Basingstoke and North Hampshire Hospital

Quality Report

Basingstoke and North Hampshire Hospital
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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

Hants Doc provides urgent medical care from a primary care centre at the emergency department within Basingstoke Hospital. The service is run by North Hampshire Urgent Care (NHUC).

The service was mostly safe but we found some problems with the management of medicines. There was good monitoring of the clinical performance of doctors but limited audits of other activities. There were some gaps in recruitment procedures.

Patients were overwhelmingly positive about the care they received but some were unhappy about the waiting room being shared with the hospital's emergency department.

The service co-operated with other organisations to improve the health care experience for patients in the area. The service responded to patients needs appropriately.

There was a good management team in place with a clear focus on patient needs but there were gaps in some audit processes which meant that issues of concern were not always identified or acted upon.

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 some aspects of the way in which the provider managed medicines that were not safe. There was good reporting and reviewing of incidents and complaints but the sharing of lessons learnt with other clinicians could be improved.

Are services effective?

Overall the service was effective. Care and treatment was being delivered in line with current published best practice. Patients' needs were consistently met in a timely manner. There was good monitoring of clinicians' performance but no systematic approach to clinical audits.

Are services caring?

Overall the service was very caring. Patients we spoke with were extremely complimentary about the level of care they received. All the patients who used the service in the weeks before our inspection and who completed a comment card were entirely positive about the care they received

Are services responsive to people's needs?

Overall the service was responsive to people's needs. There was an open culture within the organisation and a clear complaints policy. The service participated actively in discussions with commissioners about how to improve services for patients in the area. The provider responded effectively to patients' comments.

Are services well-led?

Overall the service was well led but problems relating to the management of medicines and equipment should have been identified by the management team.

Summary of findings

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

Patients we spoke with during the inspection were generally very positive about the service they received. Some patients were concerned that the service shared a waiting room with the hospital's emergency department. They told us that they could feel threatened by aggressive patients waiting to see emergency doctors. We looked at 20 comment cards filled in by patients who used the service in the week before our inspection. They were unanimously positive.

We also looked at the results of a patient survey carried out by the provider. The results were generally positive, although some patients made negative comments about delays in being seen and sharing a waiting room with the emergency department.

Areas for improvement

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

The management of medicines including controlled drugs must be improved

Ensure correct storage and control of prescription pads in the service to reduce the risk of prescriptions being misused.

Recruitment procedures must be improved to ensure that all staff have criminal record checks.

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

The proposed new integrated risk management and audit system needs to be implemented as soon as possible.

There could be better monitoring of infection control procedures in the primary care centre.

There could be better recording of equipment checks

Good practice

Our inspection team highlighted the following areas of good practice:

There was good oversight of the clinical performance of doctors.

There was an effective working relationship with the accident and emergency department where the service was located.

There was a robust process for collecting the views of patients who used the service.

Basingstoke and North Hampshire Hospital

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The inspector was supported by a GP, a nurse and a practice manager. The team also included an expert by experience.

Background to Basingstoke and North Hampshire Hospital

Hants Doc provides an evening and weekend out-of-hours primary care service for 21 practices in North Hampshire. The service is responsible for providing primary care when GP surgeries are closed. It covers a population of 217,000 and operates from a single location in Basingstoke Hospital. Patients contact Hants Doc through the NHS 111 service.

Why we carried out this inspection

We chose to inspect Hants Doc as one of the first inspections in our Chief Inspector of Primary Medical Services' new inspection programme because we were keen to visit a range of different types of out-of-hours providers to test our approach going forward.

We inspected this out-of-hours service as the provider had not been inspected before.

How we carried out this inspection

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. This did not highlight any significant areas of risk across the five key question areas.

As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us.

The inspection team spent eight hours inspecting the out-of-hours service and visited the provider's administrative offices and its primary care centre at Basingstoke Hospital. We spoke with six patients and six staff. We also reviewed 20 comment cards completed by patients who used the service in the weeks before our inspection.

