Care UK - SurreyCare UK – Surrey (formerly Harmoni Surrey)

Quality Report

Glassworks 2
Station Road
Surbiton
RH4 1HJ
Tel: 01306 267120

Date of publication:11/06/2014
Date of inspection visit: 19 February 2014

This report describes our judgement of the quality of care at this out-of-hours service. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from the provider, patients, the public and other organisations.

Summary of findings

Contents

Summary of findings

Overall summary

At this inspection, we visited the head office for the Harmoni Surrey out-of-hours service in Dorking. There were eight other 'satellite' bases throughout the locality providing out-of-hours services. We also visited the out-of-hours satellite base in Epsom General Hospital as part of the inspection.

We also reviewed information we had asked the provider to send to us such as policies, procedures and some audits they had completed. During the inspection we talked with key people within the organisation such as the medical director, the registered manager, the clinical lead nurse and the quality assurance manager.

There were problems with the management of medicines within the service. We found upon inspection that some medication was out of date, and we have asked that the provider takes action to make sure that systems are in place so that patients receive prescribed medication that is safe to use.

People said the doctor displayed a kind and caring attitude and we observed patients being treated with respect whilst their dignity and confidentiality was maintained. However, patients told us during the inspection they would have liked to have been kept informed about the length of time they had to wait before they were seen by the doctor. Some patients said they had waited up to 45 minutes to see the doctor. We also received similar comments about long waiting times to see the doctor on our patient feedback cards.

Patients told us that they felt listened to during their consultation with the doctor and that treatment and symptom advice had been explained in a way that they could understand and follow.

During the visit we looked at the treatment records of patients who used the service. We saw there was a system to ensure that patient information was promptly shared with each patient's own GP to ensure continuity of care.

The vehicle that transported the emergency doctor to patients' homes was not at the base during the inspection, so we were unable to check equipment or talk to the driver or visiting doctor on this occasion.

In November 2012, the care provider Care UK acquired the Harmoni Group and has taken over the operation of the company. Currently the service is going through change and rebranding and aligning company policy and procedures with that of the new provider.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

There were standard operating procedures and local procedures in place to ensure that any risk to patients' health and wellbeing was minimised and managed appropriately. Although we found that some of these procedures were not being implemented fully. This was regarding the safe supply of medication.

Are services effective?

Measures were in place to closely monitor the delivery of treatment and care in accordance with best practice guidance. Patients accessing the out-of-hours service reported that their health care needs were being met.

There was an effective system in place to ensure information about patients who used the service was shared with their own GP at the earliest opportunity. There was evidence of good collaborative working between other health and social care professionals.

Are services caring?

Patients, their relatives and carers were positive about their experience whilst visiting the out-of-hours service. We observed that staff treated patients with respect and protected their dignity and confidentiality.

We were told by people who used the out-of-hours service that staff had explained to patients about their treatment in a manner that reflected the patient's level of understanding.

Are services responsive to people's needs?

The provider was responsive when meeting patients' health needs. Patients can be assured that there are mechanisms in place to respond to and learn lessons from when things do not go as well as expected. Complaints about the service were taken seriously and were appropriately responded to in a timely manner.

Are services well-led?

There was a clear leadership and management structure and staff that we spoke with were clear who to approach with any concerns they might have. We saw that staff underwent an annual appraisal to enable them, among other things, to reflect upon their own performance with the aim of learning and improving the service. The performance of all clinicians was monitored, which ensured that poor performance was dealt with quickly.

Summary of findings

What people who use the out-of-hours service say

Patients who used the service, and their relatives and carers, told us that it met their healthcare needs and that both clinical and non-clinical staff treated them with respect. They said that their treatment choices had been discussed with them and they had been listened to.

During our visit to the out-of-hours base in Epsom General Hospital, we spoke with seven patients who told us about their experience of the service. They told us that they had been satisfied with the treatment and care they had received, but three patients said that they had waited a long time to be seen by the doctor; they were unhappy that they didn't get any information to say how long they would have to wait when they first arrived at the service. CQC leaves comment cards to enable patients to record their views on the service, and these also reflected this issue.

