Harmoni - 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.

Summary of findings

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Summary of findings

Overall summary

Harmoni – Warwickshire provides out-of-hours primary medical services for a population of approximately 550,000 people when GP practices are closed. The service is run from five primary care centres, two of which are open only at the weekend. We visited two primary care centres located at the George Eliot Hospital in Nuneaton and Warwick Hospital. There were two clinicians (GPs and Advanced Nurse Practitioners) on duty at each of the primary care centres when we visited, one clinician was based at the centre and the other clinician undertook home visits. There was also a GP at the George Eliot Hospital who undertook telephone consultations.

We found that there were systems in place to deliver a safe service. Incidents were appropriately managed and used to support learning. Recruitment procedures ensured staff new to the service were appropriately checked to ensure they were of suitable character and had the skills and qualifications required for their role. There were systems in place for the safe management of medicines and prescriptions which enabled them to be accounted for.

Performance was monitored through national standards and the use of audits. Concerns identified were acted on to help improve the service. The service worked with partners to help patients receive a smooth transition between different providers.

We saw polite interactions between patients and staff. Patients with complex health care needs were supported in the out-of-hours period.

We found the service was responsive to patients' needs. Staff worked flexibly to meet the changing demands for the service from patients. Where there were concerns or delays patients were contacted. Complaints were appropriately managed and responded to.

The governance arrangements in place ensured that performance was continuously monitored and action taken where needed to address performance issues. The provider actively sought feedback from patients and used this to help inform service improvement. The service was prepared for situations which may affect the smooth running of the service.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?
The service was safe.

We found that there were systems in place to ensure patients received a safe service. Incidents were appropriately reported and investigated. They were used to support learning and minimise future risks to patients. Recruitment processes helped to protect patients from unsuitable staff. We also found robust arrangements for managing and monitoring medicines used so that they could be traced to individual patients. There were systems in place to respond to changes in service demand so that patients would receive the care they needed in a timely way.

We found that some systems for checking and recording equipment and identifying whether medicines available at the primary care centres were complete were not robust.

Are services effective?
The service was effective.

Audits were used to review and monitor the quality of the service patients received and findings were acted upon to help deliver service improvement. Patients were seen by staff with appropriate skills and qualifications who were supported to maintain their knowledge. Effective joint working arrangements helped to ensure patients received a smooth transition between different providers.

Are services caring?
The service was caring.

Patients that we spoke with described the service as caring and told us that they were treated with dignity and respect. We saw staff were polite and helpful when interacting with patients.. Arrangements were in place to help support patients to access and receive the care they needed when they needed it.

Are services responsive to people's needs?
The service was responsive to people's needs.

Systems in place ensured the service was flexible to the needs of patients and ensured those with urgent need were seen as a priority. Patients were supported to access the service. Patients' complaints and concerns were listened to and responded to appropriately.

Are services well-led?
We found the service was well led.

Summary of findings

There were clear lines of accountability and governance structures to monitor and improve service delivery. Feedback from patients was actively sought and staff were supported to develop within their role. There were arrangements in place to manage potential risks to the delivery of the service.

Summary of findings

What people who use the service say

We spoke with nine patients who used the out-of-hours service during our inspection. Comments received about the service were all positive. Patients told us that they were treated with dignity and respect and that they were satisfied with the care and treatment they received. All patients we spoke with said they would recommend the service to others.

Areas for improvement

Action the service COULD take to improve

- Ensure the colour coded tag system used to identify whether medicine boxes are complete is consistently followed.
- Review and implement robust systems for routinely checking equipment used at the primary care centres to ensure equipment is in date and in good working order.
- Provide training to reception staff to help them to identify patients presenting with urgent health conditions.

Good practice

Our inspection team highlighted the following areas of good practice:

- Learning from incidents was shared with all staff on a routine basis to help deliver service improvement.

Harmoni - Warwickshire

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Inspector.** The team included three CQC inspectors, a GP and practice manager.

