Humber NHS Foundation Trust

RV9

GP out of hours services

Quality Report

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This report describes our judgement of the quality of care provided within this core service by Humber NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Humber NHS Foundation Trust and these are brought together to inform our overall judgement of Humber NHS Foundation Trust

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Overall summary

Systems and processes were in place to provide safe care and support for patients. There were processes in place to recognise and investigate incidents relating to patient safety. However, there were some inconsistencies in staff members' application of these systems and this could have resulted in the under-recording of incidents. The staffing levels and skills mix were sufficient to meet patient needs and on bank holidays and weekends extra staff were scheduled to work. However, there were occasions where the Hedon service was closed because the trust was unable to fully staff the service due to unplanned staffing issues. The service was then delivered from another centre. Equipment used to provide the service was well maintained. However, patients were not always protected from the associated risks with medicines because staff were not always properly following the monitoring systems to ensure the medication was stored at safe temperatures.

There were effective systems and processes to ensure patients received professional and competent care in accordance with national guidelines. Clinical staff understood and participated in clinical audits. Staff carried out their roles competently and worked well as teams. With respect to mental health and community nursing we found that patients received good and well coordinated care.

Staff were positive and proud of the work they did. There was effective teamwork and visible leadership at service level during the day but during the night on site, there was not a member of staff with overall responsibility. Clinical teams felt fully supported but some driver technicians did not. Patients' experience had not been sought for 2013/14.

Summary of findings

Background to the service

The GP out of hours (OOH) service provided by Humber NHS Foundation Trust was part of their unscheduled care services. The OOH service operated out of four Primary Care Centre (PCCs) throughout the East Riding area: at Goole, Hedon, Bridlington, and Beverley. They provided a service to approximately 330,000 residents and covered a geographical area of over 1000 square miles. Beverley was the headquarters of the GP OOH service. The PCCs were also supported by five fully equipped emergency vehicles to enable mobile working and home visiting.

The services operated from 6 pm to 8 am and patients accessed the service via the NHS 111 service telephone number or by walking into a primary care centre (PCC).

Care and treatment was delivered by GPs, First contact practitioners (FCP), consultant nurse with specialist training and Nurse Practitioners at the PCCs or in the patient's own home and they were supported by driver technicians and administration staff.

Each PCC had a minimum of a GP or FCP and a driver technician. Beverley, which was the busiest service, also had a receptionist. When there was a high demand for urgent care at these centres additional clinical staff would be brought in.

Our inspection team

Our inspection team was led by:

Chair: Stuart Bell, Chief Executive, Oxford Health NHS Foundation Trust

Team Leader: Cathy Winn, Inspection Manager and Surrinder Kaur, Inspection Manager, Care Quality Commission (CQC)

The team for adults with long term conditions included three CQC inspectors as well as a deputy chief nurse for community health services and a respiratory nurse specialist.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot for mental health and community health services inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit to the trust on 20 to 23 May 2014, and an unannounced inspection on 5 June 2014.

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 12 to 16 May 2014 and an

Summary of findings

unannounced inspection on 5 June 2014. During the visits, we held focus groups with staff groups. We visited the headquarters for the service at East Riding Community hospital and a Primary Care Centre at Goole.

We also spoke with a range of staff at different grades including nurses, GPs, service managers, support staff and the senior management team. We spoke with patients during our inspection at clinics. We observed how people were being cared for and reviewed care or treatment records of people who use services.

What people who use the provider say

The patient experience surveys for 2012/13, where 345 patients who had received face to face care stated:

- 82%, satisfied with the service.
- 77% would recommend the service.

