Care UK – Warwickshire

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Care UK Warwickshire on 6 March 2015. Overall this out-of-hours service is rated as good. Specifically we found this provider to be good for providing safe, effective, caring, responsive and well-led services.

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

- The out-of-hours service provided safe care and treatment. Care UK Warwickshire had procedures in place which identified and minimised risks to patients who used the service.
- Staff delivered safe care and treatment and received appropriate training and supervision to enable them to do so.
- The out-of-hours service was responsive to patients' needs. It provided face-to-face consultations, telephone consultations and home visits depending on the needs of patients.
- The out-of-hours service had procedures in place to monitor the effectiveness of its patient care and treatment. This was carried out in a consistent way which ensured the performance of the out-of-hours service was closely monitored. When improvements were needed these were identified and steps were taken to make improvements.

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 out-of-hours service is rated as good for providing safe patient care and treatment. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The out-of-hours service provided opportunities for the staff team to learn from significant events and was committed to providing a safe service. Information about safety was recorded, monitored, appropriately reviewed and addressed. The out-of-hours service assessed risks to patients and managed these well. There were enough staff to keep patients safe.

Are services effective?

Good

The out-of-hours service is rated as good for providing effective patient care and treatment. Patients' care and treatment took account of guidelines issued by the National Institute for Care and Health Excellence (NICE). Patients' needs were assessed and care was planned and delivered in line with current legislation and guidelines for providing unscheduled (out of hours) care. Staff received training and supervision appropriate to their roles and the practice supported and encouraged their continued learning and development.

Are services caring?

Good

The out-of-hours service is rated as good for providing caring services. Patients told us they were treated with compassion, dignity and respect and they were involved in their care and treatment decisions. Easy to understand information was provided to help patients understand the care available to them. We saw that staff treated patients with kindness and respect and were aware of the importance of confidentiality.

Are services responsive to people's needs?

Good

The out-of-hours service is rated as good for providing responsive patient care and treatment. It was aware of and reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients we spoke with said they were happy with the service provided and the out-of-hours service had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand. We saw the out-of-hours service responded quickly to issues raised. Learning from complaints was shared with staff and used to make improvements when appropriate.

Summary of findings

Are services well-led?

Good

The out-of-hours service is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

What people who use the service say

We gathered the views of patients from the out-of-hours service by speaking in person with twelve patients.

All the patients we spoke with were complimentary about Care UK Warwickshire. Patients said they were offered an appointment when needed. They told us they received a telephone call from the service within the agreed time scale and had been offered an appointment. Patients told us GPs and advanced nurse practitioners were professional and courteous at all times. At all three sites we visited as part of this inspection, we saw appointments to see a GP were running to time.

We looked at the results from the latest monthly patient surveys carried out in January and February 2015. We saw patients who responded gave the out-of-hours service positive ratings for areas such as care, treatment and advice.

Care UK – Warwickshire

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspection manager. The inspection team also included a second CQC Inspection Manager, a GP specialist advisor, a practice manager specialist advisor and an expert by experience (a person who has experience of using this particular type of service, or caring for somebody who has).

Background to Care UK – Warwickshire

Care UK Warwickshire provides out-of-hours primary medical services across Warwickshire when GP practices are closed. The out-of-hours service covers a population of approximately 540,000 people across the county of Warwickshire. The area covered incorporates three Clinical Commissioning Group (CCG) areas, South Warwickshire, North Warwickshire and Coventry and Rugby. South Warwickshire CCG is the lead commissioner for this out-of-hours service.

