Hampshire Doctors On Call

Quality Report

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Date of inspection visit: 26 & 27 November 2015
Date of publication: 04/02/2016

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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Hampshire Doctors on Call Service Out of Hours Service on 26 November 2015 and 27 November 2015. Overall the service is rated as good.

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

• Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.

• Patients' needs were assessed and care was planned and delivered following best practice guidance. At the time of inspection staff had not received training appropriate to their roles.

• Emergency, urgent and non-urgent face to face consultations in primary care centres were being carried out in a timely manner.

• Patients said they were treated with compassion, dignity and respect. Information was provided to help patients understand the care available to them.

• Suggestions for improvements resulted in changes to the way it delivered services as a consequence of feedback from patients and staff members.

• The service had an effective governance system in place, was well organised and actively sought to learn from performance data, incidents and feedback.

• The provider has been working with the five local Clinical Commissioning Groups to discuss how to improve and maintain response times for patients accessing the service.

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

The areas where the provider must make improvements are:

• Non-clinical staff who act as a chaperone must receive appropriate training; and the policy must reflect the role and purpose. Each staff member acting as a chaperone must have a risk assessment or a criminal records check via the disclosure and barring service (DBS). Where the decision has been made not to carry out a DBS check on staff, the service should be able to give a clear rationale as to why.

Summary of findings

• Ensure relevant staff receive all mandatory training including safeguarding children and basic life support.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The service is rated as requires improvement for providing safe services.

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Information about safety was recorded, monitored, appropriately reviewed and addressed. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff.
- The premises and equipment were clean, hygienic and well maintained.
- Vehicles used to take GPs to patients' homes for consultation were well maintained, cleaned and contained appropriate emergency medical equipment. Emergency equipment held at the treatment centres were well maintained and serviced.
- The service had robust arrangements in place to respond to emergencies and other unforeseen situations such as the loss of utilities.
- There was no assurance that staff undertaking chaperone duties had received appropriate training, checks or risk assessments.
- Personnel files of employed staff who transferred into the service were incomplete. However staff files for members of staff recruited since April 2015 were complete with appropriate recruitment checks undertaken prior to employment.
- The service had clearly defined processes and practices in place to keep people safe and safeguarded from abuse. However these were not followed for example staff training was not up to date in areas such as safeguarding and chaperoning. We also found one of the doors to the clinical waste store was not secure at one of the primary care centres and did not prevent unauthorised access.
- Patients that we talked with told us that they felt safe.

Are services effective?

Good

The service is rated as good for providing effective services.

- In October 2015, there was a drop in performance in terms of urgent consultations within primary care centres and urgent

Summary of findings

and non-urgent home visit consultations. However month on month data showed that aspects of care and treatment delivery was otherwise in line with National Quality Requirements (NQR).

- Availability of information about staff training was limited and indicated staff who had been transferred into the service required refresher training.
- Clinical audits demonstrated quality improvement and Hampshire Doctors on Call Service actioned any subsequent learning. For example, a four step antibiotic prescribing reduction plan to reduce the number of inappropriately prescribed antibiotics had been implemented.
- There was an effective system in place to ensure information about patients registered with a practice covered by the service was shared with their own GP at the earliest opportunity.
- There was good collaborative working between the provider and other healthcare and social care agencies to help ensure patients received the best outcomes in the shortest possible time.

Are services caring?

Good

The service is rated as good for providing caring services.

- Feedback from patients about their care and treatment was consistently and strongly positive. Patients, their relatives and carers were all positive about their experience and said they found the staff friendly, caring and responded to their needs.
- We observed and heard a kind compassionate culture.
- There was good evidence that the provider took positive steps to promote the service and informed patients of what they could expect from the service. There was health promotion literature available in the waiting room at both locations we inspected.
- Patient experience surveys conducted by the provider and collected for the National Quality Ratings indicated a high degree of satisfaction with the service provided and a high number of patients who had used the service would recommend it.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Summary of findings

- We found that the provider had an effective system to ensure that, where needed, GP's could provide a consultation in patients' homes.
- The provider had responded to the needs of people from a wide geographical area and provided a choice of 10 treatment centres across Hampshire for patients to maximise accessibility.
- The provider undertook continuing engagement with patients to gather feedback on the quality of the service provided.
- There was good collaborative working between the provider and other healthcare and social care agencies to help ensure patients received the best outcomes in the shortest possible time. For example, health care professionals (e.g. paramedics) could request a GP to commence a definite clinical assessment over the telephone within 15 minutes of placing the call. This reducesavoidable unplanned admissions by improving services for vulnerable patients and those with complex physical or mental health needs.
- Information about how to complain was available and easy to understand and evidence showed that the service responded quickly to issues raised.

