Albion Street Clinic

Quality Report

Albion Street
St Helens
Merseyside
WA10 2HA
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Website: Not available

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of the Out of Hours service at Albion Street Clinic on 5 March 2015, between the hours of 17.00 and 23.30 hrs. Overall the clinic is rated as good.

The provider also runs a satellite clinic in Haydock on Sunday's. This clinic was not visited by CQC and is not included in our inspection.

Our key findings were as follows:

- The clinic had systems in place that supported staff and GPs in the delivery of safe treatment of patients, both at the clinic or when attending patients in their home.
  - The service provided by the clinic was effective in terms of urgent care and treatment delivery. This was evidenced by data, for example, in relation to reduced numbers of children attending the local accident and emergency unit to access primary medical care.
  - The GP led Acute Visiting Service for older patients, responded to calls from paramedics of the North West Ambulance Service, who could seek advice from the on-call GPs. The response rate from the Out of Hours service to these calls was typically 15 minutes and contributed to reduced hospital admissions for older patients.
  - The clinic was responsive to the demand for services, by patients unable to see their own GP. The management at the clinic produced 'real time' reports that highlighted future pressure points on the service. This information was shared with the 41 practices it served and with the local hospitals who could plan for anticipated surges in demand.
  - The service provided was highly valued by patients who used it. We received 97 CQC comment cards, where patients had expressed their views. All comments were positive and described how patients had been seen and treated by caring, compassionate and helpful staff.

We saw areas of outstanding practice including:

- Responsive and flexible services which included children's clinics which delivered a 20% reduction in numbers of children from the St Helens area, attending A&E.

Summary of findings

- A pilot scheme with the North West Ambulance service, where GPs from the Acute Visiting Service provided by the clinic, worked with paramedics to stabilise and treat older patients at home, reducing the need to transport and admit older patients to hospital. Figures showed that 91% of ambulance call outs to older patients were turned around in this way, meaning patients' were safely treated at home.

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

The provider should:

- Retain copies of staff checks conducted on GPs and nursing staff.
- Evidence checks on the working hours of GPs and keep records alongside evidence of indemnity insurance.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The provider is rated as good for providing services that are safe. GPs visiting patients in their home were accompanied by a driver, who stayed in the vehicle whilst the GP attended the patient. Medicines carried in the vehicles used by the service were stored safely and securely. Systems were in place to carry out safety checks on vehicles at the end of each shift. Governance processes ensured that each call to the service was recorded and that patient records were updated correctly. Call handlers had received training to ensure they were able to deal quickly and safely with patients, providing reassurance when needed.

Are services effective?

Outstanding

The provider is rated as outstanding for providing effective services. Significantly fewer parents with children (from the St Helens area) attended the local accident and emergency unit during the initial contract period where a paediatric clinic had been delivered by the out of hours service. St Helens CCG requested that the provider extend provision of its paediatric clinic, which ran daily between 1.00pm and 7.00pm.

Analysis of data showed that the number of admissions of older patients had been significantly reduced by the work of the Acute Visiting Service (AVS), run by the clinic. These admissions were further scrutinised to check if they were appropriate, and any learning from this was shared with practices signed up to the service.

Are services caring?

Good

The provider is rated as good for being caring. When required, staff would give geographical directions and the correct postcode to be used in a satellite navigation tool. We found the call handlers identified patients quickly on the computer system, and took relevant details quickly whilst reassuring patients, treating them with understanding and kindness.

Are services responsive to people's needs?

Good

The provider is rated as good for providing responsive services. As demand for house calls to older patients by the acute visiting service (AVS) had risen, the clinic had developed working relationships with other community practitioners, for example community care planner nurses, who could assist with acute care within a patient's home. The practice responded quickly to changing patient volumes;

Summary of findings

figures were used to inform the service of when it was appropriate to increase the amount of GP hours during peak periods. For example to assist with recognised winter pressures on local accident and emergency departments.

Are services well-led?

Good

The provider is rated as good for the domain of well-led. The clinic provided training opportunities for GP registrars (trainee GPs) so that they could experience out of hours work. All staff and clinicians at the clinic described a commitment to the delivery of high quality care and to promoting good outcomes for patients. The practice leadership team used a number of data sources to monitor the quality of services provided and to drive innovative thinking in how they responded to the needs of the population. Good communications were in place between the clinic and the practices signed up to the service. Strong governance processes were evident which staff understood and followed. Leadership was visible and supportive. Risks to patients were evaluated on a case by case basis, and staff were confident when dealing with patients who required support quickly.

Summary of findings

What people who use the service say

During our inspection, we were unable to speak directly to patients visiting the clinic.