Background to Harmoni - Warwickshire

Harmoni – Warwickshire provides out-of-hours primary medical services across Warwickshire when GP practices are closed. The service provides to a population of approximately 550,000 people across the county of Warwickshire. The area covered incorporates three Clinical Commissioning Group (CCG) areas, South Warwickshire, North Warwickshire and Coventry and Rugby CCGs. 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 Shipstone and Stratford Health Centre in Stratford upon Avon are open at weekends. The administrative base for Harmoni – 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. 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 out-of-hours service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We carried out an announced visit on 5 June 2014. During our visit we spoke with sixteen members of staff including senior and local managers, administrative staff and clinical staff. The clinical staff included the clinical lead for the service, General Practitioners and Advanced Nurse Practitioners (ANPs).

We visited the Harmoni – Warwickshire main office at the George Eliot Hospital and two primary care centres also at the George Eliot Hospital and Warwick Hospital. We also accompanied a clinician carrying out home visits. We spoke with nine patients who were attending the primary care centres visited during our inspection. We also reviewed a variety of documentation provided to us by the service.

Are services safe?

Summary of findings

The service was safe.

We found that there were systems in place to ensure patients received a safe service. Incidents were appropriately reported and investigated. They were used to support learning and minimise future risks to patients. Recruitment processes helped to protect patients from unsuitable staff. We also found robust arrangements for managing and monitoring medicines used so that they could be traced to individual patients. There were systems in place to respond to changes in service demand so that patients would receive the care they needed in a timely way.

We did however find that the system for tagging medicines to ensure the medicine boxes were complete and for checking equipment used by the out-of-hours service were not robust.

Our findings

Safe patient care

The provider had arrangements in place for ensuring patients received safe care. There were clear lines of responsibilities for reporting incidents and safeguarding concerns. Staff we spoke with were aware of the systems for reporting incidents and were able to demonstrate access to these systems on their computers. Staff received training in using the incident reporting system as part of their induction. This helped to ensure incidents would be reported so that they could be acted upon.

Quality Assurance Meetings provided a forum in which multiple information sources including information from incidents, audits, patient feedback and complaints were discussed and monitored by local managers and clinical leads. This helped to ensure issues were acted upon and any trends identified to maintain safe service provision.

Since a new incident reporting system was introduced in October 2013 we saw that there had been 51 incidents recorded. We looked in detail at three incidents including one serious untoward incident that had been reported during that period. We saw that incidents were investigated by staff at an appropriate level and evidence of action taken to minimise the risk of reoccurrence, such as providing training updates to staff in relation to specific health conditions and their presentation.

Learning from incidents

Incidents were discussed at monthly regional meetings which were attended by the local service managers and regional directors. They were also discussed at a local level at the monthly Quality Assurance Meetings chaired by the clinical leads. We saw evidence from the minutes of the meetings of action and learning identified from incidents. In one example we saw how staff had been reminded to undertake comfort calls enabling the patient's condition to be monitored in the event of a delay. These forums helped ensure incidents were discussed, acted upon and learning identified.

Staff we spoke with told us that any learning from incidents was shared with them at staff meetings, by email and through newsletters. We saw copies of newsletters in which learning from incidents that had occurred locally and

nationally within the organisation were shared. These arrangements helped to ensure staff were aware of the learning and could support actions that had been implemented to help minimise the risk of reoccurrence.

There was a named lead for receiving and responding to national patient safety alerts. They were not available to speak with us on the day of our inspection. However, we saw examples from members of staff where information from safety alerts had been disseminated to them. This ensured staff were made aware of issues that could affect patient safety and could act upon it.

Safeguarding

Local managers advised us that all clinical staff were required to be trained to a level 3 (the highest level) for safeguarding children. Staff were required to demonstrate this when they worked for the service and we saw one recruitment file where a GP had provided a certificate of training as evidence for this. Safeguarding training for children and vulnerable adults was also offered through the provider if needed. Staff we spoke with confirmed that they had received training in safeguarding and that it was a mandatory requirement for this provider. There was a named service lead for safeguarding and safeguarding policies and procedures for children and vulnerable adults were in place to support staff in making a safeguarding referral. This ensured staff were equipped with the knowledge and understanding needed to help them identify and respond appropriately to safeguarding concerns.

Staff we spoke with demonstrated an understanding of safeguarding patients and what they should do if they suspected anyone was at risk of harm. One clinician was able to describe a situation in which they had made a safeguarding referral to the appropriate investigating authority when they had been concerned about a child. They also told us that they sometimes did home visits to check on a patient that failed to attend their appointment if they had particular concerns. This demonstrated that staff were prepared to report concerns and take necessary action to protect patients from the risk of harm.