The out-of-hours service is provided across five primary care centres located at George Eliot Hospital in Nuneaton, Warwick Hospital and St Cross Hospital in Rugby, which are open seven days per week. The Ellen Badger Hospital in Shipston and Trinity Court Surgery in Stratford upon Avon are open at weekends. The administrative base for Care UK Warwickshire is located at the George Eliot

Hospital. Most patients access the out-of-hours service via the NHS 111 telephone service. Patients may be seen by a clinician at one of the primary care centres, receive a telephone consultation or a home visit, depending on their needs. Patients can also access the primary care centres as a walk-in patient or be referred from the hospital accident and emergency departments.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before under its current organisation and that was why we included them. An inspection had been carried out of the previous provider – Harmoni, in June 2014.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

Before this inspection, we reviewed a range of information we held about Care UK Warwickshire and asked other organisations to share what they knew. These organisations included South Warwickshire, Warwickshire North and Coventry and Rugby Clinical Commissioning

Detailed findings

Groups (CCGs), NHS England local area team and Healthwatch. We attended listening events held by the Care Quality Commission (CQC) hospital inspectorate at University Hospital, Coventry and St Cross Hospital, Rugby.

We carried out an announced inspection outside standard working hours on 6 March 2015. This included the sites at George Eliot Hospital, Nuneaton, Warwick Hospital and St Cross Hospital, Rugby. During the inspection we spoke with a range of staff; this included the medical director, clinical lead, two GPs, the general manager, shift co-ordinator, regional clinical governance manager, home visiting supervisor and a driver. We also spoke with twelve patients.

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?

Good

Are services safe?

Our findings

Safe track record

The out-of-hours service used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, concerns had been reported about infection control procedures apparently not being followed by some clinical staff on home visits. These incidents were, investigated and relevant staff were reminded of the correct infection control procedures to be followed.

We reviewed safety records, incident reports and minutes of meetings where these had been discussed, for the last 12 months. This showed the out-of-hours service had managed these consistently over time and could show evidence of a safe track record.

Learning and improvement from safety incidents

The out-of-hours service had systems in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 12 months and we were able to review these. Significant events were discussed at staff meetings and complaints were reviewed. There was evidence that the service had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff knew how to raise an issue for consideration at the meetings.

Management told us staff attendance at team meetings had sometimes been an issue. This had been prioritised as an area that needed improvement. To ease this, meetings were revolved around the different Care UK Warwickshire sites and staff confirmed they all received details of meeting minutes and action points after each meeting.

We were shown the system used to manage and monitor incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken when a needle had been left in the back of a car after a home visit. The event had been reported, discussed with staff and actions taken to reduce the risk of it happening again. We were also shown an example of a fever that was not correctly diagnosed in a child. We saw evidence this was fully investigated and as a result revised guidelines, which included a risk assessment, were issued to all clinical staff regarding the diagnosis of fevers in children. When patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken, in line with the provider's complaints policy.

A system was also in place within Care UK to learn from safety incidents across the provider's other sites in England and share best practice with other locations. The medical director produced a regular newsletter called 'Reflect' which highlighted national concerns, incidents and updates. We were shown an example which reviewed all serious incidents which occurred between April and September 2014. Learning points from these incidents were clearly summarised.

Reliable safety systems and processes including safeguarding

The out-of-hours service had systems to manage and review risks to vulnerable children, young people and adults. This included safeguarding policies for adults and children. Staff knew how to access these policies. They were also aware of their responsibilities and knew how to share information,, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details for relevant agencies were easily available to staff and staff knew how to access this information. We were shown examples of two safeguarding concerns for adults and children. The out-of-hours service had correctly identified these and took all the necessary appropriate action.

We looked at training records which showed that all staff had received relevant role specific training on safeguarding. It was also covered when new staff were introduced to the service. We asked members of medical, nursing and administrative staff about their training and reviewed the training record. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children.

There was a system in place to highlight potentially vulnerable patients and for receiving information from other services for adults who were at risk or when a protection plan was in place for a child. Staff told us about the system to deal with occasions when a GP was unable to make telephone contact with a patient. This included a

check with the NHS 111 service to ensure they had the correct contact details for the patient and when appropriate, for example, if a patient was considered to be at risk, a visit was made to the patient's home.