Areas for improvement

Action the out-of-hours service MUST take to improve
The provider must take action to make sure that systems are in place so that patients receive prescribed medication that is safe to use.

Action the out-of-hours service COULD take to improve

- The provider may wish to assure themselves that they are following guidance from the Medicines and Healthcare Products Regulatory Agency (MHRA) on the 'Care and Handling of Oxygen Cylinders and their Regulators' to ensure the safe handling and administration of oxygen.
- Review what information patients receive when using the service, including accurate information about waiting times for appointments and regular updates if there are any changes to the appointment times.
- Display the name of the duty doctor more prominently in the waiting area to inform patients.
- Improve signage to direct patients to the out-of-hours service, to be more accurate and prominent.
- Consider providing training on safe handling of medication to staff who are responsible for ordering and stock control of medication.
- Ensure that all key members of staff have been trained in the protection of vulnerable adults.

Care UK - SurreyCare UK – Surrey

Detailed findings

Our inspection team

Our inspection team was led by:

As well as a CQC inspector, the inspection team included clinical experts (a practice nurse, practice manager, a GP) and an Expert by Experience (a person who has experience of using this type of service, or who cares for somebody who uses a service).

Background to Care UK - Surrey

Harmoni HS Ltd was founded in September 1996 by two doctors as a GP co-operative in Harrow. In November 2012, the care provider Care UK acquired the Harmoni Group and has taken over the operation of the company.

The population estimate for Surrey is 1,317,788 of which 83.6% of the Surrey population are registered with a GP. The out-of-hours services are for patients with an urgent need who cannot wait until surgery opening hours to see a GP. Access to the out-of-hours service is via NHS 111. Patients are assessed and triaged over the phone, and may, at that point, be referred to the out of hours service which is local to them.

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 provider:

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

Before the inspection we looked at a wide range of information we held about the service and asked other organisations such as the local clinical commissioning group (CCG) to share with us what they knew about it. Before our visit, we also asked patients to complete some comment cards to tell us about their experiences of the service.

We carried out an announced inspection of the service on 19 February 2014 in the out-of-hours period. During the visit we looked at the treatment records of patients who used the service. We observed how patients were cared for, and we talked with people who were using the service and the staff who were on duty at the time.

Detailed findings

We also reviewed information we had asked the provider to send to us such as policies, procedures and some audits they had completed. During the inspection we talked with key people within the organisation such as the medical director, the registered manager, the clinical lead nurse and the quality assurance manager.

Are services safe?

Summary of findings

There were standard operating procedures and local procedures in place to ensure that any risk to patients' health and wellbeing was minimised and managed appropriately. Although we found that some of these procedures were not being implemented fully. This was regarding the safe supply of medication.

Our findings

Safe patient care

People who used the out-of-hours service told us they felt safe and had confidence in the doctors and nurses. The service was located next to the hospital's Accident and Emergency department (A&E). This enabled patients to be transferred quickly and easily if there was a serious medical emergency. One person told us about a prompt assessment and transfer to A&E when they had used the service when their child was very ill. Another patient said "The doctor got straight to the point and put my mind at rest".

The staff we spoke with during the inspection had been trained in resuscitation techniques. We were told that the car that transported the emergency doctor had on board portable oxygen, some emergency medication and a portable nebuliser. We also looked at the emergency equipment at the hospital base. This is minimal as patients would be transferred immediately to A&E in a medical emergency. However, there was some portable oxygen available for use. We checked the cylinder labels to make sure the oxygen was within its use-by date. We found that it was out of date. When we brought this to the attention of the manager the cylinder was replaced immediately during the inspection. There was no evidence to demonstrate that the oxygen was checked regularly to ensure that it was safe to use. The provider may wish to assure themselves that they are following guidance from the Medicines and Healthcare Products Regulatory Agency (MHRA) on the 'Care and Handling of Oxygen Cylinders and their Regulators' to ensure the safe handling and administration of oxygen.