We carried out an announced visit on 26 March 2014. We observed how Hants Doc handled patient information received from the external call handling service. As part of the inspection we looked at the personal care or treatment records of patients, and we observed how staff cared for patients and talked with them. We also talked with carers and family members. We spoke with and interviewed a range of staff including the service manager, two directors of the company and three doctors.

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?

Detailed findings

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

Are services safe?

Summary of findings

There were some aspects of the way in which the provider managed medicines that were not safe. There was good reporting and reviewing of incidents and complaints but the sharing of lessons learnt with other clinicians could be improved.

Our findings

Incident management

The provider's medical director described a robust procedure for reviewing serious incidents and complaints. Two doctors, two nurses and a lay member reviewed incidents and complaints on a regular basis. There was the option of a second review by two other doctors if an incident was particularly serious or complex. Learning from incidents was reported to the provider's governing body through its governance committee. Details were also sent to the local clinical commissioning group (CCG). Learning was only shared with other doctors working in the service through a quarterly newsletter. This meant that there could sometimes be a delay in sharing learning with all the doctors in the team. For instance, we saw details of one complaint received in May 2013 where clinicians were not given any advice about how to avoid a similar situation until October 2013.

The service manager told us that they were in the process of updating the serious incident policy. We saw reference to this in a newsletter from October 2013. The same article reminded staff of how to report and record incidents using the existing system.

Medicines Management

We asked staff about the arrangements for protecting people against unsafe use and management of medicines. Staff showed us a range of up to date standard operating procedures relating to prescribing and medicines management. Staff we spoke with told us that people who used the service were supplied with medicines only after they had been issued with a prescription from a doctor or a nurse prescriber.

We asked staff about the procedures in place to ensure the safe storage, control, and supply of prescription forms. We were told that there were no available written instructions or policies. This meant that staff were not following the NHS Protect Security of prescription forms guidance, August 2013. This could lead to controlled stationery (prescriptions) being diverted, meaning people who used the service and others could be at risk.

People who used the service were occasionally supplied with urgent and emergency medicines by the GP from a stock held at the centre in an area accessed only by designated staff. Medicines were supplied to the centre by the hospital pharmacist as part of a contractual agreement. We saw that medicines were generally stored securely and according to the manufacturers' instructions. All of the medicines we looked at were within their expiry date.

The Drugs and medical supplies policy stated that any medicines dispensed to people who used the service should be recorded by the dispensing GP in the 'drugs log book'. Staff showed us the drugs log book and we saw that the records held were not generally in accordance with the policy. We asked for evidence that there were processes in place to monitor and review performance against the medicines management standards and none was available.

We asked about the arrangements in place for the monitoring of and replenishment of stocks of medicines. We were told that the stocks were checked daily and replenished as needed by administrative staff during the day. We asked to look at instructions given to the staff involved in the restocking. We were told that as the monitoring and replenishment of stocks of medicines was carried out in-hours, there would be no reason for the out of hours staff to be able to access the instructions and records. As we were inspecting out-of-hours, the staff did not have access to the instructions. We also asked to see records of the stock held and the checks that had been carried out, and were told these were not available for the same reason.

We saw that the list of stock items of medicines requiring refrigeration did not correspond with those stored in the refrigerator and that the notice of the location of emergency medicines in the refrigerator was incorrect.

We saw that some medicines had been dispensed by doctors in a form other than the original packs supplied by the pharmacy. Staff told us that this had been identified as a risk for people who used the service approximately six months previously and that there was work in progress towards mitigating the risk. We asked to see evidence of

Are services safe?

any revised systems, processes and practice in place and none was available. This meant identified risks had not been acted upon and there were ineffective monitoring and review processes in place.

There were separate arrangements in place for managing controlled drugs, which are medicines subject to stricter legal controls under the misuse of drugs legislation. Staff showed us records of controlled drugs which demonstrated that they were not following their own procedures to ensure frequent reconciliation of controlled drugs stock. However the stock we looked at corresponded with what was documented in the record book and it was all within date.