Are services well-led?

Good

The service is rated as good for being well-led.

- There was a clear vision and strategy to deliver high quality care and promote good outcomes for patients.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included a comprehensive improvement and development action plan and arrangements to monitor and improve quality, performance whilst identifying risk.
- The senior team encouraged a culture of openness and honesty. The provider was aware of and complied with the requirements of the Duty of Candour.
- The service had systems in place for knowing about notifiable safety incidents.
- There was a clear commitment to learn from problems, complaints and incidents. The provider demonstrated an open approach to these issues and informed staff of any learning through periodic newsletters, both clinical and general.
- Feedback from staff and patients was sought and acted on. We saw active staff forums, newsletters and other forms of staff

communication. Staff told us they were involved in decisions, for example, the possible relocation of the main headquarters and more recently testing possible vehicles to join the services fleet of cars.

- Staff had received inductions; staff who transferred into the service received a welcome pack and we saw provisional appraisal dates and saw that staff attended meetings and events.

Hampshire Doctors On Call

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 second CQC inspector, an Inspection Manager and three specialist advisors (two GPs and a nurse with experience of working in an out-of-hours service).

Background to Hampshire Doctors On Call

The GP Out of Hours service for Hampshire including Southampton and Portsmouth is provided by Portsmouth Health Limited. Portsmouth Health Limited was founded in 2009 and currently provides two services: the Out of Hours service for Hampshire and an NHS Primary Care walk-in centre and GP Practice in the centre of Portsmouth. This inspection report refers to the inspection of the Out of Hours service known as Hampshire Doctors on Call Service.

The service was launched in October 2012 with Portsmouth Health Limited as the contract holder. Portsmouth Health Limited took over the responsibility for the delivery of the contract in April 2015. This included more than 100 employees from the previous service provider transferring via TUPE arrangements into the new service (TUPE is the Transfer of Undertakings Protection of Employment Regulations 1981, implemented to protect employment rights when employees transfer from one business to another).

The service is commissioned by five Hampshire Clinical Commissioning Groups (CCGs):

- Fareham and Gosport CCG
- Portsmouth CCG
- South Eastern Hampshire CCG
- Southampton City CCG
- West Hampshire CCG (lead CCG for Out of Hours services)

Hampshire is a county on the southern coast of England, bordered by Dorset, Wiltshire, Berkshire, Surrey and West Sussex. Data shows an increasing population, specifically the over 65 year old population has increased by 21% between 2001 and 2011; nearly double the national increase of 11%. This has increased pressure on health and social care provisions in the region. 95.5% of the population are registered with a GP and there are a lower than average proportion of Black and Minority Ethnic residents in Hampshire.

The Out of Hours service provides care to patients who require urgent medical care from GPs and nurses outside of normal GP hours. Currently 347 members of staff including GPs (150 as self-employed GPs), nurses, drivers and support staff work for the service delivering care to patients.

The service operates county wide from 6.30pm until 8am Monday to Thursday, and 6.30pm Friday until 8am Monday, and all public holidays. Hampshire Doctors on Call Service does not offer walk-in appointments; access to the service is via the NHS111 service (provided by South Central Ambulance Service (SCAS)).

The service provides care to a population of approximately 1.76 million (2011 census) residing in the area and operates from 10 primary care centres geographically spread across the county. The 10 primary care centres are:

- Andover Hospital, Andover SP10 3LB
- Chase Hospital, Bordon GU35 0YZ
- Cowplain Health Space, Waterlooville PO8 8DL
- Gosport War Memorial Hospital, Gosport PO12 3PW

Detailed findings

- Lymington Hospital, Lymington SO41 8QD
- Queen Alexander Hospital, Portsmouth PO6 3LY
- Ringwood Medical Centre, Ringwood BH24 1JY
- Royal Hampshire County Hospital, Winchester SO22 5DG
- Royal South Hampshire Hospital, Southampton SO14 0YG (main primary care centre)
- Totton Health Centre, Totton SO40 3ZN

At the time of the inspection, our systems showed that there was a Registered Manager in place for the service.

