West Midlands Integrated Urgent Care - Worcester

Quality Report

Stonham House
Blackpole Trading Estate West
Worcester
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Website: www.worcsoutofhours.nhs.uk.

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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

Key findings

Contents

Letter from the Chief Inspector of General Practice

This service is rated as Good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? –Good

We carried out an announced comprehensive inspection at West Midlands Integrated Urgent Care - Worcester Out of Hours on 28 and 29 March 2018 as part of our inspection programme.

At this inspection we found:

- The service had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes.
- The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- Systems were in place to manage people who experienced long waits. For example, a telephone call (called a 'comfort call') was made to patients to check on their welfare and ensure their situation had not changed.
- The service had good facilities and was well equipped to treat patients and meet their needs. The vehicles used for home visits were clean and well equipped.
- The service had systems in place to forward plan for times of high demand for example bank holidays.
- There was a clear leadership structure and staff felt supported by the management team.
- Care UK carried out an annual staff survey and had increased responses overall from the 2016 results for example, the number of staff who would recommend Care UK services to a someone needing care had increased from 57% in the 2016 survey to 88% in 2017.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

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

West Midlands Integrated Urgent Care - Worcester

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, a practice manager specialist advisor and two additional inspectors.

Background to West Midlands Integrated Urgent Care - Worcester

West Midlands Integrated Urgent Care - Worcester Out of Hours - Care UK provides out-of-hours primary medical services to patients in the Worcester, Kidderminster, Redditch, Malvern, Evesham and surrounding areas when GP practices are closed. The administrative base is located at Stonham House, Blackpole Trading Estate West, Worcester, Worcestershire, WR3 8TJ.

The service covers a population of approximately 580,000 people across the county of Worcestershire. The out-of-hours service is provided across five primary care centres located at Worcester, Kidderminster and Redditch, which are open seven days per week and Evesham and Malvern which are open at weekends. The service also provides support to two local prisons, this is mainly by telephone however clinicians will attend if required.

The area covered incorporates three Clinical Commissioning Group (CCG) areas, Redditch and Bromsgrove, South Worcestershire and Wyre Forest. The service's workforce is made up of 66% clinical and 34% non clinical staff.

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. In addition the service has a direct contact number for local health professionals to use, which generates between 400 and 1,000 calls per month..

We carried out an announced inspection outside standard working hours on 28 and 29 March 2018. This included the sites at Blackpole Trading Estate, Kidderminster and Redditch. During the inspection we spoke with a range of staff; this included the head of contracts, the medical director/clinical lead, two GPs, the operations manager, the lead nurse, the regional clinical governance manager, a call centre manager, two base co-ordinators, reception staff and drivers. We also spoke with seven patients.

Good

Are services safe?

Our findings

We rated the service as good for providing safe services.

Safety systems and processes

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

- The provider conducted safety risk assessments. It had safety policies, including Control of Substances Hazardous to Health and Health & Safety policies, which were regularly reviewed, updated and communicated to staff. Staff received safety information from the provider as part of their induction and refresher training. The provider had systems to safeguard children and vulnerable adults from abuse. These specific policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance if required.
- The service worked with other agencies to support patients and protect them from neglect and abuse. We saw 11 examples where staff had reported directly to social services and both adult and children's safeguarding teams. Patients at risk were highlighted on the clinical system to alert staff and following any intervention the service updated the relevant services. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.
- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems in place for safely managing healthcare waste at all sites. Vehicles used by the service had checking schedules in place for equipment and clinical waste disposal instructions.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective system in place for dealing with surges in demand. The medical director was on call at busy times to ensure that high pressure situations were managed in terms of staff availability. The service had contingency staff available at the main base who could provide support to any area that was experiencing high demand.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and how to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis. The service had carried out a considerable amount of work around sepsis. The medical director had developed a sepsis support tool within the clinical system, where once patients' observations had been recorded within 15 minutes of arrival, a risk level appeared to alert staff, which had contributed to a national reduction in incidence.The medical director had delivered presentations to both clinical and non clinical staff across the region to raise awareness.
- In line with available guidance, patients were prioritised appropriately for care and treatment, in accordance with their clinical need. Systems were in place to manage people who experienced long waits. For example, we were 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.
- We saw examples of where the service carried out capacity and demand predictions for periods where demand was expected to be high for example the Easter holidays and arranged for additional call staff, clinicians, drivers and cars to be available.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.

Good

Are services safe?