The patient experience surveys for 2012/13, where 345 who had made contact with the service by telephone showed that:

- 94% thought the call handler was excellent or good.
- 96% thought it was easy to contact the service by telephone.
- 74% said the caller answered in less than a minute.
- 60% said the clinician called back within 20 minutes.
- 85.5% stated the service had met their expectations.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should make sure all staff working in the GP out of hours service are trained to use the new computer system (DATIX) for the recording of incidents and what should be recorded as an incident at the trust.
- The trust should make sure all staff are following the medication procedures robustly and medicines are stored at the correct temperatures.
- The trust should make sure all staff have completed mandatory training.
- The trust should make sure all staff are aware of the out of normal hours telephone contact numbers for the safeguarding teams.

Humber NHS Foundation Trust

GP out of hours services

Detailed findings from this inspection

The five questions we ask about core services and what we found

Are services safe?

By safe, we mean that people are protected from abuse

Summary

Staff we spoke with were aware of the trust reporting procedure for incidents, however we were not assured that incidents were being reported appropriately.

The trust had recently changed from a paper reporting system to a computerised system for recording both clinical and non-clinical incidents. We found most of the staff were not confident in using the computer system and had not received training.

The staffing levels and skills mix were sufficient to meet patients' needs. However, there were occasions where the Hedon service was closed because the trust was unable to fully staff the service due to unplanned staffing issues. The service was then delivered from another primary care centre for telephone assessment and a mobile service in the patient's home.

Equipment used to provide the service was well maintained. Although patients were not always protected from the associated risks with respect to medicines, as staff were not robustly following the monitoring systems to ensure medicines were stored at safe temperatures.

The out of normal working hours contact telephone numbers for the local authorities' adult and child safeguarding teams were not readily available for staff.

Detailed findings

Safeguarding Track Record

We spoke with managers, doctors, nursing staff, technicians and receptionists at Goole and Beverley Primary Care Centres. We found the majority of staff were aware of safeguarding procedures, spoke knowledgeably and said they had received instruction and role specific training in the safeguarding of vulnerable adults and children. The nurse practitioners said the trust staff, who led on safeguarding procedures, attended the nurse's clinical supervision meetings three times a year and also visited the PCCs to talk to staff.

The trust provided information to show the majority of staff had completed safeguarding children training. They had also written to GPs and asked them to provide evidence of training they had attended.

Staff spoke about the actions they would take had they any concerns and provided us with examples, and discussed how they had ensured other health professionals were

alerted. Administration staff and technicians told us they would always raise any issues with the clinicians. The clinical staff were aware of the contacts of the local safeguarding team, although, some staff thought the number was only available during the day. Staff said that during the night, where they felt a person or child was at immediate risk, they would contact the police. In addition patients' notes were shared with the GP surgeries by a computer system that alerted staff to any on-going safeguarding concerns. This meant people could be confident any risks of abuse would be identified and responded to appropriately.

Although we saw the out of hours services had standard operating procedures, provided staff with specific instructions when working in the evenings and nights, we noted this did not include the out of normal working hours contact telephone numbers for the local authorities' adult and child safeguarding teams.

Staff told us they had not made any recent safeguarding alerts and the trust provided us with information showing there had been one safeguarding alert made in 2013 and three in 2014.

Incident reporting and learning

Staff we spoke with were aware of the trust reporting procedure for incidents. Staff could describe how they would report clinical and non-clinical incidents and provided us with an example of an incident which had been investigated and staff notified of lessons learned. However, staff told us they had not recorded many incidents; we confirmed this was the case. We were not assured that incidents were being reported appropriately; we saw the closure of a PCC due to lack of staff was not reported as an incident. Although patient's were redirected to another centre, the trust's risk management strategy states an incident is reportable if it is contrary to the specified or expected standard of patient care or service.

The trust had recently changed from a paper reporting system to a computerised system for recording both clinical and non-clinical incidents. We found most of the staff were not confident in using the new computerised system and had not received training.

There was a process for staff to be informed of lessons learned following an incident. The GPs were informed by email. The clinical lead told us, due to the number of GPs involved in the service and their time commitments at their own GP practice, the trust did not offer peer learning. Two GPs told us they carried out informal peer group discussions to inform their learning with colleagues and there was a 'no blame' culture at the trust.