During this inspection we visited the centre at Royal South Hampshire Hospital on 26 November and Cowplain Health Space on 27 November.

Hampshire Doctors on Call Service is registered to provide three regulated activities: diagnostic and screening procedures, transport services, triage and medical advice provided remotely and treatment of disease, disorder and injury.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before we visited, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. This included information from the local Clinical Commissioning Groups (CCG) and NHS England.

During the two day inspection we spoke with 24 members of staff employed by the Out of Hours service. We spoke to a variety of staff members across all areas of the service including the senior management team, the operational team, lead nurse, dispatches, drivers and four GPs who were on duty. In addition we spoke with four patients to gain their views of the Out of Hours service.

We reviewed how GPs made clinical decisions. We reviewed a variety of policies and procedures used by the practice to run the service. We also looked at other information with regard to how the service was performing.

We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to.

We looked at the Out of Hours premises to check the practice was a safe and accessible environment. We looked at documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the premises including the arrangements in place to manage the risks associated with healthcare related infections.

We obtained patient feedback from speaking with patients, Care Quality Commission patient comment cards and the services in-house surveys.

We observed interaction between staff and patients in the waiting room.

We looked at the vehicles used to take clinicians to consultations in patients' homes, and we reviewed the arrangements for the safe storage and management of medicines and emergency medical equipment.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- We saw there was an open, transparent approach and a system in place for reporting and recording significant events. Staff were able to report incidents and learning outcomes from significant events and these were shared with appropriate staff. We saw plans including training plans for the service to commence incident reporting via an electronic incident reporting database called Datix.
- The service carried out a thorough analysis of the significant events. Staff we spoke with told us the service had embedded this analysis process into everyday practice and all the team were dedicated to learning from significant events. We saw a bi-monthly newsletter for all members of staff which anonymously highlighted learning and subsequent actions from significant events.
- Learning from incidents was also used in the recruitment of GPs, as the basis of scenarios in the interview process to assess the applicants' clinical approach and communication skills.

We reviewed safety records and minutes of meetings where these were discussed. For example, we saw an end-to-end analysis of a significant event when a GP had completed an assessment which included missing vital symptoms and signs from the patient. There was also a delay in this assessment commencing due to errors made by the NHS 111 service and operational issues within the Out of Hours service which closed the case without an appropriate review. This event had been reviewed with a multi-disciplinary team and outcomes highlighted errors within the GP assessment, the case closure process (the process of closing an assessment) and triage management process. Learning was shared with the Clinical Commissioning Groups and NHS 111 services which were recorded. Staff we spoke with demonstrated their understanding of the revised case closure policy.

Safety alerts (including medicine and equipment alerts) were monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled the service to communicate and act on risks and gave a clear, accurate and current picture of safety.

Overview of safety systems and processes including safeguarding

The service had defined and embedded systems, processes and practices in place to keep people safe which included:

- Both the primary care centres we inspected maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. All the patients we spoke with said the facilities were always clean. We observed good hand hygiene and processes throughout our inspection. However, during the inspection at the Royal South Hampshire Hospital Out of Hours base we saw the room which contained clinical waste products was not locked and the containers containing clinical waste were not locked. This room was a shared room with another department in the hospital and was rectified instantly once we brought this to the attention of the infection control lead. The lead nurse was the infection control lead and liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and infection control audits were undertaken. We saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Patient Group Directions had been reviewed in November 2015 to allow members of the nursing team to administer medicines in line with legislation.
- We observed and saw evidence which confirmed that equipment was available in sufficient quantities in each car as well as in the centre. For example, in each car there was a box which contained: a nebuliser, defibrillator, blood pressure monitor, blood glucose monitor, finger pulse oximeter and a stethoscope. The equipment was checked several times during the shift and a member of staff had to sign to confirm that they

were in working order and fit for purpose. This demonstrated that equipment was available in sufficient quantities to meet people's needs and to ensure their safety.

We saw arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff.