We collected 97 CQC comment cards which patients had used to record their experience of the service. All comments were positive. A significant number of comment cards were from parents or grandparents of children who had used the service. Many of these people had described the service using words such as invaluable, outstanding, excellent and unbeatable. Comments were made showing that some patients had been previously unaware of the service, and given their experience, would definitely use it again. Some had commented that it had prevented them having to attend the local accident and emergency unit.

The practice had used an external company to carry out a patient survey. The survey questionnaires were issued to 100 patients who had attended the clinic in January 2015. From the 100 questionnaires issued, 88% of patients responded. The results were collated in March 2015. The findings were based on qualitative (commentary/opinion) data and quantitative data (numbers). We particularly noted that when patients were asked if there was anything about the service that could be improved, many patients had responded 'Nothing'. From the patients who responded 83% said they had no long term health condition and confirmed that their visit was for an acute problem. Of those patients who responded, 76% were seen by a GP. Of those patients seen by a GP, 50% said they thought the service was excellent, 20% rated the service as very good, and 11% rated the service as good. Overall, 85% of patients would recommend the service to friends and family.

The results of the patient survey commissioned by the clinic reflected the opinions expressed by patients on CQC comment cards.

Areas for improvement

Action the service SHOULD take to improve

Retain copies of staff checks conducted on GPs and nursing staff.

Evidence checks on the working hours of GPs and keep records alongside evidence of indemnity insurance.

Outstanding practice

Responsive and flexible services which included children's clinics which delivered a 20% reduction in numbers of children from the St Helens area, attending A&E.

A pilot scheme with the North West Ambulance service, where GPs from the Acute Visiting Service provided by the clinic worked with paramedics to stabilise and treat older patients at home, reducing the need to transport and admit older patients to hospital. Figures showed that 91% of ambulance call outs to older patients were turned around in this way, meaning patients' were safely treated at home.

Albion Street Clinic

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 advisor and a practice manager specialist advisor.

Background to Albion Street Clinic

St Helens Rota Ltd, who own Albion Street Clinic, is a not for profit, GP led co-operative, that provides out of hours care and treatment services to patients in the St Helens area. The clinic is delivered by GP's from the 41 practices that the service covers. Out of hours periods are defined as being between 18.30 hrs and 08.00 hrs on weekdays and on a 24 hour basis on Saturday, Sunday and bank holidays. The clinic is registered with the Care Quality Commission (CQC) to deliver the regulated activities:

- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder and injury.

The service delivers a satellite clinic on a Sunday, in the Haydock area. This was not covered as part of this inspection.

Albion Street Clinic is located close to St Helens town centre. The clinic has some parking available for patients. A system of secure access is in place, whereby patients attending an appointment request access via an intercom. Patients are seen by a GP or nurse practitioner in one of the two fully equipped treatment rooms. The building has the facility to convert a third room to a consulting and treatment room, for example, when dealing with higher volumes of patients during peak periods in the winter.

Patients who require the services of a GP out of hours are diverted to Albion Street Clinic by the telephone system at their own GP surgery, or by ringing the out of hours service directly. Where patients have been unable to get an appointment with their own GP, they are referred to the service after their symptoms and condition has been triaged (assessed by phone) by their own GP. The clinic also receives electronic (computerised) prompts and information from the NHS 111 service. Any patient in the area that has called 111, and who has been assessed by that service as needing to see a GP, will have their computerised details sent immediately to the clinic. The clinic call handlers contact these patients to arrange an appointment at the clinic, or to arrange a home visit.

St Helens is a town in Merseyside, North West England. The proportion of people recorded as having a long term limiting illness in St Helens is higher than the England average. Deprivation rates are higher than average and just over 25% of children are defined as living in poverty. Positive performance indicators include the proportion of older people still in their own home for 91 days following discharge from hospital. In 2013-14 this figure was high, particularly for patients aged over 85 years and over, at 95% locally, compared to just 79% nationally.

Why we carried out this inspection

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

Detailed findings

requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. The practice sent us a range of information for review before our inspection, such as current policies and procedures and recent clinical audits conducted. We carried out an announced visit on 5 March 2015. During our visit we spoke with a range of staff including the lead GP who was also a Director, the Operations Director, three managers, two drivers, two call handlers and an on-call GP.

Good

Are services safe?

Our findings

Safe track record

The provider demonstrated that it has operated safely since the service was established in 2006. The clinic 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 the patients. The staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. We reviewed a number of policies and procedures that all staff could refer to, to support them to deliver services safely. Consideration had been given to risks associated with GPs making visits to patients in their own homes, throughout the 24 hour period. A recent event demonstrated that if a GP was unable to deliver a house call due to accident or injury, arrangements in place meant another GP could be called upon to deliver the house call, whilst the needs of the injured GP were met without unnecessary delay.