Maintenance of environment and equipment

During the day the premises were used by other agencies. In the two PCCs we inspected we saw equipment stored safely and driver technicians carried out cleaning and maintenance checks. We saw standard operating procedures for staff to follow detailing the responsibilities of the different roles which included what part they played to ensure the environment and equipment were safe.

The service had five fully equipped vehicles that enabled mobile working and home visiting. We saw the driver technicians completed a written checklist to ensure the vehicle had the correct equipment and the vehicle was clean and safe to use.

Effective systems were seen to be in place for the efficient transfer of people's records. Staff explained the service had computer systems, which enabled information from patient consultations at the service to be promptly alerted to and shared with the GP practices, so they could provide follow up treatment and care. Within each of the vehicles was technology, which enabled the technician to manage referrals to the service and the clinician to have access to patient information whilst mobile.

Staffing levels and caseload

There were four PCCs, based in Beverley, Goole, Bridlington and Hedon. Each had a minimum of one clinician, which could be a First Contact Practitioner or a GP and a driver technician.

In Beverley, which was the lead and busiest service, there was a receptionist whose role was to ensure people received prompt treatment from the most appropriate source. In addition the number of clinicians was increased to two at weekends to help with the potential increase in patients.

The majority of clinical staff and technicians told us this was enough staff to meet the level of activity at the services. However, due to number of staff absences, they sometimes found it difficult to maintain the Hedon service. The service was then delivered from another primary care

Are services safe?

centre for telephone assessment and a mobile service in the patient's home.There were also occasions when the Bridlington service could not be opened and people had to be directed to the nearest service or visited at home.

Clinical staff told us they had increased their number when additional pressures were identified. For instance during the winter the number of callers could increase or when there was a risk of swine flu. To enable business continuity the standard operating procedures for out of hours had details of how to cover the shift if a member of staff was unavailable at short notice.

Medicines

A system was in place to centrally monitor the fridges used to store medicines. However, we found the drugs fridge in Beverley PCC was being used, despite being decommissioned in April when the temperature reading had been abnormal. As the fridge was decommissioned the systems in place to centrally monitor the fridges had not detected this. This meant staff could not be confident the correct temperatures had been maintained to ensure medicines were prevented from any physically change, or loss of potency. We reported this to the nurse consultant who immediately arranged for the medication to be removed. We also saw staff had failed to check that medication was restocked appropriately each day in Goole and this had not been identified by management.

There were systems in place to ensure medicines used from the vehicles, were suitably stored and monitored to make sure they were intact and in date. We saw clear records of when medication was prescribed, which were checked by the pharmacy staff who would restock the medication as required.

The consultant nurse told us the nurse practitioners and GPs were audited to check their medication prescribing during their annual appraisals. This was to make sure they were following the National Institute of Excellence (NICE) prescribing guidelines. We were provided with a copy of the most recent report, about prescribing in GP out of hours services 2012/13, which reviewed the prescribing activity and provided recommendations.

The trust had introduced summary care records, which enabled clinicians to access, with the patients consent, an electronic medical record. This showed essential information such as current medication, allergies and bad reactions to medicines which helped reduce the risk of prescribing errors.

Major incident awareness and training

The service had a business continuity plan providing staff with the actions to take if there was a disruption to the services. This included re-deployment of staff, and contacting other agencies, such as 111 or Yorkshire Ambulance Services, to enable them to implement their escalation policies and the prioritising of patients. In addition, the Standard Operating Procedure (SOP) for the out of hours service, had details of what actions staff must take if the computer systems failed or if there was a bomb threat. We found staff were aware of the plan and had actioned it when staff were not available for work.

Lone and remote working

The trust has a lone and remote working policy for staff and the SOP for out of hours contains specific information about home visits, although staff said they rarely worked alone.

