NHS 111 service and urgent care services.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. However, we found examples of incidents and events that had not been raised using the provider reporting system. For example, a vehicle broke down causing delay to response times and a patient was directed to an incorrect base for assessment. Whilst we were told these incidents had been dealt with at the time, they had not been escalated, reviewed or investigated and no learning outcomes identified or shared. We were unable to establish the outcomes of these as there was no audit trail to review.
- When incidents or events were appropriately escalated, there were adequate systems for reviewing and investigating them. The service learned and shared lessons and took action to improve safety in the service. For example, clinical staff received a written reminder of reviewing lactate levels (a blood test used to detect serious illness including possible sepsis). The reminder described what normal levels should be and when concerns should be escalated using the sepsis pathway.
- The service learned from external safety events and patient safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.
- The provider took part in end to end reviews with other organisations. Learning was used to make improvements to the service. For example, the service reviewed the procedure for identifying patient levels of breathlessness during telephone triage and offered updated guidance to GPs if this is difficult to gauge over the telephone.

Requires improvement

Are services effective?

We rated the service as requires improvement for providing effective services.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed.
- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.
- Care and treatment was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. For example, the service could access crisis assessment for patients suffering from mental health issues and night sitters for elderly vulnerable patients.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients, such as patient alerts on the service computer system. There was a system in place to identify frequent service users and patients with particular needs, for example palliative care patients. Care plans, guidance and protocols were in place to provide the appropriate support. We saw no evidence of discrimination when making care and treatment decisions.
- Technology and equipment were used to improve treatment and to support patients' independence. The service had access to 17,000 care plans from various services which were available to be reviewed through the computer system. This enabled patients to receive specific or personalised care.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

From 1 January 2005, all providers of out-of-hours services were required to comply with the National Quality Requirements (NQR) for out-of-hours providers. Providers were required to report monthly to their clinical commissioning group (CCG) on their performance against the standards. The requirement to report against NQRs had recently been discontinued in favour of reporting against local standards. The provider had decided not to continue formally with NQR reporting but was continuing to use the standards to measure service activity and performance internally. They were also continuing to report to the CCG.

We were shown the providers unverified data for April 2017 to March 2018 which showed:

- Face to face assessment (urgent): to commence definitive clinical assessment within 120 minutes of arrival at an Out of Hours (OOH) centre. Data showed that the service had achieved 93% overall for this indicator compared to their target of 95%. During the 12-month period from April 2017 to March 2018 they had met or exceeded 95% for five months, exceeded 90% (but below 95%) for six months and fallen below 90% for one month.
- Face to face assessment (routine): to commence definitive clinical assessment within 360 minutes of arrival at an OOH centre. Data showed that the service had achieved 96% overall for this indicator compared to their target of 95%. During the 12-month period from April 2017 to March 2018 they had met or exceeded 95% for 10 months, exceeded 90% (but below 95%) for two months and had not fallen below 93% at any time.
- Home visit assessment (urgent): Patients classified as urgent requiring a face to face consultation at their place of residence to be seen within 120 minutes following definitive clinical assessment: Data showed that the service had achieved 91% overall for this indicator compared to their target of 95%. During the 12-month period from April 2017 to March 2018 they had met or exceeded 95% for two months, exceeded 90% (but below 95%) for five months and fallen below 90% for five months.
- Home visit assessment (routine): Patients classified as routine requiring a face to face consultation at their place of residence to be seen within 360 minutes following definitive clinical assessment: Data showed that the service had achieved 96% overall for this indicator compared to their target of 95%. During the

12-month period from April 2017 to March 2018 they had met or exceeded 95% for nine months, exceeded 90% (but below 95%) for three months and had not fallen below 90% at any time.

The service had reviewed the patient records for those identified as breaching the target timeframe. If actions were identified, these were shared with staff. For example, a failed contact (re-triage) protocol was updated and shared with GPs to clarify the process for no response calls and considering clinical risk.

The service showed us two examples of audits they had undertaken in the last three years:

- An audit of sepsis management demonstrated increased awareness and identification of symptoms over a three year period. (Sepsis is a life-threatening infection that requires rapid identification and treatment). The audit showed the number of suspected cases increased from 167 in 2015/16 to 265 in 2017/18. Of these, confirmed sepsis diagnosis reduced from 71% to 35% respectively. The results demonstrated increased awareness and use of identifying tools. There were no specific learning actions or quality improvement arising from the audit. The findings had been discussed at clinical meetings.
- We were shown an audit of patient deaths. We were offered two explanations for the audit; it had been commissioned to ascertain the effectiveness and use of patient care plans and it was being used to identify of GPs were coding patient deaths appropriately in the care records. We were not shown any learning actions and the clinical lead was unable to demonstrate quality improvement activity. We did see meeting minutes where end to end reviews and patient deaths were discussed with clinical staff. A learning from deaths policy was in place and the trust regularly reviewed trust wide patient deaths to determine if there were any lapses in care or treatment.