We reviewed how quickly the service relayed details of patient appointments or house calls made, to the patients' own GP practice. We found the service performed very well in this regard, with just over 99% of patient consultation records being relayed to the individual GP practices by 8.00am the following day.

Learning and improvement from safety incidents

The clinic had a system in place for reporting, recording and monitoring significant events. We reviewed two significant events and found that the system of analysis and reflecting on these through sharing and discussion with the other clinicians, promoted learning. One example we reviewed with a director of the service, showed that learning was shared more widely, for example, with a patient's own GP practice. This showed how communication between the out of hours service and GP practices in the community contributed to the successful delivery of safe services. Where any significant event had affected a patient, the GPs on call reacted quickly to protect the patient from harm, putting patient safety first.

The clinic monitored information closely to check that they performed to National Quality Requirements (NQR). Where they had failed to meet any of the 12 NQR indicators, GPs and the Operations and Clinical Director conducted reviews to check performance was sufficient to ensure patient safety. The clinic shared data with us in relation to the National Quality Requirements (NQR) they report on, which underpin safety of patients. One of these is the record of the clinic on sharing information with practices, by 8.00am on the morning following treatment of a patient, within the out of hours period. Data showed that in the last two reporting periods, the clinic had achieved 100% in relation to this target. Another NQR indicator is that 95% of calls to the clinic must be answered within 60 seconds. Data for the Q3 period, available to us at the time of inspection, showed that the clinic had missed this target, achieving only 93.6% of calls answered within 60 seconds. We saw that the clinic had responded quickly to this, arranging for extra call handlers to be available as demand started to rise. In management review of numbers of calls taken, we saw that analysis concluded the rise in demand was due to the start of the winter pressures period. When the clinic failed to reach NQR indicators, information and data was available to assist the investigation as to why these had not been met, and whether patient safety was compromised.

Reliable safety systems and processes including safeguarding

All staff at the clinic had received regular safeguarding training, which was refreshed and updated annually. We reviewed records of safeguarding concerns raised by staff and found that staff knew who to report their concerns to within the service, and who to go to in the wider community should this be required, for example, St Helens local authority safeguarding teams. GPs we met on the day of our inspection, who worked on rota for the service, confirmed that they had received safeguarding training to the required level (Level 3). However, records to confirm this were not in place. The clinical director said he could access copies of these records from the main practice of each GP. We were able to confirm the training of the GP safeguarding lead at the service was up to date.

We saw there was a service level agreement in place between all constituent GP practices and the out of hours service, to have a GP available to answer any queries the out of hours GP may have. For example, in relation to a patient's medication, should a patient not be able to communicate this themselves. This contributed to patient safety in acute situations.

The clinic had a chaperone policy in place, which staff were able to refer to. Staff offered this service to any patient that may require a chaperone. All staff who worked at the

service had undergone background checks via the Disclosure and Barring Service (DBS) to ensure they were not unsuitable for this work, and had received training on chaperone duties.

The clinic had systems in place to annotate patient records if a child or vulnerable adult was subject to a safeguarding plan. The system in place was reliant on each practice it served informing the clinic of any new patients that were added to a safeguarding register, for example, when a patient moved into the geographical area. The Medical Director had liaised with Social Services for the St Helens area, asking if an up to date register could be shared with them to avoid any safeguarded patients being overlooked. This request was declined. As a result of this, safeguarding patients was covered as a standard item at each staff meeting and each meeting of GPs whose practices were part of the rota. The clinic had agreements in place with all practices to ensure real time updates were provided on all practice held registers of safeguarded children and adults, as well as real time updates on registers of terminally ill patients that may require GP services in the out of hours period.

Medicines management

The service used three vehicles to visit patients in their homes. Each was equipped with a doctor's bag that was sealed by a numbered safety tie. Each box contained a standard list of medicines that a GP may require when visiting a patient. When the box was opened, this was recorded along with any medicines used at each visit. When the GP's shift was over, the medicines used were reconciled and recorded in a master stock register. All used medicines would be replaced and the bag sealed with a new safety tie. When we checked the boxes we found all medicines were in date and safe for use.