There was a chaperone policy in place and a sign to advertise this was displayed in the patient waiting rooms at the three sites we inspected. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.) We examined training records which demonstrated all appropriate staff had received chaperone training. On visits to patients' homes, drivers acted as chaperones. Drivers had been checked with the Disclosure and Barring Service (DBS). These were checks to 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 vulnerable people or children.

Medicines management

The out-of-hours service had appropriate systems in place regarding the management, safe storage and checking of medicines used to treat patients. Medicines controlled under the Misuse of Drugs Act 1971, such as strong painkillers were stored in an appropriate secure way and were properly accounted for to ensure they were not misused. We saw that medicines available were regularly checked and monitored to ensure sufficient stocks were held and they had not exceeded the expiry date recommended by the manufacturer to ensure their effectiveness. Expired and unwanted medicines were disposed of in line with waste regulations.

Medicines were delivered in complete boxes which had been assembled by the supplier. A colour coded tag system was used to signify whether a box was complete (green tag) or whether some of the contents had been used and was in need of refilling (red tag). We saw reminders had been issued to all staff to ensure this system was correctly followed. We observed this was correctly followed and staff understood the system. In our inspection of the previous provider carried out in June 2014, this procedure had not always been followed correctly. The out-of-hours service was able to demonstrate this was now correctly carried out.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the out-of-hours service and kept securely at all times. A policy was in place to only issue three days' worth of a repeat prescription at a time to avoid any abuse of medicines. For a longer supply, the patient would then need to contact their GP practice.

Cleanliness and infection control

We observed all three sites inspected to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. The service at the George Eliot hospital used a contract cleaner, but could call the hospital on-site staff at any time if they had an emergency.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received regular updates. We saw evidence that the lead had carried out a regular infection control audit. This had last been carried out in January 2015. No concerns had been identified.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. They included the safe use and disposal of sharps; use of personal protective equipment (PPE); spills of blood and bodily fluid amongst others.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The service had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the service carried out annual checks in line with this policy to reduce the risk of infection to staff and patients. The latest legionella risk assessment had been carried out in January 2015.

There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. Medical equipment included blood

pressure monitoring devices and emergency equipment such as an automatic external defibrillator (used to restart a person's heart in a cardiac emergency). Staff told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs. We checked four blood pressure monitoring devices and noted only one had been calibrated at the time of our inspection. Following our inspection, the out-of-hours service had updated these checks and recorded additional checks that had been carried out. During our inspection of the previous provider in June 2014, we noted the provider should review and implement robust systems for routinely checking equipment used at the out-of-hours service to ensure equipment is in date and in good working order. We were shown by management staff that this had been carried out.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date, January 2015. A schedule of testing was in place.

Staffing & Recruitment

We were shown how the out-of-hours service ensured there were sufficient numbers of suitably qualified, skilled and experienced staff on duty each day at each location. There was a staff rota throughout the week which covered all locations run by Care UK Warwickshire.

There was a procedure for recruiting new staff to ensure they were suitable to work in an out-of-hours environment with a recruitment policy which set out the standards required for clinical and non-clinical staff. The policy detailed all the pre-employment checks to be undertaken on a successful applicant before that person could start work in the service. This included identification, references and a criminal record check with the Disclosure and Barring Service (DBS). These were checks to 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 vulnerable people or children. Care UK had a policy of renewing DBS checks every three years. One staff member started their employment at the out-of-hours service before DBS checks were introduced. Whilst the out-of-hours service awaited the results of their DBS check, the staff member did not work alone with patients.

We checked the records of ten clinical staff and found the appropriate checks had been carried out, including registration with appropriate professional bodies, including the General Medical Council (GMC) for GPs. Memberships of professional bodies were checked annually. It was also ensured that GPs were included on the performer's list. All staff undertook a period of induction when new to the out-of-hours service. This gave them appropriate training, enabled them to settle into their new role and become familiar with relevant policies and procedures.

We were shown how all self-employed staff had their qualifications reviewed by the out-of-hours service before they were contracted to work.