The service had not recommended or made quality improvements through the specific use of audits. The clinical audits we were shown were a data collection of findings but limited outcomes were demonstrated to offer an impact on quality of care and outcomes for patients.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff. This covered such topics as familiarising themselves with trust policies and computer systems, escalating concerns, incidents or complaints and undertaking essential training such as safeguarding.
- All GPs (salaried and sessional or temporary) underwent a full trust induction and had to undertake supervised sessions before they could commence working for Westcall.
- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required.
- The provider provided protected time and training to meet the learning needs of staff. Not all records of skills, qualifications and training were maintained or requested for all staff. For example, we saw some gaps in training records for clinical staff including Mental Capacity Act (2005) training and basic life support. We were also told safeguarding training had been offered to salaried GPs but the provider had not offered this to the sessional GPs or requested their certificates of training to confirm competency.
- Staff were encouraged and given opportunities to develop.
- The provider provided staff with ongoing support. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The provider could demonstrate how it ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together, and worked well with other organisations to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. Care and treatment for patients in vulnerable

circumstances was coordinated with other services. The provider had access to over 17,000 care plans for patients to ensure their care was co-ordinated appropriately.
- Staff communicated promptly with patient's registered GP's so that the GP was aware of the need for further action. Staff also referred patients back to their own GP to ensure continuity of care, where necessary. The service worked with patients to develop personal care plans that were shared with relevant agencies.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- The service ensured that care was delivered in a coordinated way and took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that require them. Staff were empowered to make direct referrals and/or appointments for patients with other services.
- The Out of Hours service could access a trust Directory of Services such as information about the local mental health crisis team.

Helping patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.

- The service identified patients who may be in need of extra support. For example, the service had identified a lack of information and support for the local homeless community and had devised a patient leaflet with details of homeless shelters and food provision. We saw leaflets for both the Newbury and Reading areas.
- Where appropriate, staff gave people advice so they could self-care. Systems were available to facilitate this.
- Risk factors, where identified, were highlighted to patients and their normal care providers so additional support could be given. Each morning the service reviewed the previous nights activity and shift logs of patient concerns. Patient GPs were contacted directly by telephone to advise their patient may require additional support or a follow up.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The provider monitored the process for seeking consent appropriately.

Good

Are services caring?

We rated the service as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information. There were arrangements and systems in place to support staff to respond to people with specific health care needs such as end of life care and those who had mental health needs. All staff were required to undertake dignity and respect training and we were shown examples of tailoring care to offer individual support.
- We received 92 patient Care Quality Commission comment cards, of which 89 were positive about the service experienced. There were three comment cards that expressed dissatisfaction with waiting times and communication issues but stated they thought the service was good overall and staff were professional. This was in line with the results of the NHS Friends and Family Test and other feedback received by the service.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language, although we did not see notices in the reception areas informing patients this service was available. The provider told us after the inspection, they had information relating to The Big Word, British sign language and mother tongue notices available at all three sites. Patients had access to multi-lingual staff who might be able to support them. Information leaflets were available in easy read formats, to help patients be involved in decisions about their care.
- Patients told us through comment cards, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Staff respected confidentiality at all times.
- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The service monitored the process for seeking consent appropriately.

Good

Are services responsive to people's needs?

We rated the service as good for providing responsive services.

Responding to and meeting people's needs

The provider organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The provider understood the needs of its population and tailored services in response to those needs. We saw analysis of trends for attendance and how the skill mix of staff had been reviewed to ensure appropriate staff were available at different bases/units and at varying times according to demand.
- The provider engaged with commissioners to secure improvements to services where these were identified. The trust had been approached by NHS England to commence a service to patients attending the Emergency Department (ED) of a local hospital. The service was designed to offer GP services to patients who had attended the ED but did not require urgent or acute treatment at that time. ED staff undertook a brief assessment and referred suitable patients to the Primary Care Unit which was located a short walk from the ED. The service had commenced in October 2017 and was staffed by a GP and healthcare assistant from 8am until 11pm seven days a week. The service was currently seeing an average of 40 patients per day.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service, for example, where an advanced care plan or other information was available. Care pathways were appropriate for patients with specific needs, for example those at the end of their life, babies, children and young people.
- The facilities and premises were appropriate for the services delivered.
- The service made reasonable adjustments when people found it hard to access the service. Although the service was not formally commissioned for walk in patients, the service offered support and information to patients who attended the unit directly. They were assessed and offered an appointment or telephone call back where necessary.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients were able to access care and treatment at a time to suit them. The Out of Hours service operated from Monday to Friday from 6.30pm to 8am and Saturdays, Sundays and Bank holidays from 6.30pm the evening before to 8am the next working day.
- Patients were advised to access the out of hours service via NHS 111. The service was not advertised or commissioned to provide a walk-in service to patients. However, when patients arrived without having first made an appointment, they were assessed and observations taken within a timescale appropriate to determine priority. Patients were then booked into the next available appointment at the base or told to call NHS 111/referred onwards if they needed urgent care. All staff were aware of the walk-in policy and understood their role with regards to it, including ensuring that patient safety was a priority.