The service held a small amount of controlled drugs. Controlled drugs are medicines which are subject to strict licensing conditions that could be misused and abused if not correctly managed. These items were held in a safe and access to the safe was limited to specific staff. All medicines in the safe were recorded in a register; any medicines issued were recorded, alongside the name of the patient the medicines were to be issued to, for example a patient receiving palliative or end of life care at home. When we reviewed the register we saw strict protocols were being followed and that the stock in the safe matched the records kept. Any medicines taken out of the safe by a GP were transported to a patient's home address in a locked box, and only the amount required by that patient was taken. The clinic had arrangements in place for the safe destruction of controlled drugs, and records were in place to support this.

The service directors had recently reviewed prescribing of medicines, with a view to focussing on-call GPs on specific medicines management. For example, if a medicine was issued on prescription by a GP on a week night, only the amount needed to get the patient through the following 48 hours should be issued.

Cleanliness and infection control

A building control manager was responsible for the cleaning of the clinic premises. This directly employed member of staff was supported with infection control procedures by the local infection control nurse. We saw that the clinic premises were clean and well maintained. We could see that where the infection control nurse had identified any areas that needed further attention, this had been actioned quickly. Cleanliness audits were undertaken at the clinic. We noted these were carried out by the building control manager, which meant this member of staff was checking their own work.

We saw that all clinical areas had hand washing facilities with lever taps, push handle soap dispensers and paper towels. Laminated posters were in place above sinks, giving guidance on effective hand washing. We saw these posters were in place above sinks in bathroom facilities for patients. We saw that all seating was made of suitable materials i.e. easy to clean. All floor coverings in treatment rooms and patient waiting areas were sealed and washable. When we checked toilet facilities for patients we saw these were clean, tidy and that baby change facilities were clean and checked regularly.

Sharps bins were stored in places where they would not be knocked over. We checked how sharps (needles) were carried in vehicles. We found sharps boxes suitable for use in vehicles, for example, sealed and small in size to ensure they were safely disposed of after each shift. Throughout the clinic we found accessible stocks of plastic aprons and gloves; gloves were also carried in each of the vehicles used by the service. We found drivers had also been trained in

infection control procedures. 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.

Equipment

The service had contracts in place and a register they used to systematically check all equipment used was safe and fit for purpose .This covered all items within the clinic and the vehicles, for example defibrillators (used to restart a person's heart) and nebulisers (for treatment of respiratory problems). All electrical items such as computers, laptops, portable telephones chargers, mobile phone chargers and any portable satellite navigation equipment was subject to PAT (portable appliance testing). In checks we made we saw all equipment was well maintained and ready for use. All electrical items in staff areas had also been PAT tested, for example kettles. Certificates were held on file for calibration of any medical equipment such as blood pressure cuffs.

Staffing and recruitment

The GPs who provided services for patients using the out of hours clinic, were drawn from the 41 practices that contracted with Albion Clinic to provide out of hours cover for their patients. GPs from these practices provided cover on a rota basis. As such, recruitment of GPs was not carried out directly by the clinic. The practices shared information with the service on things such as training updates GP's had received, appraisal dates and dates for re-validation. Locum use was minimal and was only required, for example, in peak holiday periods. When we interviewed the on call GP they confirmed that they were asked annually to show evidence of indemnity insurance and updated CPR training. If CPR training was found to be out of date, they would be assigned a place on CPR training delivered at the clinic, which is held twice a year. The clinic also did a check on how much rest time a GP had before reporting for their first shift following a period of annual leave. Although we were able to corroborate this by speaking to an on-call GP, the service did not keep detailed records of this and of the sharing of information on GPs training, indemnity insurance and hours worked.

Employees at the service were all long standing members of staff. Staff turnover was low. We reviewed the recruitment and training records of two staff members. We saw that an application form had been completed, and that the recruitment policy had been followed. Appropriate referencing and background checks had been conducted on all staff members. The service had recently recruited an advanced nurse practitioner for ad hoc cover in peak periods. The nursing registration and qualifications of this nurse had been checked and recorded.

Monitoring safety and responding to risk

The service demonstrated that it responded well to emerging risks, and through monitoring of appointments at the clinic and home visits required, it was able to plan for delivery of services in peak times of need, for example, in winter periods. The service had been involved in a pilot scheme with the North West Ambulance Service, whereby paramedics responding to a 999 call could contact the on call GP for advice on patients who had been seen through the acute visiting service. (Patients generally over 60 years old.) Review of data showed that this scheme had been extremely successful, but importantly, that there was no identifiable additional risk in the patient being treated by the paramedic or on call GP, rather than being admitted to hospital.

We saw that staff were competent and fully supported when addressing situations that could result in patient harm. We saw several examples of this. In one instance a call handler had been able to communicate with a patient experiencing a mental health crisis, in a way that de-escalated the level of potential harm, whilst passing details to on call GPs to attend to them urgently. This level of staff competence and experience contributed greatly to the safe running of the service.