Medication

We found there were appropriate arrangements in place to provide medicines when required. For example the provider supplied pre-packed medication to allow patients to be given a full course of treatment at the time of their consultation. Controlled drugs were not kept on site, but drug packs for palliative care were kept securely at the Dorking site. Arrangements are in place to obtain these drugs if they are required. When we looked at the medication administration we found that there was a lack of audit over the medicines stored. We found one item of medication that was past its 'use by date'. There was no written record of the amount of stock held at the base or when the medication stock had been checked to make sure it was safe and in date. Lack of recording and the absence of records regarding the stock control meant that medication could potentially be open to misappropriation. We were told that there is about to be a new medication system implemented which will change the way in which medication is ordered, stored and checked at the Epsom base. However until such time as the system changes the provider must make sure that the current system is suitable so that patients are kept safe. In addition the provider may wish to consider training the reception staff in the safe handling of medication procedures, as it appeared they were responsible for ensuring the safe storage, ordering and stock control of medication at the bases.

Staff recruitment

We saw a robust and rigorous procedure for recruiting staff. The provider checked GPs' fitness to practise, for example their General Medical Council registration and inclusion on the NHS GP performers list, as well as obtaining suitable and verifiable references. We saw all GPs were required to produce indemnity insurance that included out-of-hours cover. There was a process in place to ensure that clinical staff continued to be registered with their appropriate professional body, whether it is the Nursing and Midwifery Council or General Medical Council.

All staff were subject to checks to ensure their suitability to work with vulnerable people. We saw that there was an induction process that enabled staff to be assessed as competent in areas relevant to their work. We were given a copy of the induction programme and the clinical nurse lead explained how the induction process worked and how they observed staff to assess their competence.

Are services safe?

We were also told that all locum doctors are employed through a 'preferred agency'. Locum doctors are subject to the same recruitment interview and checks as a permanent employee of the company. We saw evidence of this in the staff files we looked at during the inspection.

Infection control

All areas of the base were visibly clean. We looked at infection control audits that had been completed. If an issue was identified a detailed, time bound action plan was put in place. This meant appropriate action was taken to rectify the issue and reduce the potential of further risk.

Staff told us that they received instruction and training in infection control and one member of staff told us that it had been covered in induction and then later followed up with an online e-learning course. The records confirmed this.

Safeguarding

There was a policy and procedure for staff to follow if they suspected someone was at risk of abuse. Although training was provided in the protection of vulnerable children, not all staff had been trained in the protection of vulnerable adults. We talked to staff about the protection of vulnerable people. They were able to tell us about they would do if the suspected someone was potentially at risk of abuse or harm and what procedures they wold follow.

However, the posters on display and the local operating procedure needed to be updated, as they only provided details of agencies who to contact in an emergency situation during normal working hours. This could mean that concerns may not be escalated appropriately in an emergency situation out of normal hours.

Are services effective?

(for example, treatment is effective)

Summary of findings

Measures were in place to closely monitor the delivery of treatment and care in accordance with best practice guidance. Patients using the out-of-hours service reported that their health care needs were being met.

There was an effective system in place to ensure information about patients was shared with their own GP at the earliest opportunity. There was evidence of collaborative working between other health and social care professionals.

Our findings

National Quality Requirements (NQRs)

There are National Quality Requirements for out-of-hours providers. These are national targets which are reported monthly to the local CCG to demonstrate that the service is safe, clinically effective and delivered in a way that gives the patient a positive experience. One of the NQRs relates to timescales of face-to-face consultations. These can be carried out either at a centre or at the patient's place of residence. Emergency consultations must take place within one hour of the patient contacting the service; urgent cases must be dealt with in two hours and less urgent within six hours. The CCG advised us that Harmoni Surrey have experienced some difficulties in meeting these targets in the past, however there has been a significant improvement over the past year and targets for the reporting period of June to November 2013 were being met. At the time of the inspection, there was no further data available for analysis, however the manager did tell us that the disruption to service caused by the extreme flooding and poor road conditions in December and February would have a negative impact on these targets.