Monitoring safety and responding to risk

The monthly Quality Assurance meetings were the main forum for monitoring and managing risks within the service. Risk management was a standing data item in which the risk register was updated and other health and safety issues discussed. This ensured safety issues were routinely considered and responded to.

We saw that there were systems in place to manage risks relating to staffing levels. Staff rotas were published three months in advance and if necessary, shortfalls were covered by agency staff. A teleconference was held twice weekly between the operational and clinical leads to check the weekend staffing arrangements This enabled any potential shortfalls in staffing to be identified early so that appropriate action could be taken to remedy any shortfall.

Each shift was covered by a co-ordinator who was responsible for managing any immediate changes in service demand. The escalation policy identified strategies for managing demand when they met certain levels including redeploying staff, blocking appointments and temporary closing one of the primary care centres until back logs had been cleared. This enabled patients to be seen in a timely manner.

There were arrangements in place for dealing with medical emergencies. The primary care centres visited during the inspection were located on hospital sites. Staff told us that they would summon the hospital emergency crash team and use the hospital emergency equipment if an emergency situation arose. One member of staff told us that they had recently done this. Staff we spoke with confirmed that they had received training in basic life support and knew where the emergency equipment was located if needed. This provided assurance that staff would know what to do in a medical emergency.

Patients with immediate medical needs were referred directly to hospital. However, clinical staff undertaking home visits were provided with emergency equipment such as a defibrillator and nebuliser. This enabled them to respond to any unexpected need when visiting patients in their home.

Reception staff told us that they had not had any specific training in recognising urgent health care needs but would consult a clinician on duty if they were concerned about someone's health condition. They also had access to an assessment tool for assessing the priority of walk-in patients. This enabled walk in patients to be seen as appropriate.

Are services safe?

Medicines management

Medicines used by the out-of-hours service were stored in boxes or cassettes each for specific purposes such as pain relief, antibiotics and emergency situations. There were also specific boxes for use by clinicians on home visits. We saw that these were kept locked away when not in use to minimise the risk of unauthorised access. The boxes included a list of contents and forms for recording medicines used which were reconciled with the prescriptions issued. Systems in place ensured that medicine used could be accounted for.

Staff told us that they had arrangements with a pharmaceutical supplier to check and replenish the medicine stocks on a weekly basis. We saw that medicine returns were audited on return from the supplier to check for completeness. In the meantime a colour coded tag system was used to identify whether the medicine boxes were complete or not. We found that this practice was not consistently being followed and therefore could not be relied upon as an indication of the completeness of medication contained within the cassettes. Staff would therefore have to check inside the boxes to determine that medication within them was present. This presented a risk that medication may not be available when needed and could lead to delays to patients receiving treatment.

We looked at how prescription pads were managed by the service. Prescription pads are controlled stationery because stolen prescriptions may be used to unlawfully obtain medicines. We saw that prescription pads were locked away when not in use and that there were processes in place for signing in and out prescriptions to clinicians. We saw that records were kept of individual prescriptions used by the clinicians. This enabled the provider to keep an audit trail for prescriptions used.

We looked at how controlled drugs were managed. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. We saw that there were arrangements in place for the secure storage of controlled drugs. Access was through a key code which had to be requested from the on call supervisor and was changed after each use. We saw records to show that the controlled drugs were checked each week to ensure all could be accounted for.

Cleanliness and infection control

We visited two of the five primary care centres from which the service was provided and saw that they were clean and tidy. We spoke with one receptionist who advised us that they checked the rooms were clean at the start of the shift. We saw that staff had access to appropriate hand washing facilities and gloves. Sanitising gel was available throughout the primary care centres for staff and patients to use and clinical wipes were available for cleaning equipment. There was clear segregation of clinical and non-clinical waste.

Staff advised us that there were arrangements in place with the local hospital for cleaning and waste disposal at the primary care centres situated in the hospitals. We saw that monthly infection control checks were undertaken at the five primary care sites. These had not raised any major concerns.

Clinicians undertaking home visits were provided with sanitising gel for use where appropriate hand washing facilities were unavailable as well as sharps boxes to ensure the safe disposal of used sharp instruments such as needles while out. This helped to minimise the risks of cross infection while undertaking home visits.