The service had a health and safety policy. Health and safety information was displayed for staff to see at the clinic. Risk assessments on lone working and on GP's visiting patients in their homes were conducted and reviewed following any incident. This also included review of how quickly the service could deploy another on call GP in the event of a GP being injured or becoming ill. We saw that systems were in place whereby any driver would ring a GP if they had been in a property beyond what would be considered the usual timeframe. The service demonstrated that it had a good track record in monitoring safety of staff and patients

Arrangements to deal with emergencies and major incidents

Good

Are services safe?

The service had plans in place to deal with emergencies and major incidents. There was a business continuity plan with details of how the service would respond and continue to provide services in the event of loss of IT, premises, staff shortages and pandemic. There was also a winter pressures staffing plan, which was comprehensive and provided flexibility to manage capacity and demand. Staff had defined roles they would take in the event of an emergency.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The needs of patients who telephoned the service were quickly assessed by call handlers who offered patients an appointment with the clinic. When we observed staff taking calls we saw they followed guidance on call handling and that they did not make decisions as to who should be seen by a GP. Where call handlers identified that dental treatment was required, they would refer patients to the local out of hours dental care provider, giving the address and contact details, along with any directions required.

Details of patients who had telephoned the NHS 111 service, and had been assessed as needing to see a GP, were passed to the clinic electronically. These patients were telephoned by the clinic and invited to attend an appointment, if they were well enough to do so. Those patients who could not attend the clinic where scheduled to receive a home visit by the on-call GP. The 111 service transferred patient records securely from their computer system to the clinic; both services used the Adastra IT system, which facilitated this information transfer.

When patients were seen by a nurse or GP in the clinic, their needs would be assessed. When appropriate, clinicians could prescribe treatment. If a patient required medication immediately, this could be issued from stocks held at the clinic. The Acute Visiting Service (AVS) visited older patients in their home. We saw that good communication was in place between the patients' own practice GPs and the out of hours service GPs. Details of those patients who may require a visit in the out of hours period, were shared between the patients practice and the clinic which showed that the GPs of the AVS had sufficient information in most circumstances to reduce the need for them to respond in a simply 'risk averse' manner, but to offer assessment and treatment that avoided hospital admission for many older patients.

Management, monitoring and improving outcomes for people

The acute visiting service (AVS) for older patients commenced in 2006 and was the first of its kind in England. The service had been developed by GPs to improve out of hours care for older patients, which avoids unplanned admission for those patients who may have multiple health conditions. The service focussed on making each initial visit more effective, reducing the possibility of being called out to the same patient, or a call to the 999 service.

The AVS had made a significant impact on the reduction of unplanned admission to hospital of older patients. Data we reviewed showed that in 2010 the AVS delivered 2,370 visits to older patients who needed to see a GP. Of those patients, only 4.43% were admitted to hospital. (Older patients between 2010 and 2013 were classified as patients over the age of 65 years). In 2011, AVS delivered 1,910 visits to older patients. Of those patients, 8% were admitted to hospital. In 2012, AVS delivered 2, 147 visits to older patients needing to see a GP. Of those visits, 5.17% of patients were admitted to hospital. In 2013, the number of visits delivered by the AVS dropped, due to the scheme being restricted by the local clinical commissioning group to those patients over 80 years of age, where as previously the service covered patients over 65 years of age. As a result of this, in 2013 the service delivered 1,980 home visits to patients over 80 years of age who needed to see a GP. Of those patients, only 5.5% were admitted to hospital. In 2014, the scheme was extended to cover patients over 60 years of age. In 2014, the number of visits delivered by the AVS was 3, 916, with 7.5% of those patients being admitted to hospital.

Effective staffing

The service reviewed its allocation of GP and nursing hours, to respond to winter pressures and to ensure sufficient call handling staff were available to work at peak periods. We also noted that call handling staff who worked from 12.00 midnight until 7.00am, and who would be working in isolation during this period, were sufficiently experienced to do so. This was verified when we looked at the staff member's length of service, their relevant previous experience and details of any incidents they had dealt with. There were clear lines of accountability in place; staff told us they felt comfortable reporting any concerns they had to their line managers. We found the team leader and management structure was supportive of staff. Staff received regular one to one support and appraisal, where any areas of development could be discussed and training options explored.

The service typically provides 323 GP hours per week. The planning of clinics could be altered during peak periods to provide greater availability of appointments at the clinic,

and also by bringing in the services of an advanced nurse practitioner. Analysis of historical and 'real time' data meant that the clinic could 'ring fence' (protect) the provision of GP services allocated to the AVS and to the paediatric clinic.