We were shown the business continuity plan which had been developed by the out-of-hours service which advised what to do should there be an shortage of GPs and practice staff due to sickness. This included arrangements for using locum GPs. This would help to ensure sufficient availability of GPs to continue the primary care service provision to patients.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. This included emergency risk assessments in place for children, patients who arrived without an appointment, non-arrival of patients, regular checks of the building, medicines management, staffing, dealing with emergencies and equipment. We were also shown that when a GP was late for a home visit, a telephone call (called a 'comfort call') was made to patients to check on their welfare and ensure their situation had not changed.

The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative who had received appropriate training for the role.

Identified risks were included on a risk log. Each risk was assessed and rated and actions recorded to reduce and manage the risk. We saw that any risks were discussed during staff meetings. For example, operational difficulties with the NHS 111 service that had an impact on patients.

Arrangements to deal with emergencies and major incidents

The out-of-hours service had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including oxygen and an automated external defibrillator (AED). This is a portable electronic device that analysed life threatening irregularities of the heart including ventricular fibrillation and was able to deliver an electrical shock to attempt to

Good

Are services safe?

restore a normal heart rhythm. When we asked members of staff, they all confirmed they had been shown the location of this equipment and records confirmed that it was checked regularly. Emergency medicines were available in a secure area of the out-of-hours service and all staff knew of their location. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. Emergency equipment was also available in cars used to transport GPs on home visits, including oxygen and an AED. Staff had received training in cardiopulmonary resuscitation (CPR). This is a first aid technique that can be used if someone is not breathing properly or if their heart has stopped.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the out-of-hours service. This identified the responsibilities of key members of staff in identifying and managing the risks to the provision of the out-of-hours service. Risks identified included risks to patients. There was no specific risk assessment for patients whose condition might have deteriorated whilst waiting for their appointment, but staff we spoke with clearly explained how they would summon help if the situation arose. One staff member we spoke with explained how a patient had arrived earlier that evening with chest pains. Staff immediately called for help and the patient received immediate medical support.

A disaster recovery plan was in place. This gave guidance on dealing with emergencies such as fire, telephone and computer failure and reduced staffing availability. The out-of-hours service had carried out a fire risk assessment in and all staff received regular fire safety training.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

Patients' needs were assessed and care and treatment was planned and delivered in line with their individual needs and preferences. Staff followed guidelines issued by the National Institute for Health and Care Excellence (NICE) – the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment. We were shown how new guidance was regularly reviewed and highlighted to staff during staff meetings and were shown records of meetings that demonstrated revised guidelines were identified (for example with the treatment of children with a fever) and staff were trained appropriately. This ensured patients received safe care and treatment in line with current guidelines. GPs we spoke with were able to outline their rationale for care and staff demonstrated they were fully aware of current best practice guidelines.

Management, monitoring and improving outcomes for people

Systems were in place to monitor and improve outcomes for patients. The out-of-hours service had a system in place for completing clinical audit cycles. Examples of completed clinical audits included prescribing and safeguarding. Dates had been set to repeat audits to determine their continued effectiveness, some of which were determined nationally by Care UK for all of its locations across England, for example, safeguarding.

All new clinical staff were audited on their patient consultations for their first month and were given feedback by email. Audits of telephone consultations were also carried out, a total of 20 every month and the results of these were fed back to clinical staff. We were shown records that demonstrated the out-of-hours service made changes to processes and procedures if appropriate following these audits. The out-of-hours service audited 1% of all clinical records every month. For example, the procedure for telephoning patients to check on their welfare if the GP had been delayed was changed following one of these audits. We saw evidence feedback was given to clinical staff following the completion of these audits. A GP told us this feedback was very useful.

Effective staffing

The out-of-hours service employed staff who had the appropriate skills and training to perform their required duties. This included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support and safeguarding. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff had annual appraisals as part of the procedure to monitor individual staff performance. The appraisals identified learning needs from which action plans were documented. Staff had individual development plans which highlighted objectives for learning and development. This was reviewed as part of the regular 121 process and annual appraisal scheme. Management staff told us the out-of-hours service was behind on staff appraisals, but we saw a plan had been put in place to deal with this backlog. We were shown the staff training records. We were told that a new system was currently being developed which would also highlight when training was due and when it was overdue. A staff induction system was in place. This included shadowing existing staff and mentoring.