Staff explained they were provided with telephones and the vehicles were alarmed. At the Beverley service we were told the consultation rooms, treatment room and reception were only accessed with a key fob. The reception also had an alarm at the desk to summon help from security if needed. In addition the computer system also alerted staff where people had posed risks to staff previously.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

There were effective systems and processes to ensure patients received professional and competent care in accordance with national guidelines. Clinical staff understood and participated in clinical audits. Staff were competent to carry out their roles and worked well together as teams. With respect to mental health and community nursing, we found that patients received good and well coordinated care.

Mandatory training figures for 2014 showed in some areas the OOHs staff were not meeting the trusts own required levels of compliance.

Detailed findings

Evidence based care and treatment

Individual roles and responsibilities were well understood by staff in the delivery of evidence based care, which was often in line with national guidance and pathways. The GPs who worked in the service showed us that National Institute Clinical Excellence (NICE) guidance was adhered to. In addition the lead clinician carried out regular audits of the GPs work. This was confirmed by two GPs who said safe prescribing audits were carried out and the lead clinician provided feedback to the GPs regarding the results of the National Quality Requirements (NQR). They also used NICE care and treatment pathways for diabetes, chronic obstructive airways, asthma and the "green book" for immunisation advice. The green book held the latest information on vaccines**,** and vaccination procedures for vaccine preventable infectious diseases in the UK. We saw the clinical staff had access to current guidance via computers.

We saw two NICE audits on a feverish child and a head injury, which had been carried out by the nurse consultant. Both demonstrated the appropriate guidance had been followed. One of the doctors commented the FCPs were "excellent"

Monitoring and improvement of outcomes for people

The service was monitored, by various operational systems, to help identify ways to improve. For example, there were day to day audits of the equipment ensuring they were safe to use. The competency of the clinical staff recording and dispensing medicine were audited against NICE guidance by the lead practitioner and the nurse consultant. Any issues were raised in supervision or annual appraisal.

We saw there were clinical meetings for clinical staff, where any issues about practice would be discussed. The lead clinician told us GPs would make contact with them if they had identified any issues where improvements could be made.

We saw the unscheduled care services had carried out a successful pilot where they had opened the minor injuries services at the weekends and bank holidays at the Beverley PCC.

The service manager used an adapted version of the Royal College of General Practitioners tool kit to assess the performance of its doctors and FCPs. This contributed to the appraisal process.

We were provided with a copy of The National Quality Requirements in the Delivery of Urgent Care, that had been collated by the Yorkshire Ambulance service. This information demonstrated how promptly the OOHs had responded to the urgent calls and how quickly people had been seen by a clinician. The lead clinician told us the trust reviewed this information to look at ways of improving outcomes for people. Further comments about this information are noted in the section that covers the responsiveness of the service.

Staff talked enthusiastically about the service and what monitoring and improvements that could be made, such as face to face appraisal for the doctors. We saw a draft business plan for 2014 to 2015. This showed that the trust were reviewing the service and ways to make improvements.

Performance and call handling

Calls to the service were handled by the NHS 111 service, with life threatening calls identified by call handlers and diverted to the relevant emergency services. All calls were assessed for urgency by the external service before being transmitted electronically to the out of hours service. The PCCs dispatcher would then send the calls to the PCC, who

could respond promptly. The clinician then contacted the patient to assess whether they were able to visit the PCC or whether a home visit was required. New calls were directed to the laptops in the cars but could also be re-directed to another PCC if a more urgent response required. The telephone calls were recorded so that any complaints or concerns could be investigated.

Out of hours providers are required to regularly report on their performance against a series of national quality requirements (NQR). The activity was collected monthly by Yorkshire Ambulance Service. The National Quality Requirements in the Delivery of Urgent Care shows, for face-to-face clinical assessment for urgent cases and face to face consultations at home, the performance was below the expected 95%. However, the trust reported, since the implementation of NHS 111 service, the timescales they were working to were not applicable and they were working with external agencies to develop more realistic performance indicators.