- When there were changes to services or staff the service assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. Special patient notes were sent to the service to provide details of patients in specific circumstances and an additional clinical system was used to monitor care plans for patients receiving end of life care.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

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

- The systems and arrangements for managing medicines, including medical gases, emergency medicines and equipment, and controlled drugs and vaccines, minimised risks at all sites. The service kept prescription stationery securely and monitored its use both at bases and in vehicles. Arrangements were also in place to ensure medicines and medical gas cylinders carried in vehicles were stored appropriately.
- We noted secure arrangements for managing controlled drugs which included notifications to the administrative base when the controlled drugs storage had been accessed. Only senior management had access to the storage codes.
- The service carried out regular medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The service had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Processes were in place for checking medicines and staff kept accurate records of medicines.
- Palliative care patients were able to receive prompt access to pain relief and other medication required to control their symptoms.

Track record on safety

The service had a good safety record.

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

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. There was a computer based system in place to record all incidents that was available to all staff. Staff we spoke to explained their access to the system and gave examples of incidents that they had reported. Leaders and managers supported them when they did so.
- There were comprehensive systems for reviewing and investigating when things went wrong. The service learned and shared lessons identified themes and took action to improve safety in the service.
- The service learned from external safety events and patient safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.
- The provider took part in end to end reviews with other organisations. The management team met on a monthly basis with integrated urgent care partners to look at challenges, and performance. Learning was used to make improvements to the service.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the service as good for providing effective services.

Effective needs assessment, care and treatment

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

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed by carrying out regular monthly audits.
- Telephone assessments were carried out using a defined operating model. Staff were aware of the operating model which included the use of clinical navigators to triage calls in order to assess the level of intervention required. For example, requests for repeat medicines where a face to face appointment was not necessary.
- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- Care and treatment was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. Flags on the clinical system identified if a patient was vulnerable and the service worked closely with support agencies to give appropriate care to this group of patients.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with patients who contacted the service repeatedly. There was a system in place to identify frequent callers and patients with particular needs, for example palliative care patients, and care plans, guidance and protocols were in place to provide the appropriate support.
- When staff were not able to make a direct appointment on behalf of the patient clear referral processes were in place. These were agreed with senior staff and clear explanation was given to the patient or person calling on their behalf.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

- From 1 January 2005, all providers of out-of-hours services were required to comply with the National Quality Requirements (NQR) for out-of-hours providers. The NQR are used to show the service is safe, clinically effective and responsive. Providers reported monthly to their Clinical Commissioning Group (CCG) on their performance against the standards which includes: audits; response times to phone calls: whether telephone and face to face assessments happened within the required timescales: seeking patient feedback: and, actions taken to improve quality.

The service was meeting its locally agreed targets as set by its commissioner.

Data from November 2017 showed that service dealt with 5,762 patient contacts. Of those:

- 97% patients assessed as urgent received a face-to-face consultation within two hour, against a target of 95%.
- 98% patients assessed as less urgent received a face-to-face consultation within six hours, against a target of 95%.
- 100% patients assessed as an emergency had a home visit within 60 minutes, against a target of 95%.
- 100% of walk in patients were triaged within 20 minutes, against a target of 95%.
- 100% of walk in patients requiring 999 services were passed over within 3 minutes, against a target of 95%.

- The service was actively involved in quality improvement activity and made improvements through the use of completed audits. Audits were regularly carried out in a number of areas, for example infection prevention control (IPC), medicines management, safeguarding and clinical safety. In addition a monthly audit was completed on 1% of all clinical contacts. This had achieved a positive impact on quality of care and outcomes for patients. We saw evidence feedback was given to clinical staff following the completion of these audits. A GP told us that this feedback was very useful.

Effective staffing

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

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff.

Good

Are services effective?

(for example, treatment is effective)

This covered such topics as information governance, health and safety and safeguarding. In addition all new starters shadowed each of the three shifts to gain an understanding of the whole service.

- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The provider provided staff with ongoing support. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The provider could demonstrate how they ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable. Staff had regular 1:1s and appraisals where performance was reviewed and the clinical audits of consultations if there were performance issues and the medical director oversaw and managed these results.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. Care and treatment for patients in vulnerable circumstances was coordinated with other services.
- The service worked closely with a local hospice and meetings were held regularly to discuss individual patients and to update care plans.
- Staff communicated promptly with patients' registered GPs so that the GP was aware of the need for further action. Staff also referred patients back to their own GP to ensure continuity of care, where necessary. There were established pathways for staff to follow to ensure callers were referred to other services for support as required. Any referrals were also discussed at monthly meetings with other care providers.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- The service ensured that care was delivered in a coordinated way and took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that require them. Staff were empowered to make direct referrals and/or appointments for patients with other services.