Staffing levels were regularly reviewed to ensure appropriate staff with appropriate skills were on duty during each shift to meet the demands of patients. Use of locum GPs and nursing staff was managed through a service level agreement with the appropriate staffing agencies. We were shown how this was monitored and any concerns were raised with the relevant agency. GPs had clearly defined roles for carrying out face to face consultations (both at the out-of-hours locations and in patients' homes) and also telephone consultations. Clinical staff working in the out-of-hours locations were supported by reception and administrative staff. Visiting GPs had drivers who had also received training to act as patient chaperones.

Working with colleagues and other services

The out-of-hours service worked with other healthcare organisations. This included the NHS 111 service and

Good

Are services effective?

(for example, treatment is effective)

locally based district nursing teams. As the Nuneaton location was close to the George Eliot Hospital accident and emergency department, patients were able to receive co-ordinated care and treatment which depended on their individual needs. The out-of-hours service had appointments reserved for patients to be referred from accident and emergency, which meant less urgent cases could be handled by the out-of-hours service. This could be used to reduce pressure on the accident and emergency department at busy times. There was a shared electronic system with an agreed pathway in place to facilitate this because the IT systems were not linked.

Management staff told us they had regular discussions with other local out-of-hours providers to identify concerns, including staff who worked too many shifts and therefore became a potential risk to patients.

The practice held staff meetings every month to discuss concerns. Minutes of these meetings were emailed to all relevant staff afterwards. This ensured staff who had been unable to attend a meeting were kept informed.

Information sharing

The out-of-hours service had systems in place to ensure staff were provided with information they needed. An electronic patient record system was used to document, record and manage care. There was a system for communication carried by GPs whilst on home visits to ensure relevant information was available when required.

The out-of-hours service used an electronic system to communicate with other providers. For example, the local district nursing teams. Following patient consultations, each patient's GP received an update by 8am the next day, in line with out-of-hours guidelines. The out-of-hours service monitored this and we saw results which demonstrated this target had been consistently met. All staff had received training on these systems.

Consent to care and treatment

There were processes to obtain, record and review consent decisions obtained within the out-of-hours service. This included verbal and implied consent. Clinical staff we spoke with demonstrated a clear understanding of the importance of determining if a child was Gillick competent especially when providing contraceptive advice and treatment. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding the implications of the proposed treatment, including the risks and alternative options.

Staff we spoke with had an understanding of the Mental Capacity Act 2005 and demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability.

The practice used an interpretation service to ensure patients understood procedures if their first language was not English. This was included within the appropriate policies, along with sign language.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We obtained the views of patients who used the out-of-hours service and spoke with 12 patients. All patients we spoke with were complimentary about the service. Patients told us they were treated with dignity and respect by all members of staff. During our inspection we observed within the reception area how staff and patients interacted with each other, in person and over the telephone. Staff were helpful, polite and understanding towards patients.

Staff we spoke with were aware of the relevant policies for respecting patients' confidentiality, dignity and privacy. Reception staff told us how patients could be seen in a private room if they wished to have a private conversation with a receptionist.

The out-of-hours service obtained patient feedback by surveying 1% of patients every month. This comprised of an onsite and postal survey. This included questions about whether patients would recommend the service, their overall experience, whether they felt listened to, had enough time and whether they had been treated with dignity and respect. We reviewed the results of the patient survey carried out in January and February 2015. In January, patients had expressed concerns about delayed home visits. The out-of-hours service reviewed this and intended to address the arrangements for telephoning patients with the drivers. Some of the responses received from patients in February included comments on how excellent and professional the service was. Staff were referred to as helpful and professional.