We saw that there were systems and processes in place to receive and act on safety information relating to medicines and medical devices.

Maintenance of equipment

Staff we spoke with told us that doctors and nurses were supplied with equipment to aid clinical diagnosis when treating people at the centre, and also when treating people at home. We saw that this was the case and that it was generally stored suitably. Equipment was also provided for use in the event of a medical emergency, and all the staff we spoke with correctly identified its location and described how to use it.

We asked staff what checks were in place to ensure that the correct clinical and emergency equipment was provided, maintained, suitable for its purpose and was used correctly. Staff we spoke with told us the checks were the responsibility of the administrative staff and drivers, and that equipment was checked on a regular basis particularly after it had been transported to home visits. We were shown a schedule of equipment checks that should take place each week. We asked to see records of the completed checks for equipment including emergency equipment but none were available. This could lead to incomplete or expired equipment stocks putting people at risk.

Infection prevention and control

Staff told us that they followed the hospital's infection prevention and control policies as part of a contractual agreement. The primary care centre appeared clean and clear from clutter and any offensive odour. We saw that there were suitable hand washing facilities and instructions in place for staff and people who used the service, and that arrangements for the safe disposal of clinical waste and sharp objects were in place and were being followed. We saw that personal protective equipment was available for clinical staff within the centre as well as for doctors visiting people in their homes. We asked for evidence that infection prevention and control procedures were being monitored and reviewed and none was available.

Managing foreseeable emergencies

Staff we spoke with told us that the emergency team at the hospital would provide assistance in the case of a medical emergency at the centre and showed us that the emergency telephone number was displayed in each consulting room. All the staff we spoke with, including clinicians, administrative staff and drivers, told us they had successfully completed relevant training in managing medical emergencies. All of the staff accurately described their specific responsibilities in managing emergencies and correctly located the emergency equipment. Emergency medicines were stored alongside other medicines in the designated medicines storage area.

Whistle blowing

There was an up to date whistle blowing policy in place. A recent staff newsletter had drawn the attention of staff to the policy and had explained its key principles. Staff we spoke with told us they were familiar with the policy and they felt any concerns they had would be treated seriously.

Are services effective?

(for example, treatment is effective)

Summary of findings

Overall the service was effective. Care and treatment was being delivered in line with current published best practice. Patients' needs were consistently met in a timely manner. There was good monitoring of clinicians' performance but no systematic system of clinical audits.

Our findings

Auditing and monitoring

The service used an electronic tool known as 'clinical guardian' to monitor doctors' consultations with their patients. A clinical audit team made up of 2 GPs used the system to monitor the performance of the doctors by analysing and scoring a percentage of consultations each week. Any consultation which was of concern was further reviewed by the clinical governance team. The system was used to provide regular feedback to doctors about their performance. Newer doctors, or doctors with lower performance scores, were monitored more closely.

We saw a clinical risk register. The register contained only a brief description of 13 identified risks. Twelve of the risks had been added when the register was created in July 2011. There was no evidence of any action to mitigate any of the risks identified. We saw the minutes of a clinical governance meeting from May 2013 in which it was simply recorded that the committee needed more time to consider the register. Since then the service had agreed to purchase a new integrated risk management and clinical audit database system, although we were told that this was not yet in place.

The service had recently decided to reduce the range of medicines it kept in stock. The medical director had audited the medicines the service used and had consulted the local medicines management team about the revised formulary.

We did not see evidence of any completed clinical audit cycles.

Recruitment

Staff showed us the policy and application processes for recruitment and induction of GPs. We were told that all staff were appointed following a face to face interview and satisfactory references. We looked at personnel records and saw that evidence of criminal record bureau or disclosure and barring service checks was not in place for all staff. The provider told us that they did not have a procedure in place to ensure that clinical staff employed were physically fit for work. However we saw evidence that non clinical staff were asked to declare their health status on their application form.

We saw evidence that all the doctors and nurses working within the service were currently registered with their professional regulator and there were checks in place to ensure that they kept their registration up to date and met the regulatory requirements.