Training

The provider reported that they had a statutory and mandatory training programme that enabled all staff to acquire the skills and knowledge required. Due to the working hours of many of the staff, much of the training was available online for staff to complete at their convenience. Where courses needed to be completed face-to-face, training was offered at different times and dates to allow staff to attend.

Continuing professional development was provided for staff to enable them to maintain their professional registration and also advance their professional and personal development.

Working with others

We saw that accurate records regarding treatment were maintained by the out of hours doctor when patients used the service. These records were sent directly to the patient's record held at their own doctor's surgery. This meant that information was available the next working day for the patient's own doctor to review. This demonstrated continuity of patient care.

There was good collaborative working between the provider and other health and social care agencies to help ensure patients' needs were met by the most appropriate agency. For example, the district nursing service and other health care professionals had a direct telephone number to the out-of-hours service so they could liaise immediately with the out-of-hours GP on duty, to obtain help and advice about the treatment of a patient who they were concerned about.

We found that there was very little information given to patients when they used or visited the service. One person told us that they "Did not know what to expect". Another wrote "When I arrived for my appointment I was told it would be a two hour wait, why wasn't I told this on the phone when the appointment was made? The service doesn't do well in giving patients information that's important like waiting times."

The sign on the entrance door to the service showed the name of the previous out-of-hours provider (Thamesdoc).This could lead to some confusion as there was no information for patients to instruct them where to go or what to do on arrival at the hospital. The provider should review what information it gives to patients when using the service. This should include accurate information about waiting times for appointments and regular updates if these are changed. In addition there should be accurate and clear signage to direct patients to the service. Patients said they would also find it helpful if the name of the duty doctor was displayed more prominently. This would help patients to feel better informed and respected when visiting the service.

Are services effective?

(for example, treatment is effective)

Serious untoward incidents

All staff have access to training on risk assessment and management and incident reporting. All serious and untoward incidents – whether clinical or operational in origin – are reported on. The level of risk identified to patients would determine the priority of subsequent investigation and possible actions.

The Registered Manager, Quality and Patient Safety Manager and the Clinical Director ensured all incidents were investigated, and identified that any learning or changes in practice were actioned promptly.

Are services caring?

Summary of findings

The majority of patients, their relatives and carers were positive about their experience whilst visiting the out-of-hours service. We observed staff treating patients with respect and protecting their dignity and confidentiality.

We were told that staff had explained to patients about their treatment in a manner that reflected the patient's level of understanding.

Our findings

Before the inspection we asked people who used the service to complete comment cards to tell us about the care and treatment they had received. We received five completed cards. Three cards had positive comments about how they had been treated by the staff.

We also talked to patients during the inspection and asked about their experience whilst visiting the out-of-hours service. They told us they felt that they had been involved in decisions about their care and treatment and that the doctor given them plenty of time to ask questions and responded in a way they could understand. They were satisfied with the level of information they had been given regarding any follow-up treatment or care.

Staff were trained to respect people's dignity and privacy. We saw that staff treated people with respect and were kind. Patients also confirmed this, one person said "The doctors are very supportive, I feel listened to and the doctor always explains things well". Another commented that they had used the service four times in the past and felt safe and well cared for during all of the visits.

Some of the positive comments from patients included: "Very good advice and was listened to by the doctor", and "After a short wait we were very satisfied. I was given a thorough examination."

"The care my son received was great". Another patient said "I've been treated okay and I have felt listened to. Staff are caring and I have been given explanations that I can understand". These positive comments demonstrated that staff are kind, caring and compassionate to the patients who used the service.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The provider was responsive when meeting patients' health needs. Patients can be assured that there are mechanisms in place to respond to and learn lessons when things do not go as well as expected. Complaints about the service were taken seriously and were appropriately responded to in a timely manner.