Competent staff

The service manager, the lead clinician and the nurse consultant told us they had a proactive approach to the safe recruitment and retention of staff. All staff had an interview where their specific skills were tested to ensure they met the requirements of the job. References and professional registration with the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) were always sought.

The trust employed approximately 70 GPs who in the main worked locally in their own GP practices. We were told, following a recent incident, that the trust had commenced checking the GMC register weekly to make sure the GPs who worked that week continued to meet the requirements of the GMC. New GPs were inducted by the clinical lead who worked alongside them for their first shift.

The GPs told us the clinical lead carried out annual appraisals of their work and provided feedback by email. Where issues were found a face to face interview was carried out. Additionally, the trust had commenced an audit of the supervision and training undertaken by the GPs to enable them to remain on the NHS performers list. We looked at a sample of two appraisals and found these were a brief review of data rather than a full appraisal, which would have included a discussion and a reflection on the data by the GP and the appraiser.

We saw that where a trainee GP participated in the out of hours service, they always worked with the GP who supervised their practice.

Induction training for other staff was carried out by the line manager and specific to their roles. For instance the FCPs were inducted, clinically supervised regularly and appraised by the nurse consultant. However we found a different approach had been adopted for the technicians. They had an annual appraisal but did not have formal supervision throughout the year. Also the mandatory training figures for 2014 showed us that in some areas the OOHs staff were not meeting the trusts own required levels of compliance.

Staff told us they had been provided with Mental Capacity Act and Mental Health Act training. Information provided to us by the trust showed that 95% of staff had completed Deprivation of Liberty safeguard (DOLs) and 74% had completed Mental Capacity Act (MCA) training.

We were also told that the FCP had received additional mentor training to ensure they were competent to assess people's mental capacity. Staff were aware the trust had issued a revised Do Not Attempt Cardiopulmonary Resuscitation (DNA CPR) policy. This included guidelines for staff when they discussed DNA CPR with patients and families.

Multi-disciplinary working and working with others

The GP out of hours service fostered close working relationships with other health care teams, within the trust, and externally. For example, PCC staff reported a good integrated care pathways developed between the psychiatric crisis response team and the out of hours district nurses. Staff also told us that for people with long-term conditions, who attended the service regularly, they would contact the community matron to make sure the appropriate support was being offered to the person within normal working hours. Also during home visits, fall assessments were carried out on older people, and if any concerns were identified they were referred to the district nursing team. They would also call the district nursing team to assist if a patient had pressure sores.

Staff told us all of the information was recorded on a computer system (ADASTRA) and this was shared with the GP practices. This also ensured the information was with

Are services effective?

the patient's GP by the time they opened in the morning. The nurse consultant told us they attended meetings twice a month with the 111 service to monitor the services and ensure any issues were attended to promptly.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

Staff treated patients with dignity, compassion and respect. Patients and their representatives have made positive comments about the care and treatment they received. The comments showed patients and their relatives felt involved in their care and supported with their emotional needs.

Detailed findings

Respect, Dignity, Compassion & Empathy

During our inspection we met with three patients who all indicated they were satisfied with the care and treatment provided. One told us they found the service "Invaluable" because they were not always able to attend their GP surgery in working hours.

The patient experience surveys for 2012/13, where 345 patients who had received face to face care, reported a satisfaction rate of 82%, and 77% stated they would recommend the service. Regarding the attitude of staff 17 people made positive comments about the friendly and courteous manner of staff and their professionalism. However, we also noted that there were some negative comments, in the main about the attitude of some of the GPs.

From a survey of people who had made contact by telephone, 94% thought the call handler was excellent or good.

The staff, from the different teams and roles, complimented each other on their caring and compassionate attitude. The nurse consultant told us that verification of a person's death at home would be prioritised to reduce distress to the relatives. They would also make sure the close relative was not left alone and that there was a follow up the next day by the relatives GP.