GP hours allocated for the AVS totalled 90 hours per week. GP hours for the paediatric clinic totalled 30 hours each week. We looked at figures to see how effective the investment in GP hours for these two groups of patients had been. In November of the performance year 2013-14, 617 children presented at the local accident and emergency unit requiring what are considered to be GP services (Primary Medical Services). In the performance year 2014-15 when the paediatric clinic was being delivered, 492 children attended the local hospital requiring GP services. This represented a reduction of 20%. Closer analysis of attendances at local hospital by children showed that in December attendances were reduced by 10% and in January 2015 by 29%.

Overall, in its first quarterly period from November 2014 – January 2015, the attendance of children at the local hospital, who required GP services had been reduced by 20%.

Working with colleagues and other services

The clinic had a service level agreement in place with the practices that used the service. This included the provision that one GP from each practice would be available during the on-call period to discuss any patient that an out of hours GP may have concerns about, or may need to ask questions about. For example, about any medication prescribed earlier in the day. We saw how this worked well in practice and examples we reviewed demonstrated that it promoted high standards of care and treatment to patients by out of hours GPs.

The clinic had been involved with a pilot scheme with the North West Ambulance Service, whereby paramedics could ring the AVS out of hours GP for advice when attending a patient. This approach had led to 91% of patients, for whom an ambulance was called for using the 999 service, not being admitted to hospital. Following the initial success of this scheme, the pilot has continued into 2015-16.

The clinic was able to offer its services with a degree of flexibility. For example, in response to significantly reduced numbers of children attending the local accident and emergency unit, St Helens Clinical Commissioning Group (CCG) had requested that the provider extend provision of its paediatric clinic, which ran daily between 1.00pm and 7.00pm. Originally, this service was planned for three months and to be delivered between November 2014 and January 2015. This scheme contributed significantly to reducing 'winter pressures' on local hospital services and due to its success, the CCG had requested the service be extended until April 2015.

Information sharing

The clinic took steps to ensure that all information shared by practices was recorded appropriately. The clinic relayed information regarding visits to patients in the out of hours period, to the patients' own GP practice, by 8.00am each morning. Notes on any treatment delivered by the out of hours GP included details of any medication issued to a patient. We asked the clinic staff if they had any compliance checks in place to ensure that information sharing was effective, particularly that patient information was relayed practices by 8.00am, so GP's could schedule any follow up visits or telephone contacts with patients. The clinic was able to show us monitoring data from March 2014 to February 2015. This showed that the 99.22% of patient call outs and treatment information was relayed to practices by 8.00am each morning.

The clinic staff were aware that the computer system they used was not the same as the one generally used by practices in the local area. To address this, the clinic had a system in place whereby practices sent patient summary details, of those patients who may require a GP in the out of hours period. For example, those receiving palliative care or vulnerable patients who had recently been discharged from hospital. This was further supported by each of the practices signed up to the service, having one of their GP's on call, who could answer any queries from the visiting out of hours GP.

The service had systems in place to follow up on any patients who had failed to attend an appointment at the clinic. It was clear that patient safety was a priority to all staff; if a patient failed to attend their appointment at the out of hours clinic, staff would try and contact the patient. If unable to speak directly to the patient, staff contacted the local accident and emergency departments to see if the patient has presented there. If not, staff requested that the on-call GP visit the patient at home. All failure to attend appointments were reported back to the patient's own GP practice.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

The clinic was able to demonstrate that all medical staff had up to date training and awareness of issues around consent to care and treatment, the Mental Capacity Act 2005 and Gillick competency. Staff gave us examples of how advance care planning, particularly for those patients who were terminally ill, or in a nursing home, had assisted the out of hours GP's in the delivery of patient centred care. For example, where people had expressed a wish not to be admitted to hospital for end of life care, this had been shared in the care plan and followed by visiting GPs. GPs were able to describe how the death of any patient subject to a Deprivation of Liberty Order should be reported to a coroner, and how any best interest decisions should be made to ensure a patients safety.

Health promotion and prevention

The clinic staff we spoke with were able to show us a range of leaflets and information that they gave to patients using the out of hours service. We saw that this was done in a helpful way, with a view to increasing awareness of how, for example, childhood illnesses could progress quickly, and what action parents should take. Management staff reviewed attendance figures for the clinic and the details of GP call-outs, to spot any patterns emerging, for example, the same person using the service in the out of hours period, rather than making an appointment with their own GP. This could then be addressed by the patient's own GP practice.