Training

We looked at the training policy and training records and saw evidence that all staff were expected to successfully complete a structured induction programme on appointment and that they undertook ongoing learning and development including mandatory training, supervision and an annual appraisal. Staff we spoke with told us they felt well supported in accessing ongoing learning and development.

Multi-disciplinary working

We saw evidence of good working relationships between the provider and other health and social care professionals. For instance, there were good links with the local rapid response mental health team to provide support for patients with out-of-hours mental health needs. It was also possible for health care professionals to refer patients to the out-of-hours service without going through the NHS 111 service. The service also had an arrangement with the local hospital's paediatric department to ensure that out-of-hours doctors were aware of patients already under the care of the hospital's paediatric team.

We looked at the electronic records of people who had been assessed and treated at the centre. We saw that prescriptions for people who used the service were recorded electronically and that information was shared with the person's general practitioner within 24 hours. This meant that, in the case of people attending the centre, clinical records were communicated to relevant parties in a timely manner to ensure continuity of care.

Are services caring?

Summary of findings

Overall the service was very caring. Patients we spoke with were extremely complimentary about the level of care they received. All the patients who used the service in the weeks before our inspection and who completed a comment card were entirely positive about the care they received.

Our findings

Patient survey

A sample of patients were written to each month to seek their views on the service they received. We saw that the returned surveys were attached to the patient's consultation notes to give the reviewer the full context of the comments. We saw that patients were overwhelmingly satisfied with the care and treatment they received from the doctors, but some made negative comments about the time they waited in a waiting room shared with the hospital's emergency department. A statistical analysis of the results was being carried out and the results were to be shared with all staff.

Privacy and dignity

The service had a patient dignity policy in place. Staff were familiar with the steps they needed to take to protect people's dignity. Consultations took place in purpose designed consultation rooms with an appropriate couch for examinations and curtains to protect privacy and dignity. There were signs explaining that patients could ask for a chaperone during examinations if they wanted one. Patients told us that they felt that staff and doctors had effectively protected their privacy and dignity.

Involving patients in their treatment

The provider did not operate a patient participation group or have patient representation at its service meetings although the provider's governing body was chaired by a lay person. Individual patients told us they felt that they had been involved in decisions about their own treatment and that the doctor gave them plenty of time to ask questions. They were satisfied with the level of information they had been given and said that any next steps in their treatment plan had been explained to them.

Staff attitude

Staff told us that they enjoyed their work and liked their working environment. We observed staff talking to patients in a calm, respectful and reassuring manner. Patients we spoke with were very happy with the way they had been dealt with by staff. They told us that they were never made to feel as if they were wasting the doctor's time. We saw an article in a recent newsletter produced by Hants Doc urging doctors to check that their patient's' local pharmacy had the necessary medication in stock before prescribing it. The article said that this would be a compassionate thing to do at a time of patient stress.

Reception and waiting room

Patients who were invited into the primary care centre for an appointment were greeted by staff from the hospital's emergency department where the service was located. The emergency department and the out-of-hours service shared a waiting room and some patients told us that they did not like this arrangement as they could feel threatened if there were drunk or aggressive patients attending the emergency department.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Overall the service was responsive to people's needs. There was an open culture within the organisation and a clear complaints policy. The service participated actively in discussions with commissioners about how to improve services for patients in the area. The provider responded effectively to patients' comments.

Our findings

Meeting peoples' needs

Hants Doc regularly met the local clinical commissioning group to discuss ways of responding to the needs of local patients. Hants Doc worked alongside staff at the hospital emergency department where the service was located to provide a day time GP for patients who had attended the department when it was not an emergency. Hants Doc also had resources in place to provide a similar service during the out-of-hours period. Triage staff in the emergency department were able to refer patients directly to the out-of- hours service using a compatible computer system. The two services shared a waiting room so patients received a seamless service.