- The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare.
- The service had appointed a dedicated senior GP who had additional responsibilities as lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All of the staff we spoke with knew who the safeguarding lead was and who to speak to if they had a safeguarding concern.
- Although all non-clinical staff we spoke with including dispatchers, call handlers, drivers and reception staff demonstrated an understanding of what constituted abuse, and knowledge of the procedure for reporting suspected abuse, they had not received formal safeguarding training relevant to their role. Staff members told us they had received safeguarding training from the previous service provider in June 2014 and the training matrix confirmed this. We saw a rolling programme of mandatory and essential training, including safeguarding and chaperoning was due to commence in December 2015.
- All GPs who work for the service are only able to work if they have completed level three safeguarding certification for children and appropriate training for adults. We checked adherence to this requirement and all of the GPs we spoke with had completed level three safeguarding.
- We were informed of two recent safeguarding referrals made to social care. One referral was regarding the lack of administration of medication to a patient who lived in a nursing home and the other referral over a child's welfare.
- There was a system in place for receiving information from other organisations for adults who were at risk, or that a protection plan was in place for a child. This was recorded securely on the out-of-hours computer system as a Special Patient Note (SPN). This was to alert the GP to liaise with the safeguarding authority before seeing the patient.
- There was a chaperone policy which was visible in the waiting rooms and on the doors of consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Staff we spoke with who acted as chaperones understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. However there was no formalised chaperone training. Some non-clinical members of staff did say they had received local informal training from the previous service provider. There was no assurance that staff

Staffing and recruitment

In April 2015, Portsmouth Health Limited took over the responsibility for the delivery of the contract and over 100 staff transferred into the service from the previous provider. We reviewed a sample of personnel files of staff who had transferred to the service, a driver, a nurse and a receptionist. We saw there were inconsistent personnel files, for example one member of staff had an empty staff file with no information in and another member of staff had minimal information in their file.

We reviewed three personnel files of employees that had joined the service since April 2015 and found that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

We discussed our concerns with the provider who was already aware of the missing files and had actioned plans to resolve. We spoke with one member of staff whose file we reviewed and they confirmed that there had been contact made two months prior to our inspection to provide the missing documents.

We saw the service had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Requires improvement

Are services safe?

Thorough checks were undertaken of GP's to ensure their fitness to practice for example General Medical Council registration and inclusion on the performers list. Suitable and verifiable references were sought.

We saw comprehensive arrangements for forecasting, planning and monitoring the number of staff and combination of staff needed to meet patients' needs. Staff told us there were enough staff to maintain the smooth running of the service and there were enough staff on duty to ensure patients were kept safe.

A forecasting analysis that had been carried out by the out of hours service was detailed and comprehensive. The forecasting and planning manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. For example, in October 2015, 14,650 calls were forecasted and the actual demand was 14,654.

However, at the time of the inspection, the service had filled 75% of the required hours for the Christmas period. We saw an action plan including twice weekly update meetings were in place to help fill the missing hours which included contacting staff for additional shifts, moving shifts and split shifts. We saw the service was using historic data to identify known busy periods and had recognised the potential increase in demand on the service over the Christmas period.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents. However there was no evidence of all staff receiving annual basic life support training.

- There was an instant messaging system in all the consultation and treatment rooms which alerted staff to any emergency.
- Emergency equipment was available including access to oxygen (with adult and children's masks available) and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.
- Emergency medicines were available in a secure area which were accessible by out of hours staff. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. All the emergency medicines we checked were in date and fit for use.
- The service had a comprehensive business continuity plan in place for major incidents such as power failure or telephony outage including serious malfunction or failure of telephone system used by the NHS111 service. The also included contingency plans if one of the vehicles used for home visits was to breakdown. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The Hampshire Doctors on Call Service does not offer walk-in appointments; access to the service is via the national NHS111 call line. In Hampshire this is a service provided by the South Central Ambulance Service (SCAS) from their base at Otterbourne near Winchester.

- Following a telephone triage (clinical assessment) completed by the national NHS111 Out of Hours service patients may be referred to the Out of Hours GP service.
- Referred patients received a telephone call from one of the Out of Hours GPs who undertook a further assessment of their needs. From the outcome of this assessment, the GP would make a decision for the patient to receive telephone advice with no onward referral, a visit to one of the primary care centre, visited at their place of residence or a referral to an alternative provider (e.g. the emergency services or Emergency Department). Decisions made depended on people's diverse needs. This meant that the appropriate care and treatment was delivered to meet people's individual needs.

The service used National Quality Requirement (NQR) and other quality indicators which it submitted to the Clinical Commissioning Group (CCG) to monitor the quality of the service patients received. NQRs for GP Out of Hours services were set out by the Department of Health to ensure these services were safe and clinically effective.