The management and staff at the clinic were able to demonstrate that they had managed to change, or alter patient behaviours, which impacted positively on other acute health services, for example, the local hospital accident and emergency department. As the clinic provided for children between 1.00pm and 7.00pm had established itself, people who could not get to their own GP practice, or could not get an appointment, had used this clinic, rather than attending the local accident and emergency unit in the out of hours period. We received a significant amount of comment cards, which detailed parents' experiences of the clinic services for children, and how they had found this a very valuable service.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff we spoke with were aware of the importance of providing patients with privacy and of confidentiality. Staff told us that all consultations and treatments were carried out in the privacy of a consulting room when patients attended the clinic. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. We saw patients had access to a chaperone service. When patients were offered a chaperone, this was always recorded in the patient's electronic notes. If a patient declined the services of a chaperone this was also recorded.

When we observed call handlers taking incoming calls from patients who required an appointment at the clinic, we saw that they were responsive to patients' concerns. No calls were triaged and all patients were offered an appointment. The Operations Director told us that only at times where the service was operating beyond its planned capacity would calls be triaged by a GP.

Care planning and involvement in decisions about care and treatment

Any patients who required the services of an out of hours GP, and who could not travel to the clinic, would be offered a home visit by a GP. The requests for visits would be previewed by the on call GP to assess urgency and to check whether advice over the phone would meet the patients' needs. We saw that all patients were assured that the GP would be happy to make a home visit if a patient's needs merited this.

Patient/carer support to cope emotionally with care and treatment

The acute visiting service (AVS) provided by Albion Street Clinic, to patients who were generally over 60 years old, worked in conjunction with the patients' own GPs, to provide care and treatment that meant the patient, wherever possible, could stay in their home setting. The GP who delivered this service spoke of the reassurance they provided to carers and family members, when visiting older patients. The service had developed strong working relationships with local providers and community teams to ensure joined up care. We saw that information from patients' own GP practices was received and uploaded onto patient records. This provided background information for the on call GP from the acute visiting service, as well as significant information on any advanced decisions, preferred treatment location at end of life, and details of next of kin.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We were not able to speak directly with any patients during our visit to the clinic. However, we collected 97 CQC comment cards which patients had used to record their experience of the service. All comments were positive. A significant number of comment cards were from parents or grandparents of children who had used the service. Many of those people had described the service as 'invaluable', 'outstanding', 'excellent' and 'unbeatable'. Comments were made showing that some patients who had previously been unaware of the service, would definitely use it again. Some had commented that it had prevented them having to attend the local accident and emergency unit.

Tackling inequity and promoting equality

The clinic reviewed data to ensure that all patients were given equal access to services. In cases where it appeared a patient used the service regularly, rather than visiting their own GP, this was reported by staff to the relevant GP practice, so any issue could be addressed. The clinic staff were able to show us how they would deal with homeless patients when they came to the clinic, and how issues around 'no fixed abode' were addressed, enabling this patient group to access the service.

Access to the clinic was via a remotely controlled door at the front of the building. Staff could see the patient waiting outside the door on CCTV screens, located in the reception area. Staff told us any patients with restricted mobility or wheelchair users, would be helped to open the door by staff on duty in the reception area. All other rooms in patient and treatment areas were fully accessible. Staff told us they had access to interpreter services, should any patient require this.

One of the on call GPs we spoke with told us they had seen an increasing number of calls for out of hours mental health care. The GP told us they were aware of referral pathways for mental health patients in the out of hours period and how to contact mental health crisis teams. Staff based in the clinic who took calls from patients also had access to this information.

Access to the service

The clinic typically provided 323 GP hours per week. The structure of GP appointments meant the clinic was staffed from 6.30pm to midnight each week day. Two GPs were on duty in this period, with one delivering home visits, the other delivering patient appointments at the clinic. From midnight each week day, there was one GP on duty who could see patients at the clinic and deliver home visits. The clinic also operated throughout the weekend, offering appointments and home visit services.

We spent time with call handlers at the clinic. We saw sufficient staff were available to take calls, and that patients were able to get through to the clinic quickly. Call handlers were trained and we saw that they did not make decisions on whether a patient should be seen by a GP. If all available appointments had been booked, the call handlers would pass patients' details to a GP, to call back and determine whether an appointment or home visit was needed. At the time of our inspection the clinic was piloting a triage system for home visits at the weekend. The results of this pilot would be reviewed to ensure patients' needs were met, and that the resource available was used effectively but responsively to demand.