Our findings

Two patients told us of long delays waiting to be seen by a doctor on a weekend. One person said they had waited two hours. Another person wrote that they had an appointment booked but upon arrival at the service were told they would not be seen for at least another hour. They did comment that the receptionist had re-booked them into another appointment slot later in the day and that overall they were satisfied with the care and treatment they had received. The provider needs to consider ways to tell patients about the possible waiting times when visiting the out-of-hours service, as patients told us that not being told about a delay in seeing the doctor promptly was an issue. This point was raised in particular by parents with young children who needed to see a doctor. One parent wrote "I was given an out of hours appointment for my son, when I arrived I was informed it would be a one to two hour wait. This is outrageous when you have a sick child to make them wait that length of time, why could I not be informed of this before I turned up, they had my phone number".

We saw that seating in the waiting area allowed reception staff to see patients, which helped them identify those who might need earlier intervention if their health deteriorated. During the inspection we saw that a baby whose condition was deteriorating was given priority to be seen over a patient who was stable and whose condition appeared to be less urgent. This meant that staff were aware of the changing health needs of patients and were able to identify when a patient required priority treatment.

Concerns and complaints

The service had an effective complaints policy and procedure. We saw that complaints were logged and responded to appropriately, in line with the policy.

Staff told us that they would try to rectify any 'concerns or grumbles' raised with them straight away if they could. They said they would always tell patients about the complaints procedure if they were unable to resolve the matter at the time. Staff said that it was important to them that patients remained satisfied and happy with the service they received. During the inspection we saw that information was available to patients at the reception desk titled "How to make patient feedback". It described the stages of the complaint process and what to do if they needed to complain about any aspect of the service.

Between 1 January and 31 December 2013, the location received 54 complaints. Of these, 26 complaints were not upheld, 10 were partially upheld and nine were fully upheld. At the time of the inspection there was no known outcome for the remaining nine. In the 19 complaints that were either partially or fully upheld, the issues were either addressed with the relevant member of staff or the learning was circulated more widely to all staff.

Are services well-led?

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

Summary of findings

There was a clear leadership and management structure and staff told us they were clear who they could approach with any concerns, they might have. We saw that staff underwent an annual appraisal to enable them, among other things, to reflect upon their own performance with the aim of learning and improving the service. The performance of all clinicians was monitored, which ensured that poor performance was dealt with quickly.

Our findings

Clinical audit and leadership

The medical director and the nurse clinical lead were responsible for making sure that clinical standards were maintained. We saw that records of patient consultations were reviewed and audited using the Royal College of General Practitioners consultation assessment tool. The clinical assessors made comments about the consultations and these were available for the doctor to see. Doctors received feedback and were then monitored to establish whether their practice had changed. Failure to change could result in the doctor being removed from the out-of-hours service.

Improvement

All staff were involved in audit monitoring within the organisation and there was a willingness at all levels to respond to change to improve and enhance the service. The quality of treatment and services is monitored internally by monthly quality assurance meetings, monthly quality reports to the board and a robust audit programme. It is also monitored externally by commissioners at monthly contract meetings, and through feedback from stakeholders and patients. Regular audits were undertaken to monitor the quality of treatment and services provided. The audits included infection control, documentation of consultations, training and performance against the National Quality Requirements.

Patient feedback comes from patient satisfaction questionnaires and also by telephone interviews. The provider is about to use an online survey for patients, which will be available for people to access when they attend the treatment centres.

The service operated an 'open culture' and actively sought feedback and engagement from staff all aimed at maintaining and improving the service. However, the clinical nurse lead had not had an appraisal or clinical supervision for nearly two years. This meant some staff were not getting regular formal opportunities to discuss their performance and any training needs they might have.

Training

We looked at the training records for both clinical and non-clinical staff. The records showed that staff were provided with a range of training which the provider considered essential. This included areas such as information governance, safeguarding, equality and diversity, basic life support, infection control and conflict resolution. Due to the working hours of many of the staff, much of the training was available online for staff to complete at their convenience. Where courses needed to be completed face-to-face, training was offered at different times and dates to allow staff to attend.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider was not protecting patients against the risks associated with the unsafe use and management of prescribed medicines.