We reviewed the NQR standards for the previous six months and found that the service had continually met all primary care centre (NQR12) standards required. For example data for September 2015:

- 100% of emergency calls received a face to face consultation at a primary care centre within one hour.
- 96.3% of urgent calls received a face to face consultation at a primary care centre within two hours.
- 96.1% of less urgent calls received a face to face consultation at a primary care centre within six hours.

Although, in October 2015 we saw performance had declined, specifically for urgent face to face consultations within two hours:

- 100% of emergency calls received a face to face consultation at a primary care centre within one hour.
- 87.8% of urgent calls received a face to face consultation at a primary care centre within two hours.
- 96.1% of less urgent calls received a face to face consultation at a primary care centre within six hours.

We continued to review the NQR standards and found that the service had shown an improvement in the performance of home visit consultation standards. For example data from August 2015 showed increased performance in meeting home visit consultation standards from the previous month, this improvement continued in September 2015. However, the latest data we saw indicated a reduced performance for October 2015. For example:

- 88.8% of urgent calls received a face to face consultation through a home visit within two hours.
- 85.3% of non-urgent calls received a face to face consultation through a home visit within six hours.

The target for all performance standards was 95%.

The service had continually met the standard for all emergency consultations in the patient's place of residence to be started within one hour.

The service was fully aware of the areas for improvement and we saw investigations into individual breaches for the percentage of patients where standards were not met. During the inspection we saw the call queues were being effectively monitored, managed and intervention was taking place when targets were not being met. The service had recently appointed two members of staff to monitor real-time performance.

The patients we spoke with during the inspection were positive about the timeliness and efficiency of the consultations.

Management, monitoring and improving outcomes for people

We found evidence of clinical audits being undertaken in order to demonstrate improvements to the service and so ensure the best outcomes for patients.

- The service conducted a monthly clinical audit of 1% of all consultations. This audit comprises of a review of both written notes following face to face consultations as well as listening to voice recordings of triage

consultations.The service uses an audit tool based upon the Royal College of General Practitioners (RCGP) out of hours Audit Toolkit. This toolkit is designed to support Out of Hours providers in delivering effective clinical audit.

- These audits were undertaken by the GP lead or staff peers using the (RCGP) toolkit and feedback was provided to clinicians via email or during meetings. Consultations with patients (face to face and telephone) were audited in areas which included history taking, clinical assessment and signposting to other services.
- The clinical audit process specifies that any GP who gains two consecutive red or four amber results will be contacted and performance monitored. We saw audits from April 2015 where there were two GP's who had two consecutive red audit results. These GPs received support, coaching and their performance monitored and evaluated to ensure consistent improvement.

We saw the service provided clinical audit updates to the CCGs via clinical quality review meetings (CQRM).

We were shown details of a clinical audit which was being completed between April 2015 and June 2015 and to be repeated within six months.

- Information from the local CCGs has been shared with the service, highlighting there is above average prescribing of the specific antibiotics, known as the four C's (cephalosporins, ciprofloxacin, co-amoxiclav and clindamycin) within the Out of Hours services (14%) as opposed to in-hours services (6%).
- Inappropriate use of these antibiotics increases the risk of complications such as Clostridium Difficile (a type of bacterial infection that can affect the digestive system. It commonly affects people who have been treated with antibiotics). The service audited the appropriateness of antibiotic prescribing and has a four step antibiotic prescribing reduction plan. Actions implemented by the service include, a trajectory for reducing the use of these antibiotics, correspondence with all GPs regarding prescribing these antibiotics, encouragement of notes for justification of usage and a development on the IT systems to highlight high risk antibiotics.
- Between 15 April 2015 and 30 June 2015, a sample selection of 2% (214 cases) of the total antibiotic prescriptions was audited by the Executive Medical Director. Each prescription was assessed for compliance with the local 'antibiotic prescribing in the community 2014' guidelines document. The total number of cases with questionable prescriptions was 1.6% which amounts to approximately three patients. Of the 1.6% that were questionable, two patients may not have required an antibiotic to treat their symptoms.
- Findings of the audit were featured in the Summer edition of the Hampshire Doctors on Call Service newsletter and all GPs whose prescribing was reviewed as questionable have reflected on their practice and received support and advice from the Executive Medical Director and Clinical Leads.

Effective staffing

We were not assured that staff had the skills, knowledge and experience to deliver effective care and treatment.