Helping patients to live healthier lives

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

- The service identified patients who may be in need of extra support.
- Where appropriate, staff gave people advice so they could self-care. Information was available at the centres and on the service website.
- Risk factors, where identified, were highlighted to patients and their normal care providers so additional support could be given.
- Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

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

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

Good

Are services caring?

Our findings

We rated the service as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information. Call handlers gave people who phoned into the service clear information. There were arrangements and systems in place to support staff to respond to people with specific health care needs such as end of life care and those who had mental health needs. All staff had undertaken mental health training to help them support patients in this group.
- Comfort calls were carried out by call handlers and drivers to check patients' conditions and to inform them how long it would be before they would receive a home visit or telephone consultation.
- All of the eight patient Care Quality Commission comment cards we received were positive about the service experienced. This was is in line with the results of the NHS Friends and Family Test which showed that 94% of patients would recommend the service.
- The service had compiled a bereavement pack which contained a wealth of information from reporting the death to who to contact, emotions and feelings and useful contact numbers for assistance and support. These packs were carried in the cars so they were available to give to the relatives of patients who had died.

Involvement in decisions about care and treatment

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

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

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the service as good for providing responsive services.

Responding to and meeting people's needs

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

- The provider understood the needs of its population and tailored services in response to those needs. The provider engaged with commissioners to secure improvements to services where these were identified.
- The provider improved services where possible in response to unmet needs.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service. The service received 'special notes' from local GPs and had access to advance care plans to ensure that all up to date information was available. Care pathways were appropriate for patients with specific needs, for example those at the end of their life, babies, children and young people.
- The facilities and premises were appropriate for the services delivered.
- The service made reasonable adjustments when people found it hard to access the service.
- The service was responsive to the needs of people in vulnerable circumstances.

Timely access to the service

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

- The service provided GP out-of-hours services Monday to Friday from 6.30pm to 8.00am, and for 24 hours at weekends and during bank holidays.
- Patients were advised to access the service via the NHS 111 service and were primarily referred to the out-of-hours service via this route. They would then be allocated an appointment time during their telephone consultation. Patients could also access the service either as a walk in-patient, or by referral from a healthcare professional. Appointments for face to face and telephone consultations were prioritised according to the clinical needs of each patient. Staff told us patients would not be turned away if they walked into the service without an appointment.
- Patients were generally seen on a first come first served basis, although the service had a system in place to facilitate prioritisation according to clinical need where more serious cases or young children could be prioritised as they arrived. The reception staff had a list of emergency criteria they used to alert the clinical staff if a patient had an urgent need. The criteria included guidance on sepsis and the symptoms that would prompt an urgent response. The receptionists informed patients about anticipated waiting times.
- The service kept two appointments available in each session for emergencies.
- Waiting times, delays and cancellations were minimal and managed appropriately. Where people were waiting a long time for an assessment or treatment there were arrangements in place to manage the waiting list and to support people while they waited. The service had put in place a contingency team based at the main site who could support any site in times of increased demand on the service, comfort calls were carried out by call centre staff and drivers to update patients on expected call times and to check if the patient's condition had changed. At the centres reception staff we spoke with demonstrated how they would inform patients of waiting times.
- The service engaged with people who were in vulnerable circumstances and took actions to remove barriers when people found it hard to access or use services.
- Patients with the most urgent needs had their care and treatment prioritised. We saw evidence of this where calls were received and staff would alert drivers and clinicians of a new emergency. Also at the service kept two emergency appointments reserved in each session. Any patient presenting to the service with an urgent need wold be seen as a priority especially babies, children or elderly patients.
- Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.
- Referrals and transfers to other services were undertaken in a timely way.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

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

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The service received 39 complaints in the last year. We reviewed four complaints and found that they were satisfactorily handled in a timely way.
- Issues were investigated across relevant providers, and staff were able to feedback to other parts of the patient pathway where relevant. We saw evidence of action plans and discussions with individuals, where appropriate and feedback to all staff to share learning
- The service learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care.

Are services well-led?