Staffing and recruitment

All staff who worked for the service underwent a formal recruitment process prior to undertaking a shift to ensure they were suitable for their role. We looked at the recruitment records for two clinical and one administrative member of staff. We saw that checks had been undertaken to ensure they were of suitable character and had the necessary skills and qualifications. In all cases the staff had undergone disclosure and barring service (DBS) checks to ensure they were suitable to work with vulnerable people. Clinical staff were asked questions based on clinical scenarios to assess their skills and knowledge.

For relevant staff, checks were undertaken to ensure that they were registered with their appropriate professional bodies, had professional indemnity and that they were registered on the GP performers' list (a requirement for GPs to work in primary medical care). This enabled the provider to identify whether the applicant met the requirements of their professional body and had the right to work in their professional capacity.

Dealing with Emergencies

We saw that there were arrangements in place for business continuity in the event of an emergency affecting the running of the service. We saw that there was a disaster recovery plan which identified different action for various

case scenarios such as evacuation of the primary care centres, IT or telephone failure. We saw that there was a disaster recovery box located at the primary care centres visited. These contained action cards and various information such as contact details and paper based systems for manually tracking patient contact. These arrangements would help enable the service to continue while normal services were restored.

Equipment

We saw evidence that equipment used by the out-of-hours service, such as defibrillators and nebulisers, were appropriately maintained. We saw copies of service reports and calibration records for equipment. The service also had a fleet of five cars for undertaking home visits. There were arrangements in place in the event of vehicle breakdown. Staff advised us that that tax and insurance for the vehicles were arranged at head office and that they received notifications from head office as to when the MOT and service for the cars were due. We saw evidence of this in the diary. This provided assurance that equipment was being regularly maintained to ensure it was kept in working order.

However, we found systems for checking equipment including single use items on a routine basis were not robust. Reception staff told us that they were responsible for setting out equipment for the clinicians at the primary care centres, whilst the driver took responsibility for the equipment used on home visits. During our inspection we found not all items for use on home visits were in date but there did not appear to be an immediate risk to patients. This was brought to the attention of the provider so that they could take appropriate and immediate action. One of the clinicians on duty also commented that equipment was sometimes not complete when they came on shift. This meant staff may not always have appropriate equipment needed to do their job which could put patients at risk.

Are services effective?

(for example, treatment is effective)

Summary of findings

The service was effective.

Audits were used to review and monitor the quality of the service patients received. Patients were seen by staff with appropriate skills and qualifications who were supported to maintain their knowledge. Effective joint working arrangements helped to ensure patients received a smooth transition between different providers.

Our findings

Promoting best practice

Staff had access to guidance and information to support them in their role. There were a range of policies and procedures accessible to staff on their computers when they needed them. Staff also had access to best practice guidance from the National Institute for Health and Care Excellence and the British National Formulary to support staff when prescribing medicines. Staff we spoke with showed us how they accessed the policies and procedures.

We saw examples of staff following best practice guidance in relation to the Mental Capacity Act 2005. During our visit we saw a clinician was mindful of a patient with dementia and did not proceed with an examination when it was clear the patient did not want them to.

During our inspection we saw clinicians providing patients with advice in relation to prescribed medication such as dosage and storage and what to do if they did not improve. This helps ensure the patient takes the medication correctly.

Management, monitoring and improving outcomes for people

We saw that there was an audit programme in place. We looked at some of the audits that had been carried out during the last 12 months. These included prescribing audits to identify inappropriate prescribing by clinicians such as issuing repeat prescriptions or inappropriate antibiotic use. We saw that individual clinicians were informed of any concerns with their prescribing. Audits are a useful tool for identifying areas for service improvement.

The annual audit programme for the service included audits of clinical staff consultations. Staff confirmed that these took place and that they received feedback from them. They also told us that the audits helped to support them with their own appraisal process. The GP appraisal is part of a process in which GPs must demonstrate their fitness to practice to remain licensed with their professional body, the General Medical Council (GMC). These audits were used to help drive improvement in standards of care.

Performance against the National Quality Requirements (NQRs) were monitored daily and where breaches were identified the data reviewed to identify any trends. NQRs were also discussed at monthly quality assurance meetings

Are services effective?