Patients had timely access to initial assessment, test results, diagnosis and treatment. The provider had collated the June 2018 data for initial triage, time from triage to assessment and OOH base arrival to consultation. This data had been specifically collected for the CQC inspection, although we were told the provider routinely monitored patient arrival time, appointment time, consultation start and consultation finish times and altered service provision where the need was greatest. The data we were shown demonstrated that:

- The lowest average wait for GP telephone triage was 22 minutes.
- The longest wait for GP telephone triage was documented at 934 minutes. This had been reviewed and assessed as a no response call where the GP had attempted to call back and handed over to the next shift for further attempts. These had been attempted but not documented appropriately before the decision was made to close the episode.
- The average wait for patients from arrival to discharge was 38 minutes at the Newbury Primary Care Centre (PCC) and 45 minutes at the Reading PCC.
- The longest wait for a patient from arrival to discharge was 432 minutes at the Newbury PCC and 581 minutes at the Reading PCC. Both these cases involved the patient being discharged in person from the service but the patient record being held open until a later time.

We were told the variance in triage, assessment and discharge times were often due to how the information was

recorded. For example, patients often arrived ahead of their appointment time (sometimes by one or two hours) but the system logged their arrival time as the start of their appointment. All patients were assessed upon arrival and any concerns escalated accordingly. If the patient could wait until their allocated appointment they would be advised to wait. This made the patient waiting time appear longer from arrival time to consultation start and discharge as patients were seen in appointment time order and not arrival time order. In addition, we saw reviews of the longest recorded times from start to end of consultation. The analysis we were shown had identified how a patient record had been kept open so additional information (such as a test result) could be added later.

Overall waiting times for both primary care centres (PCC) for June 2018 demonstrated most patients were seen within their designated disposition time after triage had been undertaken:

- 93% of patients were seen, diagnosed, treated and discharged from a PCC within two hours after the telephone triage call had finished.
- 98% of patients were seen, diagnosed, treated and discharged from a PCC within six hours after the telephone triage call had finished.
- 95% of patients were seen, diagnosed and treated at their place of residence within two hours after the telephone triage call had finished.
- 95% of patients were seen, diagnosed and treated at their place of residence within six hours after the telephone triage call had finished.

We saw patient experience surveys where timely access to services was recorded. The questionnaire was undertaken between January 2018 and March 2018 with 161 responses returned:

- 80% of patients felt their call was returned without unreasonable delay.
- 77% of patients were satisfied at the length of time before the doctor arrived.
- 85% of patients felt they were seen promptly once they had arrived at the primary care centre.
- Waiting times, delays and cancellations were minimal and managed appropriately. Where people were waiting a long time for an assessment or treatment there were arrangements in place to manage the waiting list and to support people while they waited. The service offered calls to patients who were waiting beyond the expected time for triage or a home visit. At the bases, we saw information leaflets explaining the service and appointment system.
- The service engaged with people who are in vulnerable circumstances and took actions to remove barriers when people found it hard to access or use services. The service had a notice board in the base units specifically for the use of Westcall. The information boards offered details and photographs of the staff on duty each day so patients could identify who they were seeing.
- Patients with the most urgent needs had their care and treatment prioritised.
- Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.
- The appointment system was easy to use.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Thirteen complaints were received in the last year. We reviewed 10 complaints and found that they were satisfactorily handled in a timely way.
- Issues were investigated across relevant providers, and staff were able to feedback to other parts of the patient pathway where relevant. The service involved external stakeholders, such as NHS 111, where cross sector complaints were made.
- The service learned lessons from individual concerns and complaints. It acted as a result to improve the quality of care. Where learning actions were identified, these were explained to the complainant and shared with the clinical team. For example, GPs were reminded to fully inform patients and their relatives of the need for physical examination during a consultation.

Requires improvement

Are services well-led?