Good

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

Our findings

We rated the service as good for leadership.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the service strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. All managers visited all bases on a regular basis to be visable to staff and this was confirmed by the results of the staff survey where in 2016 only 47% of staff knew who the senior managers compared to 80 % in the 2017 results.
- Senior management was accessible throughout the operational period, with an effective on-call system that staff were able to use.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.
- The service recognised that it was difficult to recruit drivers who were able to cover particular shifts so had advertised specifically for twilight shift drivers so as to only attract applications from those who were interested in this particular shift.

Vision and strategy

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

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

Culture

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

- Staff felt respected, supported and valued. They told us they felt proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. We saw evidence where incidents were shared with stakeholders and staff as appropriate and detailed correspondence with patients including chronological records of actions. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year and 1:1 meetings held by telephone for staff working remotely. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff. The service was an active participant in the Cycle to Work Scheme which as well as health benefits offered tax benefits to staff.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.

Are services well-led?

Good

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

- There were positive relationships between staff and teams. For example the service held a monthly 'Healthcare Hero Award' for staff and the organisation held a National Care UK awards ceremony to recognise staff achievements and accomplishments.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities in respect of safeguarding, information governance and infection prevention and control. Staff explained what actions they would take if they had a concern.
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. Care UK had a suite of policies which were available across the whole organisation with specific policies relevant to each site or geographical area.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The provider had processes to manage current and future performance of the service. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of Medicines and Healthcare Regulatory Agency (MHRA) alerts, incidents, and complaints. Leaders also had a good understanding of service performance against the national and local key performance indicators. Performance was regularly discussed at senior management and board level. Performance was shared with staff and the local Clinical Commissioning Group as part of contract monitoring arrangements.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality. The medical director undertook audits on a monthly basis of all 1% of all clinical interventions. The results of these were fed back to the individuals and if there were concerns raised this would be flagged and if necessary would prompt a performance review. The service carried out listening audits on a monthly basis and staff were encouraged to listen back to calls to learn from and improve the service provided.
- The providers had plans in place and had trained staff for major incidents. The service had introduced an emergency grab bag at each site and in all cars, which contained essential equipment and contact details to enable staff to maintain the service in the event that a site was not available due to an incident. We were told of an incident where this system had already been put to use to good effect.
- The provider implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care. For example a handover sheet for receiving blood results had been developed which had resulted in a more consistent approach to referrals. Also the GPs had access to the laboratory processes which had resulted in a reduction in the problems with blood results.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service used information technology systems to monitor and improve the quality of care.

Are services well-led?

Good

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

- The service submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. The service received feedback from patients in a variety of ways including electronically in waiting areas via an electronic device. The service had recently developed a virtual patient participation group to gather feedback and disseminate information to patients.
- A newsletter was published and distributed to all staff. It contained information on changes to the service, updates for staff on complaints and significant events where appropriate and highlighted members of staff who had been acknowledged for good work. The management team also gave out post cards to staff for good work and to provide encouragement.
- The service had introduced a staff survey asking a number of questions about staff experience of working in the various sites and bases. There had been an improvement in results from the 2016 results for example:
- The number of staff who would recommend Care UK services to a someone needing care had increased from 57% in the 2016 survey to 88% in 2017.
- The number of staff who knew the Care UK's purpose and values had increased from 72% in the 2016 survey to 93% in 2017
- Staff were able to describe to us the systems in place to give feedback. For example at staff meetings either face to face or by teleconference and during 1:1s. This gave the opportunity for all staff including those who worked remotely to be engaged and be able to provide feedback. We saw evidence of the most recent staff survey and how the findings were fed back to staff. We also saw staff engagement in responding to these findings.
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- The service was transparent, collaborative and open with stakeholders about performance. Following a suggestion from patients to engage in a more appropriate and beneficial way for all concerned, the service had developed an innovative new role for a patient and stakeholder engagement lead. This purpose of this role was to work with patients and stakeholder including the ambulance service, emergency departments, the palliative care team and local hospice staff to review and improve patient pathways and processes.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement at all levels within the service.
- The service held an annual study day for both clinical and operational staff. Other out of hours providers were also invited to attend. Mangers and service leads gave presentations and a number of topics were covered including, learning from complaints, communication issues, managing expectations and conflict resolution.
- Staff knew about improvement methods and had the skills to use them.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- There was a strong culture of innovation evidenced by the number of pilot schemes the provider was involved in. For example, working with Age UK to improve clinical pathways for care home residents and a project with Oxford University looking at point of care testing (POC) for patients.

Are services well-led?

Good

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

- The medical director had developed a system whereby once a patient's observations were recorded on the clinical system they would be alerted if sepsis was suspected so that correct and rapid action could be taken.