- Throughout the inspection, staff including new members of staff and staff who had been transferred into the service told us they had not received mandatory and essential training. We viewed training records and the training matrix which confirmed training had not commenced. The training matrix had been analysed, job descriptions evaluated and staff had been informed of appropriate training they were required to complete to meet learning needs and to cover the scope of their work.
- We saw the service was about to launch a rolling programme of mandatory and essential training, including safeguarding, basic life support, infection prevention and control, chaperoning and patient confidentiality starting in December 2015. Staff would access training materials via e-learning training modules and in-house training. We saw all staff members had an appraisal provisionally planned within 12 months of the launch of the service.

Information sharing and consent to care

The Out of Hours service used an electronic patient record system. Information provided through the NHS111 service and from local GPs about patients was accessible to clinicians through this system. The system was also used to document, record and manage care patients received.

Good

Are services effective?

(for example, treatment is effective)

- Information relating to patient consultations carried out in the out-of-hours period was transferred electronically to patients' GPs by 8am the next day in line with National Quality Requirements (NQR).
- Staff sought patients' consent to care and treatment in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004. Staff also described how they seek consent in an emergency situation in line with the services consent policy.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. For example, a clear understanding of the Gillick competency test. (These were used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).
- Where a patient's mental capacity to consent to care or treatment was unclear the GPs assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We obtained the views of patients who used the Out of Hours service through the Care Quality Commission comment cards patients had completed. We received five comment cards and spoke with four patients who had used the service between April 2015 and November 2015, all positively described the service including comments about the facilities, the staff and the care received.

We observed and heard throughout the inspection that members of staff spoke to patients, both attending the primary care centres and on the telephone in a respectful, empathetic and polite manner.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Patients were called from the waiting room individually and taken to a consultation room. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.
- Hampshire Doctors on Call Service telephone triage service was located away from the reception desk and waiting room and could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. We saw that staff were mindful and adherent to the service's confidentiality policy when discussing patients' treatments so that information was kept private.
- Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the manager and record it as an incident.

The provider also collected feedback about the service experience on an on-going basis. As part of the NQRs, Out of Hours services are required to regularly seek feedback from people that have used the service and report any action taken to improve quality to commissioners.

In October 2015, 14,654 calls were made to the service and the service received 238 completed surveys, this equates to a response rate of 1.6%. The survey asks respondents if they would recommend the service, in October 2015, 96.2% of respondents answered positively and they would recommend the service. This was similar to August 2015 (96.0%) and September 2015 (96.0%) figures.

Care planning and involvement in decisions about care and treatment

Patients that we spoke with and comments on cards indicated that patients were satisfied with their involvement in decisions about their care and treatment. Clinicians were alerted to special patient notes (SPNs) from the patient's usual GP if these were available. Special notes are a way in which the patient's usual GP can raise awareness about their patients who might need to access the out-of-hours service, such as those nearing end of life and their wishes in relation to care and treatment.

Staff had a good understanding of consent and involving patients in decision making. A range of information was made available to clinical staff around capacity and decision making to support them in their work. This included up to date policies (reviewed in October 2015) and case studies which detailed consent, capacity, advance decisions, best interests seeking consent in an emergency situation.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Access to the service

The service operated from 6.30pm to 8.00am Monday to Thursday and from 6.30pm until 8am Friday to Monday inclusive. The service also operated on all bank holidays.

Services are provided from 10 primary care centres and GPs also provide consultations in the patient's place of residence. In total there were 414.5 hours of service per week available to patients. This included 64 hours of service per week at Royal South Hampshire Hospital Out of Hours base with an average of 203 patients seen per week and 105 hours of service per week at Queen Alexandra Hospital Out of Hours base with an average of 197 patients seen per week.

Patients we spoke with were satisfied with the appointments system and said it was easy to use despite several telephone discussions taking place before any appointment was given. Patients told us they would speak with NHS111 and then later receive a call from a GP from the out of hour's service to re-confirm earlier discussions for telephone advice or an appointment.

Tackling inequity and promoting equality

The Out of Hours service understood and responded to patients with diverse needs and those from different ethnic backgrounds.