(for example, treatment is effective)

and any breaches against targets were reviewed. We saw evidence that performance issues were followed through with personal actions for individual staff. Routine monitoring of performance helped to identify and address issues that may be affecting performance at an early opportunity.

Staffing

New staff received induction training when they were first employed in order to familiarise themselves with the service, location of equipment and local referral processes. We saw the induction pack which detailed the induction process new staff needed to follow. Both clinical and administrative staff we spoke with during the inspection confirmed that they had received an induction when they first started working for the service. This included various on line training and shadowing shifts. Staff were shown how to use the computer systems and learned about policies and procedures.

Staff were given access to training opportunities. One member of staff showed us a range of training programmes that were available through the provider for which they could sign up. Records of training were maintained and were in the process of being centrally collated. This helped ensure staff were able to maintain and update their skills and knowledge.

Staff were given opportunities to discuss their work and performance. Annual appraisals had been carried out for the Advanced Nurse Practitioners (ANP) and salaried GPs and we saw evidence of these. We were advised that the self-employed GPs were also offered the opportunity for an appraisal but these were not always taken up. Staff we spoke with confirmed that they had annual appraisals but did not receive regular one to one or supervision meetings. However they told us that the clinical leads were supportive if they wanted to discuss anything and that they received feedback from the consultation audits. Appraisals and supervision are a way in which any issues relating to work can be raised and addressed.

GPs in training were given the opportunity to gain experience of out-of-hours work with the service. They were only able to work if appropriate supervision by a GP was in place. Supervising GPs were given training by the clinical lead which would count towards their own personal development. This helped to provide GPs in training with a wider working knowledge and experience.

Working with other services

We saw examples of joint working arrangements with other services. The 111 NHS telephone service which triages the phone calls for the out-of-hours service was delivered by a different provider. We saw that there were standard operating procedures for these joint working arrangements to help staff deliver a seamless service to patients. Where there were breaches in some of the joint quality standards these had been discussed with the NHS 111 telephone provider and commissioners to help ensure patients received care or treatment in a more timely manner. The out-of-hours service had also been involved in the winter planning meetings with commissioners and the acute hospital trusts to help meet patient need in times of high demand for health services.

Regular meetings were held with the commissioners of the service to discuss performance. Minutes of these meetings recorded discussions to promote the use of special notes. Special notes are a way in which GP practices can share information about patients with complex health care needs. Provision of this information can help improve the experience and consistency of care for the patients as out-of-hours clinicians may not be familiar with the patient's medical history.

Information about patients seen by the out-of-hours service was shared with the patient's usual GP practices by 8am the next day. We were advised that they would fax or email directly the practice if there were any issues with transferring information. Sharing information about care and treatment in a timely manner helps ensure patients receive a good continuation of care.

Are services caring?

Summary of findings

The service was caring.

Patients that we spoke with described the service as caring and told us that they were treated with dignity and respect. We saw positive interactions between patients and staff. Arrangements were in place to help support patients to access and receive the care they needed when they needed it.

Our findings

Respect, dignity, compassion and empathy

We spoke with two patients who used the out-of-hours services based at the George Eliot Hospital and Warwick Hospital. Patients that we spoke with were very complimentary about the service they had received and told us that they were treated with respect.

During our inspection we observed positive interactions between staff and patients. We saw patients being spoken to in a polite and respectful manner. Patients were kept informed by reception staff about how long they may have to wait to be seen. We found the clinician was respectful of the patient's privacy and dignity when conducting an examination.

People's privacy and confidentiality were respected. Reception staff told us that there were rooms that they could use if someone wanted to speak in private. We saw during a home visit that care was taken to ensure patient's confidentiality when writing up consultation notes.

Staff told us that patients who needed a physical examination were offered a chaperone to accompany them. One patient we spoke with confirmed that they had been offered a chaperone during a previous visit to the service. However, we did not see that there was any information displayed informing patients that they could request a chaperone if they wanted one. Provision of a chaperone helps to provide some protection to patients and clinicians during sensitive examinations.

We saw that information was available to keep patients informed about the service such as waiting times and opening times for local pharmacy services. This helped to manage patient expectations and provide information to support them receive the treatment they needed.