Care planning and involvement in decisions about care and treatment

We looked at patient choice and involvement. GPs explained how patients were informed before their treatment started and how they determined what support was required for patients' individual needs. Patients we spoke with told us they felt informed about and involved with their care. GPs described treating patients with consideration and respect and said they kept patients fully informed during their consultations and subsequent investigations. Patients we spoke with confirmed this and told us decisions were clearly explained and options discussed when available. Patients had the information and support available to them to enable them to make an informed decision about their care and treatment needs.

A system of 'comfort calling' patients was in place to ensure patient welfare if the GP was going to be delayed for a home visit. Drivers who undertook comfort calls had received appropriate training for this.

Medical students often attended out-of-hours consultations as part of their training. We saw a notice was displayed in the reception area to information patients of this and also of their right to refuse to have a medical student present during their consultation if they so wished. Trainee GPs medical students and advanced nurse practitioner students often attended out of hours consultations as part of their training.

For patients who did have English as a first language, a translation service was available if required and language cards were available on the wall by reception desks to assist with communication.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The out-of-hours service was responsive to patients' needs and had appropriate systems in place to maintain the level of service provided. There are National Quality Requirements (NQRs) produced by the Department of Health that out-of-hours providers are required to comply with to ensure services are safe, clinically effective and responsive. NQRs include arrangements for managing periods of peak demand. They are measured by auditing response times for initial telephone calls and both telephone and face to face consultations, waiting times and appointments. We saw the out-of-hours service monitored these on a daily basis. We looked at performance data for the last 12 months and saw the out-of-hours service had mostly met these during that time. When the service had failed to meet targets, a plan had been put in place and appropriate action taken. The service level agreement with the NHS 111 service was monitored to ensure the out-of-hours service responded promptly to demands placed upon the service by referrals made by NHS 111.

Within the out-of-hours location, the service prioritised children and potentially vulnerable people to ensure they received appropriate care and treatment in a timely way.

Tackling inequity and promoting equality

The out-of-hours service understood and responded to the needs of patients with diverse needs and those from different ethnic backgrounds. For patients who did not have English as a first language, a translation service was available if required and language cards were available on the wall by reception desks. The out-of-hours service had an induction loop to assist people who used hearing aids and staff could also take patients into a quieter private room to aid the discussion if required. The building was fully wheelchair accessible apart from the main entrance door which was not automatic; however staff could assist a patient who experienced difficulty.

The standard appointment time was 12 minutes; however we were told that clinical staff had freedom to extend this time if a patient needed longer because of their needs, for example, a patient with a learning disability.

Access to the service

Patients were primarily referred to the out-of-hours service by the NHS 111 service and were then allocated an appointment time during their telephone consultation. Appointments for face to face and telephone consultations were prioritised according to the clinical needs of each patient. During our inspection, we saw appointments ran to time and patients were promptly seen. Staff told us patients would not be turned away if they walked into the service without an appointment.

The main out-of-hours service was located in a building adjoining the George Eliot Hospital, Nuneaton. We saw the patient waiting area could easily accommodate patients in wheelchairs and with prams. There was also easy access to the consultation rooms.

Listening and learning from concerns & complaints

The out-of-hours service had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for out-of-hours services and GPs in England. There were designated responsible people who handled both clinical and non-clinical complaints in the service. We were shown how patients' concerns were listened to and acted upon. There was information about how to complain displayed in the waiting area. All of the patients we spoke with said they had never had to raise a formal complaint. The complaints procedure identified how complaints would be dealt with. It also identified the timescales for responding to and dealing with complaints. The practice had a complaints summary which summarised the complaints for each year. This was used to identify any trends.

We looked to see whether the out-of-hours service adhered to its complaints policy. In the last 12 months, 31 formal complaints had been received by the service. All had been handled within the timescales publicised within its complaints procedure. No patterns were evident regarding the types of complaint received. Complaints were discussed at monthly staff meetings and information and learning points from complaints were cascaded to all relevant staff by email. We examined a complaint where a non-clinical member of staff had appeared to have given clinical advice to a patient. Following this, the out-of-hours service issued a reminder to all non-clinical staff not to do this. It was also clear that verbal complaints were dealt with in the same way as written complaints.