Involvement in decisions and consent

Staff told us they adhered to the requirements of the Mental Capacity Act 2005 and the Children Act 1989 and 2004. Mental capacity assessments and competency assessments of children and young people checked whether adults, children and young people had the maturity and capacity to make decisions about their treatment.

The patient experience surveys for 2012/13, where 345 patients who had received face to face care,18 patients made positive comments about how the staff explained the actions they were taking.

We found clinical staff understood how to make 'best interest' decisions for people who lacked capacity and sought appropriate approval for treatments, such as vaccinations, from the children's legal guardian. The patient admission form required patients to sign showing they had given their consent and the trust could share their records with other health professionals.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

Overall, people's needs were met in a timely way. There were systems in place to make sure people accessed the most suitable service for their needs. People were seen as quickly as possible and information was shared with people's GPs promptly.

Complaints about the service were taken seriously and were responded to in a timely manner.

The trust had implemented systems that had proved to be successful in preventing people from having to attend A&E with minor injuries and fractures. Pathways were in place to refer to local services for diagnosis and treatment, for example for people with suspected deep vein thrombosis or bladder concerns.

Detailed findings

Meeting the needs of individuals

Staff told us they treated every patient as an individual in assessing their needs. They used the referral information from the NHS 111 service, the initial assessment telephone call by the clinical staff and the follow up appointment at the PCC or the person's home. They gave each patient the time they needed to make sure their needs were met. For instance, during the initial telephone call they would assess whether a visit to the service or a home visit was the best option for the person. Staff told us visits to the home depended on the age, disability and location of the person and ensuring the person was seen promptly. At the appointment staff followed care pathways and assessed if any further areas needed to be addressed. We saw the admission checklists encouraged clinical staff to review other areas which may give rise to concern, such as headaches, bleeding or pain.

Additionally, for specific groups, they would consider other actions. For example, people with long term medical conditions who were persistent users of the PCC. In these cases they would contact the community matrons. For older people, they would always expect the consultation to take longer, consider capacity and carry out a falls assessment. For children, they always considered child protection services. For younger people, they could provide sexual health information. For people with a learning disability, they would anticipate a longer consultation and ensure consent was appropriately obtained.

Staff told us, where possible, they would prevent the patient from having to go to A&E. For instance the FCP said they would attend to some minor injuries. Where patients walked into the service, they would be seen, or referred to the appropriate service. The trust had carried out a trial and opened an out of hours minor injuries clinic at the weekend for six months. This had proved to be successful in preventing people from having to attend A&E with minor injuries and fractures. Pathways were in place to refer to local services for diagnosis and treatment, for example for people with suspected deep vein thrombosis or bladder concerns.

Where people's first language was not English, staff said they had access to interpreter or translation services and guidance was available in the standard operating procedures.

Consultations took place in purposely designed consultation rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity, although there were no signs in the waiting rooms telling patients they could ask for a chaperone during examinations.

Access to services/care as close to home as possible/access to the right care at the right time/ flexible community services

There were four Primary Care Centre (PCCs) throughout the East Riding serving a population of approximately 330,000 residents and covering a geographical area of over 1,000 square miles. All the PCCs were strategically placed to attempt to minimise travelling for people. If a service was closed they would try to make sure the person was not inconvenienced.

The initial phone call by the clinician meant people, who were inappropriately referred by the NHS 111 service and needed to go to A&E, went straight from their homes. Staff worked with other nursing teams in the trust and told us

Are services responsive to people's needs?

they had good working relationships with district nurses, community psychiatric nurses and the crisis mental health team. This meant people were able to access appropriate care at the right time.

The National Quality Requirements in the delivery of urgent care sets an objective of services meeting over 95% in key areas. The trust had met 8 out of 13 objectives and partially met another for the year 2013/14. Face-to-face clinical assessment for urgent cases started within 20 minutes of the patient arriving at OOH centre where a prioritisation system operated, had achieved 80% within those 20 minutes and within 60 minutes 91%. This was not meeting the requirements.