We spoke with clinical staff about the care of patients at the end of life. They told us that local GPs were generally good at sharing information about their patients who were at the end of their lives. This enabled the out-of-hours clinicians to provide the patient with a good continuity of care. A variety of pain-relieving drugs were available for clinicians to help manage patient symptoms and comfort at the end of life stage. Staff also told us that there was a speaker coming to a future staff meeting to talk to them about palliative care. These arrangements helped staff to support patients requiring end of life care.

Are services caring?

Involvement in decisions and consent

The provider had a consent policy in place which made reference to the Gillick competency for assessing whether children under the age of 16 years are mature enough to make decisions without parental consent for their care. It also made reference to the Mental Capacity Act 2005. This legislation governs decision making on behalf of adults and applies when people do not have the mental capacity at that point in their lives for specific decisions. This ensured staff had current information to support them when they needed to obtain consent from patients who used the service.

During our inspection we observed a clinician attending a patient in a care home. They checked the do not attempt resuscitation (DNAR) form in place at the home. DNARs are recorded decisions about the use of cardiopulmonary resuscitation and should be shared between healthcare professionals. This provided some assurance that DNAR decisions and patient wishes would be taken into account by the out-of-hour clinicians.

We spoke with staff on duty about how they supported patients who did not speak English. Staff were aware that there were translation services available but told us they had not needed to use them. Reception staff showed us a card that they could use to help identify a patient's native language. This would enable an appropriate interpreter to be contacted to support the patient to access the service.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The service was responsive to peoples' needs.

Systems in place ensured the service was flexible to the needs of people who used the service and ensured those with urgent need were seen as a priority. Patients were supported to access the service. Patients' complaints and concerns were listened to and responded to appropriately.

Our findings

Responding to and meeting people's needs

There were policies and procedures in place where patients after initial triage did not turn up for their appointments or could not be contacted. Based on information provided to them clinical staff would make a decision to undertake a home visit. This would ensure patients whose condition may have deteriorated were seen.

We spoke with clinicians on duty during our visit about the management of patients with mental health issues who may be at their most vulnerable when attending the service. Clinical staff were aware of the local referral arrangements for mental health crisis teams. The phone numbers for various services were made available to staff through the co-ordinator.

Access to the service

Patients accessed the out-of-hours service mainly via the NHS 111 telephone service. They could also be referred from the accident and emergency department or arrive as a walk in patient. The provider of the NHS 111 telephone service was able to book appointments directly with the out-of-hours service as 'urgent' or 'routine' or refer them to the service for a telephone consultation with a clinician who would decide whether the patient needed to be seen. Calls received were managed by the co-ordinator on shift who was able to use staff flexibly if necessary to help where they were most needed.

Patients were seen by clinicians according to the clinical priority assigned to them at triage by the NHS 111 telephone service. The out-of-hours service is required to meet specific waiting time targets to ensure patients are seen in a timely manner according to their need. Staff we spoke with were aware of the waiting time requirements.

Where staff were likely to exceed waiting time targets courtesy calls were made to patients waiting for a home visit to ensure that their condition had not deteriorated and to inform them of any delay. Staff told us that if the patient's condition had deteriorated then they would review the situation and priorities. We saw that there were local operating procedures in place for staff undertaking courtesy calls and during our visit we witnessed staff calling

Are services responsive to people's needs?

(for example, to feedback?)

patients to inform them that they were on their way and of anticipated delays. This meant during periods of high demand the patient's condition would be kept under review and if necessary could be re-prioritised.

We saw that there was clear signage for the out-of-hours service located at the George Eliot Hospital. This was not the case at the Warwick Hospital. As the provider did not own the building they were limited to what they could do in terms of signage. Staff told us they dealt with this by giving directions about the location of the service during the patient call. Records of patients who attended the accident and emergency department by mistake were noted and used to identify the call handler to remind them to do this. This demonstrated a proactive approach to ensure patients were able to find and access the service they needed.

As the services were located at hospital sites each was accessible to patients with mobility difficulties or with pushchairs.

Concerns and complaints

There were arrangements in place for dealing with complaints. During the last 12 months 11 complaints had been received about the service. Depending on the nature of the complaint these were investigated by the clinical lead or local manager. We looked at two complaints received and saw these had been appropriately investigated and the patient had been responded to in line with timeframes set out within the provider's complaints policy.