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 out-of-hours service had a clear vision and strategy to deliver out-of-hours care. Patient and staff experience was a top priority with patients at the heart of the service with staff making a real difference. Staff we spoke with during our inspection reflected this vision in their discussions with us and knew what their responsibilities were in relation to these.

Systems put in place by the out-of-hours service clearly focussed on outcomes and improvement in the delivery of out-of-hours care. The service actively sought and focussed on areas where they could improve outcomes for patients. Through regular audit, review and the views of patients and staff, appropriate changes were made when necessary.

Governance Arrangements

Key staff all had lead roles and specific areas of interest and expertise. This included governance with clearly defined lead management roles and responsibilities, safeguarding, infection control and complaints. During the inspection we found that all members of the team we spoke with understood these roles and responsibilities.

Care UK Warwickshire displayed an atmosphere of teamwork, support and open communication. The practice held regular meetings of clinical staff which included discussions about any significant event analyses (SEAs) that had been done, audits, complaints and performance issues. We saw action plans were used to address any areas for improvement.

We reviewed the minutes of the service's quality assurance group held in November 2014. This demonstrated all emergencies had been responded to within one hour and all details of patient consultations had been passed to each patient's GP by 8am the next day. Other areas monitored were within target, but had still shown improvement from one month to the next.

Leadership, openness and transparency

The out-of-hours service had a clear management structure with clearly identified lines of accountability for clinical and non-clinical staff. Staff had regular meetings to discuss any relevant developments, updates, concerns and complaints. Management staff told us that as Care UK Warwickshire operated from five locations, attendance at these meetings was an issue at times. To facilitate this, the meetings were moved around the different locations used by the service and all staff received email updates. We saw evidence of this. Staff told us they felt able to raise concerns. This could be formally through the relevant computer based information system, or informally via email, face to face staff contact or by telephone with the line manager or any of the management team. Shift concerns could be reported to the shift co-ordinator and followed up later by the relevant manager or supervisor. We were shown evidence of the shift co-ordinator's log.

Practice seeks and acts on feedback from users, public and staff

The out-of-hours service obtained patient feedback by surveying 1% of patients every month. This comprised an onsite and postal survey. This included questions about whether patients would recommend the service, their overall experience, whether they felt listened to, had enough time and whether they had been treated with dignity and respect. Patient feedback forms were available at the three sites we inspected.

We reviewed the results of the patient survey carried out in January and February 2015. Patient comments were mostly positive and patients were satisfied with the service they received. When areas of concern were highlighted, the out-of-hours service took appropriate steps to investigate and deal with the concerns. For example, in January, patients had expressed concerns about delayed home visits. The out-of-hours service reviewed this and intended to address the arrangements for telephoning patients with the drivers.

There was also engagement with staff to seek their views about the service and had the opportunity to make comments and suggestions about the way the service was managed. These were actively sought and were discussed in team meetings. For example, we saw a recent suggestion from a staff member to introduce patient observations when patients were waiting for consultations when there were suitably trained staff available. Management had agreed to implement this and a discussion was underway on how to best implement it. Feedback from staff and patients was also used to track the performance of individual staff members.

Management lead through learning & improvement

We saw evidence the out-of-hours service was focussed on quality, improvement and learning. There were

Are services well-led?

Good

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

management systems in place which facilitated learning and improved performance. Staff we spoke with confirmed they received annual appraisals and their learning and development needs were discussed. Management systems demonstrated the service sought to learn, improve patients' experience and deliver high quality care. Records demonstrated regular audits were carried out as part of the quality improvement process to improve the out-of-hours service and patient care. We looked at audits for telephone consultations and prescribing and saw that staff had been given relevant feedback when appropriate. The results of significant event analyses and clinical audit cycles were used to monitor performance and contribute to staff learning.