- For patients who did not have English as a first language, a translation service was available. We saw notices in the reception areas informing patients this service was available.
- We saw that the provider had sought advice from the voluntary sector about how to best interact with and provide a high standard of care to patients with no fixed abode. This included highlighting the risks of inappropriate prescribing within the homeless community.
- We inspected two primary care centres and found the premises were easily accessible to patients who used a wheelchair and for pushchairs with obstacle free access throughout, electronic doors, wide passage ways, disabled toilets and a hearing loop available. Several of the primary care centres share premises with other services; both centres we inspected had signage ensuring the patients knew where to locate services.

Listening and learning from concerns and complaints

One of the NQRs set by the Department of Health requires all Out of Hours service providers to operate a complaints procedure that is consistent with the principles of the NHS complaints procedure. Each provider is required to report anonymised details of each complaint, and the manner in which it has been dealt with, to the CCG.

- We found the service had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England and the NQR standard.
- Since the launch of the service in April 2015 there has been 103,976 total patient contacts and the Out of Hours service had received 36 complaints. This amounts to 0.03% of patient contacts making a complaint.
- We looked at a sample of seven complaints received since April 2015 and found all reviewed complaints were satisfactorily handled, demonstrated openness, honesty and transparency whilst dealt with in a timely way.
- The service reviewed each complaint and could identify any patterns and shared the learning with the full team. For example, in October 2015, six complaints were received. Out of the six complaints, two complaints were regarding the consultation, three were regarding a time delay and one complaint was a general dissatisfaction in the service. During the inspection we saw the investigation was ongoing for five of the six complaints as these events included contact with different services.
- We saw minutes of these meetings which demonstrated a discussion of the complaints, identified the relevant learning points and action taken to as a result to improve the quality of care. In response to a previous complaint and patient survey feedback a frequently asked questions leaflet has been drafted and published to try to help explain the difference between in hours and out of hours GP services.

In May 2015, there were no overall themes identified by the service from complaints and health professional feedback however, there were two medication errors noted in two of

Good

Are services responsive to people's needs?

(for example, to feedback?)

the complaints. These did not relate to the same GP however both involved prescribing for children. We saw that the service had contacted all GPs and reminded how they can access the British National Formulary for children.

We saw that information leaflets were available within the primary care centres to help patients understand the complaints system. Contact details were provided for the Health Service Ombudsman and independent advice and advocacy. None of the patients we spoke with or comments on the comment cards we received had ever needed to make a complaint about the Out of Hours provider.

Are services well-led?

Good

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

Our findings

Vision and strategy

The senior team within Hampshire Doctors on Call Service acknowledge the service is at the start of the journey to deliver a safe, effective and responsive service with patients central to their strategy and future development.

The service had documented strategic ambitions and a clear plan to achieve set milestones after one year, three years and five years. Each plan had specific processes and objectives which included how they would measure success, objectives included, patient experience, quality, safety, risk and clinical performance. For example:

- The one year plan addressed immediate business needs following the launch of the service, staff training needs and staff engagement planning.

Staff we spoke with confirmed they were aware of plans and these had been shared via emails and newsletters.

Governance arrangements

The service had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. There were signs identifying which staff had lead roles in areas such as safeguarding, health and safety and infection control.
- Service specific policies had been recently reviewed, were in place and available to all staff. However, some policies had not been embedded into the day to day running of the service.
- There was a comprehensive understanding of the performance of the service and areas such as urgent and less urgent consultations in the patient's place of residence were addressed. For example, through effectively monitored, managed and intervention of call queues.
- There was a programme of continuous clinical and internal audit in place, which was used to monitor quality and to make improvements. For example, the appropriateness of antibiotic prescribing audit and the subsequent four step antibiotic prescribing reduction plan.
- There had been delays since registration for training arrangements. However, we saw steps were in place and a rolling programme of mandatory and essential training, including safeguarding, basic life support, infection prevention and control and chaperoning was due to start in December 2015.
- We saw minutes and designated actions from Christmas/Winter Planning meetings which included escalation plans and preparing the fleet of cars for winter conditions. However recruitment of sufficient staff remained a key concern for the service.

Leadership, openness and transparency

The senior management team ensured the service provided high quality and accessible care in the Out of Hours environment across Hampshire. They prioritised safe, high quality care and were visible within the service. Staff told us morale had improved in recent months and spoke respectfully and highly of their immediate line managers and of the senior management team. Staff added that there had been a change in culture and improvement in openness and support offered.

We reviewed a number of policies, for example, the recruitment and qualification checking procedure. We were shown the staff handbook which was available to all staff. This included sections on equality, health and safety and pensions. Staff we spoke with knew where to find these policies and the staff handbook if required.