Listening and learning from concerns and complaints

The clinic had a complaints policy in place. This was referred to in the clinic leaflet, which was available in the reception area. We reviewed a complaint that had been received within the past 12 months. We saw that this followed the complaints handling policy, and that the complainant had received a response from the clinic. The complaint had been reviewed using the same approach applied to significant events, to ensure learning from the complaint was shared. The staff and GPs we spoke to told us the clinic had an open, no blame culture; staff said they felt supported by managers. Any verbal complaint was responded to immediately and staff confirmed they had access to a manager if a patient wished to speak to one.

Calls to the clinic were recorded and monitored for training purposes. Calls made from GPs to patients from mobile phones were also recorded. These were regularly reviewed by the operations and clinical directors, to ensure that patients access to the service timely and that the standard of telephone consultations provided by GPs met required standards.

Are services well-led?

Good

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

Our findings

Vision and strategy

The clinic did not have a 'defined' written strategy, but all staff were committed to the delivery of high quality care and to promoting good outcomes for patients. We saw evidence of planning for the future of the service. This included detail on how the service would be staffed and how it may be different to the model of out of hours care currently delivered.

Staff turnover was particularly low; the GP we spoke with on the day of our inspection had been working for the service for over 20 years. All call handling staff had been employed at the clinic for more than two years. Staff we spoke with told us they felt part of a team that was committed to providing access to care for patients that needed it. All staff expressed their pride in being part of a team that delivered a service that was highly valued by those patients who used it.

Governance arrangements

The clinic has a number of policies and procedures in place to govern activity and these were available to staff. The clinic had four managers in post who reported to the operations director. Each manager had responsibility for various functions within the clinic, for example policy and procedures, review of these and building and premises management. We saw that all necessary checks were in place to ensure the health and safety of staff and patients who used the building.

Performance and quality of GPs work was reviewed by the clinical director who reviewed 5% of GPs call outs per month. Checks were made that GPs were following set policies, for example, in relation to anti-biotic prescribing. Checks were also made that any prescribing followed medicines management policy, for example, on issuing only sufficient medication to patients to last them until they can see their own GP. We saw that patient waiting times were reviewed on a regular basis, especially for those patients requiring home visits. The directors communicated the results of some audits to the practices that used the service. For example, there was an audit each week which checked whether the wishes of patients regarding place of care at end of life, were followed. Regular weekly staff meetings were in place, when the findings of weekly audits and performance data were shared with the clinic staff.

Leadership, openness and transparency

The practice was led by the board of directors. Some took a lead role in the day to day management and delivery of services at the clinic. The clinical director and operations director provided visible leadership to staff. These leads used key data and outcomes to focus staff on priorities and to encourage engagement. The level of team working at the clinic extended beyond those employed by the service. For example, we saw how staff at the clinic, observed any instructions on patient records, with regard to contacting a patient's named GP, if a patient's condition had deteriorated overnight.

Leads at the clinic understood the challenges that GPs and staff faced when delivering care to patients in the community. Staff safety was a priority and we saw that staff welfare was protected. Staff were offered support when dealing with situations that could be stressful, and were encouraged to talk about any incidents they had been involved in. The behaviours of leaders were mirrored by staff; staff told us they felt valued, respected and that their commitment to the service was acknowledged by their leaders.

Leads had recently compiled a bid to deliver out of hours services from 2016. Within this we saw that consideration had been given to future staff planning and the skills set required to deliver out of hours services in the future.

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

As Albion Clinic is an out of hours service it did not have a patient participation group (PPG). However, the clinic did commission an annual patient survey. We reviewed the results of the most recent survey, (2015) which showed the clinic performed well in all areas that are known to be important to patients, such as accessibility, availability of appointments, waiting times and environment.

Staff told us they felt they could express their views openly and that they would be listened to. Full staff meetings had proved problematic due to the 24 operation of the service,

Are services well-led?

Good

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

but a number of other meetings did take place regularly, for example communication meetings, significant event meetings, performance review meetings and various staff nights/days out.

Management lead through learning and improvement

The clinic had used data to target improvements to the service. This data was reviewed year on year, to provide a picture of how well the service had progressed. One particularly good example of this was the analysis of the effectiveness of the acute visiting service (AVS). The clinic had also applied a further test to measure inappropriate admissions. These were determined by the length of stay of a patient on admission to hospital. If a patient was discharged within 24 hours with no further treatment, the admission was regarded as being inappropriate. This information was used to review how out of hours GPs made decisions about referring patients to hospital and to see if all steps were taken to reduce the possibility of unplanned admission. We saw that management worked with all the practices to deliver a service that supported good patient outcomes. For example, by following of care plans and advanced decisions of patients regarding preferred place of care.