The provider took note of information from complaints to improve the service. We saw that the provider collected information from verbal and informal complaints arising from patient feedback as well as formal complaints. These were also investigated and any learning shared. Staff confirmed that they were made aware if a complaint had been raised against them. Complaints received about the service were discussed at the monthly Quality Assurance meetings with local managers and clinical leads.

During our inspection we visited two primary care centres. The complaints policy was displayed at one of the primary care centres for patients to see but not the other. We asked the receptionist at this primary care centre what they would do if someone wanted to make a complaint. The receptionist showed us the form that they would give to the patient to complete. We noticed that the complaint form did not have an address to return the form to. This would make it difficult for patients to make a complaint and may prevent some patients from doing so.

Are services well-led?

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

Summary of findings

We found the service was well led.

There were clear lines of accountability and governance structures to monitor and improve service delivery. Feedback from patients was actively sought and staff were supported to develop within their role. There were arrangements in place to manage potential risks to the delivery of the service.

Our findings

Leadership and culture

We saw that there were clear lines of leadership throughout the organisation at local and corporate level. Staff we spoke with described the leadership within the service as supportive and approachable. They told us that they could go to the clinical lead for advice and support if needed. Senior managers also spoke highly of the staff, describing the local team as having strong managers and loyal clinicians. Information was openly shared throughout the service. Clear leadership and an open culture helps to drive and maintain the standards of service patients receive.

Governance arrangements

We saw that there was a national governance structure within the wider organisation. Operational issues and shared learning took place at regional and local level. The monthly quality assurance meetings which were attended by the local operational managers and clinical leads were the main forum for discussing performance, organisational risks, incidents and complaints. Meetings were also held with clinical staff on a quarterly basis to keep staff informed. These arrangements provided the forum for addressing issues that may affect the smooth running of the service.

Systems to monitor and improve quality and improvement

Evidence from the minutes of the quality assurance meetings, audits and conversations with staff demonstrated that the service was proactive in driving service improvement. Information from different sources was discussed at the Quality Assurance Meetings which helped to identify any issues that affected the service and drive any action needed. For example we saw how the service had reinforced the message among staff to deliver courtesy calls to patients following an incident and was working with partners to deliver shared targets when there were concerns about waiting time breaches.

Patient experience and involvement

All the patients that we spoke with during our inspection told us that they were satisfied with the service they had received and would recommend the service to others.

Satisfaction questionnaires were sent out to five percent of patients who had used the service each month. We saw that feedback from the questionnaires was discussed by

Are services well-led?

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

managers and clinical leads at the monthly Quality Assurance Meetings. We saw that where patients had raised concerns through the patient survey these were logged as concerns and investigated in line with the complaints process. Feedback from the questionnaires was not anonymous and patients were made aware of this and were asked if they could be contacted if required in the accompanying letter. We saw that patients could also provide anonymous feedback from satisfaction questionnaires available at the reception desks in the primary care centres. This demonstrated that the provider actively sought and used patient feedback to help improve the service delivered.

Staff engagement and involvement

Staff meetings were held on a quarterly basis to provide a forum for training and discussing incidents, complaints and other issues about the service. Staff told us that they felt able to raise issues if they wanted to. Minutes of the meetings were held on-line so staff that were unable to attend could read them. Staff we spoke with told us about other lines of communication such as emails and news bulletins which enabled information to be shared with them. We saw evidence that incidents, complaints and patient feedback was discussed with individual staff including compliments that had been made. These arrangements enabled the service to communicate with staff who often worked remotely and ensure information was shared.

Learning and improvement

The provider told us they had introduced a system of peer reviews in which staff visited other out-of-hours services across the provider organisation to learn from each other and share good practice. This was still in its infancy and the service had yet to receive its visit.

Staff were given opportunities to develop within the organisation if they wanted to. One receptionist spoke to us about opportunities within the organisation and how they were supported to become a co-ordinator. Another member of staff explained how the clinical lead had provided support and supervision while undertaking further qualifications. Clinicians showed us a programme of in house training that they could sign up to and presentations they had attended such as one on palliative care. This enabled staff to expand and develop their knowledge within the service.