The service was aware of and complied with the requirements of the Duty of Candour. The senior management team encouraged a culture of openness and honesty. There was a system in place for notifying safety incidents.

When there were unexpected or unintended safety incidents:

- The service gives affected people reasonable support, truthful information and a verbal and written apology.
- They kept written records of verbal interactions as well as written correspondence.

Are services well-led?

Good

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

Seeking and acting on feedback from patients, public and staff

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the service to improve outcomes for both staff and patients.

The service encouraged and valued feedback from staff, proactively gaining employees feedback in the delivery of the service. It had gathered feedback from staff through meetings and more recently staff forums.

- Hampshire Doctors on Call Service is considering relocating their headquarters and main base from Royal South Hampshire Hospital, Southampton to Cowplain Health Space in Waterlooville. Staff have been consulted with for their opinions on this possible relocation.
- One of the staff forums within the service is the 'Drivers Forum' consisting of six drivers. Drivers are employed by the service to facilitate the transportation of GPs when completing consultations in patient's place of residence. We saw information about a 'Drivers Forum' and drivers we spoke with confirmed details of this forum.
- The service had consulted with the 'Drivers Forum' in purchasing 12 new cars to join the fleet of cars. Following a forum meeting it was decided which two models of cars would be most appropriate, drivers were involved in testing and trialling the two models to assess which model of car the service would purchase. Drivers and a service support manager informed us how they tested the cars in terms of car layout, comfort and driving experience. They also told us how they enjoyed being involved in the forum and the decision making process to purchase the new fleet of cars.

The service had a whistleblowing policy which was available to all staff. Staff we spoke with told us that they were aware of the whistleblowing policy.

Hampshire Doctors on Call Service gathered patient feedback on an on-going basis. Since April 2015, a total of 1,043 patients had completed the survey and each month patients responded positively and said they would recommend the service. For example, in September 2015, 96% of patients would recommend the service and in October 2015, 96.2% of patients would recommend the service.

We also noted an increased effort to increase the number of surveys completed.

- For example, in September 2015, 102 surveys out of 12,812 cases had been completed, that equates to a response rate of 0.8%. Whilst in October 2015, 238 surveys out of 14,654 cases had been completed, that equates to a response rate of 1.6% (double the response rate from the previous month).

In response to feedback from patients a frequently asked questions leaflet has been published to try to help explain the difference between In Hours and Out of Hours GP services.

Management lead through learning, improvement and innovation

We saw plans for all members of staff to have a yearly performance review meeting and provisional appraisal dates were being planned for the known quieter months for Out of Hours providers in summer 2016.

We were presented with a comprehensive improvement and development plan which had been complied by the service. This plan was a working document, updated regularly and assigned different actions to key members of staff. The plan had defined sections including aligned work streams, tasks, activities, assurances, outcomes, an owner and target completion date.

- For example, one recent area of improvement was the review of Patient Group Directions. This was aligned to the clinical management work stream, detailed the tasks involved, the executive medical director was the owner and this was completed in November 2015.

Following our inspection, we were sent an updated plan which included aspects of our initial feedback we provided at the end of the inspection. This demonstrated the service is reactive to our feedback and confirmed their focus of continuous improvement.

Clinical and non-clinical staff told us they worked well as a team and had good access to support from each other. There were processes in place for reporting and investigating safety incidents.

Are services well-led?

Good

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

There was a strong focus of improvement at all levels within the service. Hampshire Doctors On Call Service was forward thinking and part of a number of pilot schemes to improve the service and ultimately improve outcomes for patients.

- Specifically, in February 2016, 74 Italian GPs will begin the recruitment process to join Hampshire Doctors on Call Service. There is a known surplus of GPs in Italy and the training process is similar to England. If successful, the Italian GPs will relocate to Hampshire, consolidate their training with Health Education England and commence shifts working for in-hours GP practices and Hampshire Doctors on Call Service Out of Hours service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Non-clinical staff who acted as chaperone had not received appropriate training to reflect the role and purpose. They did not have a risk assessment or criminal record check via the Disclosure and Barring Service (DBS). Where the decision has been not to carry out a DBS check on staff, the provider had not given a clear rationale as to why. Regulation 12 (2)(b)

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: We found not all relevant staff had completed or updated as needed mandatory training including subjects such as safeguarding children and basic life support. Regulation 18(2)(a)