We rated the service as requires improvement for providing well led services.

Leadership capacity and capability

Leaders endeavoured to deliver high-quality, sustainable care. However, there was minimal oversight from the provider and leadership capacity and capability had not been effectively monitored.

- Leaders aspired to deliver the service strategy, although not all risks were identified or addressed. For example, safeguarding training had not been monitored or identified as a risk, infection control audits had not been undertaken and the service was not carrying out quality improvement activity.
- They were aware of issues and priorities relating to the quality and future of services. They understood there were challenges and were addressing most of them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- Senior management was accessible throughout the operational period, with an effective on-call system that staff were able to use.
- The provider had processes in place to develop leadership capacity and skills, including planning for the future leadership of the service.

Vision and strategy

The service had a clear vision and strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- The service developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The provider planned the service to meet the needs of the local population.
- The provider monitored progress against delivery of the strategy.
- The provider ensured that staff who worked away from the main base felt engaged in the delivery of the provider's vision and values.

Culture

The service had a culture of high-quality sustainable care.

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance of staff that was inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. All the incidents and complaints we viewed demonstrated an open and honest approach, including where the service had not performed to the required standard. Patients were offered an apology and advised of any learning actions taken by the provider. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All eligible staff had received an annual appraisal in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between managers, staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management. However, we noted these were sometimes inconsistently applied.

- The service had not ensured staff were clear on their roles and accountabilities in respect of safeguarding and infection prevention and control. There was a lack

of oversight of infection control processes at local service level. We found there had been no infection control audits undertaken for two of the premises used by Westcall and some concerns around cleaning and equipment had not been identified. Safeguarding training had not been monitored to ensure all staff were trained to the appropriate level for their role or competent in safeguarding procedures.

- There were clear structures, processes and systems to support the governance and management framework. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Leaders and managers did not always have access to information about the service which was held at trust level. For example, we found the service leaders did not have oversight of premises risk assessments.
- Leaders had established proper policies, procedures and activities to ensure safety. These were regularly reviewed to identify if they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks and issues, although some areas required a review.

- There were processes in place to identify, understand, monitor and address current and future risks including risks to patient safety. However, the provider had not considered or assessed the risks associated with GPs undertaking long working hours of up to 17 hours.
- We were shown a risk register of risks identified by Westcall. The register did not include the lack of safeguarding training for GPs.
- The provider had processes to manage current and future performance of the service. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of MHRA alerts, incidents, and complaints.
- Leaders had a good understanding of service performance against the national and local key performance indicators. Performance was regularly discussed at senior management and board level meetings. Performance was shared with staff and the local CCG as part of contract monitoring arrangements.
- The providers had plans in place and had trained staff for major incidents.
- The provider implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The service acted on appropriate information. However, not all the information the service used was accurate or up to date.

- The information used to monitor performance and the delivery of quality care was inconsistent and not always accurate. Not all incidents or events had been escalated according to the provider policy and reporting procedures and the risk register did not fully reflect all identified risks.
- The service used some performance information which was reported and monitored, and management and staff were held to account. However, the clinical audits we were shown did not demonstrate how the service had improved quality of care or outcomes for patients. There was minimal auditing of prescribed medicines to identify if guidelines were being followed or to demonstrate if the prescribing of high risk medications (including medicines at risk of misuse) was being monitored.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used information technology systems to monitor the quality of care.
- The provider submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. (Give examples).
- Staff were able to describe to us the systems in place to give feedback, although not all incidents or events were

Requires improvement

Are services well-led?

reported through the provider reporting system. Staff who worked remotely were engaged and able to provide feedback through formal and informal reporting channels.

- The trust carried out staff surveys but we were unable to view the feedback specific to only Westcall staff. We were told managers were hoping to gain Westcall staff feedback through a staff survey in October 2018.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the service. The service had reviewed skill mix and offered staff the opportunity to upskill into different roles and responsibilities.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- There was a culture of innovation and aspiration to improve the service. The provider had introduced paramedic practitioners and advanced nurse practitioners since the last inspection and were hoping to increase the team in the near future.
- There were systems to support improvement and innovation work.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met…** There were limited systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • Not all incidents and events had been reported by staff to inform the provider of themes and trends. • The provider had not engaged in effective quality improvement activity (including prescribing) to demonstrate impact on patient outcomes. • The provider had not risk or safety assessed GP working hours. • The provider had not risk assessed infection prevention and control for all service sites. **This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met…** The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular: • The provider had not monitored staff training to ensure all staff were up to date with Safeguarding training to the appropriate level, mental capacity act training or basic life support.

This section is primarily information for the provider

Requirement notices

This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.