The primary care centre was accessible to patients with mobility difficulties. The consulting rooms were large with easy access for patients with mobility difficulties. There was also a toilet for disabled patients. Staff said they had access to interpreter or translation services for patients who needed it, and there was guidance about using interpreter services and contact details. They said that although they asked patients who their normal GP was, they did not refuse to see anybody if they were not registered with a GP.

If a patient wanted to see a doctor of a particular sex that was not available in the primary care centre, staff were able to seek support from doctors working in the adjacent hospital emergency department.

The provider publishes key performance indicators on its website to enable patients to see its current performance levels.

Learning from experiences, concerns and complaints

The service had an open culture and staff told us that there was a 'no blame' culture in the service. We saw that there was a robust complaints procedure in place. The medical director regularly audited the performance of doctors. Any specific issues were raised directly with the doctor concerned. General learning points were shared with the whole team using a regular newsletter. We saw evidence that learning from complaints and incidents was discussed at clinical governance meetings. We also saw a reminder to doctors in a newsletter to explain to patients why they might consult a mobile phone or other electronic device during a consultation. This followed complaints from two patients who thought that the doctor was being disrespectful. The provider published a summary in its annual report of every complaint it received together with the action it took in response. Each month, 5% of patients who received a service were written to seek their views on the service they received. We saw that the returned surveys were attached to the patient's consultation notes to give the reviewer the full context of the comments.

Staffing levels

The service had procedures in place to ensure that the number of clinicians available matched the anticipated demand. There were additional clinicians on duty at peak times in the evenings to meet demand and a nurse was able to talk with patients from both of the provider's locations.

Are services well-led?

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

Summary of findings

Overall the service was well led but problems relating to the management of medicines should have been identified by the management team.

Our findings

Structure

Hants Doc provides an evening and weekend out-of-hours primary care service for 21 practices in North Hampshire. The service is responsible for providing primary care when GP surgeries are closed. It covers a population of 217,000 and operates from a single location in Basingstoke Hospital. Patients contact Hants Doc through the NHS 111 service.

The service is managed by North Hampshire Urgent Care which was formed in 2006 following a merger between Hants Doc and Frimley Primary Care Services. There is a management council which meets quarterly. Day to day business is managed by the management executive supported by a number of sub committees, including an audit committee and a clinical governance committee.

There was clear accountability within the management team, and people took responsibility for their actions. Staff told us that the senior managers were visible and approachable.

Risk management

We saw a basic risk register for the service which identified a number of risks but did not include any details of measures planned or taken to reduce them. Five of the risks identified were four years old. The manager told us that service had recently agreed a contract to purchase a new integrated risk management and clinical audit database system, although this was not yet in place. The need for a more robust risk management system had recently been identified by NHS South West which had audited North Hampshire Urgent Care as a quality requirement of its membership of Urgent Health UK, a consortium of non for profit OOHs providers

National quality requirements and key performance indicators

Hants Doc reported its performance against the national quality requirements for providers of out-of hours primary medical services to the local CCG on a monthly basis. Since NHS 111 had started handling initial calls on behalf of the service in January 2013, Hants Doc had met the NQRs for face to face assessment response times. Hants Doc had also worked with the CCG to design a suite of locally agreed KPIs. Hants Doc also reported their performance against these indicators on a monthly basis. According to the most recent contract monitoring meeting notes, the CCG was satisfied with Hants Doc's performance.

Strategy

Hants Doc is part of North Hampshire Urgent Care (NHUC). In its most recent annual report, NHUC listed progress against the objectives it set itself last year. It reported good progress against all objectives with many being fully achieved. We saw the minutes of a strategy meeting held in October 2013. It showed that NHUC was thinking about the future in a positive way which would benefit the local health economy.

Internal audits

There was not a programme of audits planned for the service on ongoing basis. The management team should have acted upon identified problems with the management of medicines in the service.

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
Treatment of disease, disorder or injury	Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Patients were not protected from the risks associated with the use and management of medicines.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. There was not an effective recruitment procedure in place to ensure that persons employed were of good character and that they were physically fit for work. Regulation 21 (a) (i) and (iii)

Regulated activity	Regulation