For face-to-face consultations at home with urgent cases seen within 120 minutes of definitive clinical assessment the trust had met this for 83% of the time. However the trust told us they recognised this was a requirement that needed attention. They were planning to look at the activity in June in greater detail to determine whether there were particular issues, causes, patterns or trends. They planned to review why this had worsened following the introduction of the NHS 111 service. They also told us this requirement was also a challenge due to the large geographical area that they covered and level of demand from an ageing population.

Service planning and delivery to meet the needs of different people

We were told the service managers reviewed the routine referrals to the local outpatients departments to see how many had been delayed and whether the delay had resulted in people visiting the out of hours service. The managers hoped the review would help to identify any issues and cause a reduction in the visits to out of hours by people whose appointments that had been delayed. Such as people with long term needs.

Complaints handling (for this service) and learning from feedback

Staff told us they would always refer a person who wanted to make a complaint to the Patient Advice and Liaison service (PALS) and provided the details. We saw the SOP had the contact details for PALS and the compliance office at the trust. However, we did note that although a complaint was not always an incident, the SOP referred to incidents and complaints together.

The service manager told us there had been 17 formal complaints in the previous year for unscheduled services and one had been upheld. For every complaint an investigation would be carried out and referred to the clinical lead if necessary. Following an investigation a response would be sent by the chief executive of the trust and any learning points shared with the staff. The lead clinician explained that as part of the GP appraisals they were required to reflect on any complaints and consider improvements. We were provided with an example of when they had cascaded any lessons learnt to the GPs.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

Staff were positive and proud of the work they did. There was effective teamwork and visible leadership at service level during the day but during the night on site, there was not a member of staff with overall responsibility. Clinical teams felt fully supported but some driver technicians did not. Patients' experience had not been sought for 2013/14.

Detailed findings

Leadership of this service

Day to day management of the service was by a service manager, who also held the overall responsibility for the other unscheduled care services such as the out of hours nursing service and the minor injuries clinics. The service manager was line managed by a general manager for unscheduled care who was also responsible for inpatient services at the community hospitals. Staff commented the service manager was often visible but the general manager was not.

The GP out of hours service had three teams. The nurse practitioners and FCP, the GP and the driver technicians. Each of the team managers reported to the service manager. Each communicated to their teams using the most appropriate means dependent upon the teams working practice.

The GP and the nurse practitioners all told us they had been supported in their roles by their line managers and they communicated well with them. However, some of the driver technicians did not feel this to be the case.

As part of the day to day operations, there was an on call manager who was not on site but held overall responsibility for the service. Each member of the PCC team had responsibility for their own areas of work. However, staff told us the on call manager had no experience of the GP out of hours service and was often unaware of how it operated. There was also no one member of staff designated as responsible for the management of the service when it was operating.

Vision and strategy for this service

The GP out of hours service was part of the Unscheduled Care Service and aimed to facilitate continuous care via a single point of access. It also had strong partnerships with other local integrated unscheduled care services, such as the minor injuries units, overnight community nursing teams and the neighbourhood care services.

We were told the service aimed to provide a comprehensive, safe and efficient service for urgent conditions whereby patients would be able to see the most appropriate clinician, in the most appropriate setting according to their needs. Care was to be delivered as close to the person's home as possible to prevent avoidable admission to an acute hospital. The care could be delivered within the patient's own home or in a more suitable environment, such as a care facility or community hospital.

Public and staff engagement

The out of hours service provided information about patient experience from the patient experience surveys for 2012/13 where 345 patients, who had received face to face care stated a satisfaction rate of 82%, and 77% stated they would recommend the service. Also from a survey of people who had made contact by telephone (214) 85.5% stated the service had met their expectations. Although the surveys asked what the service did well and what could be done better, both surveys did not include any action points in response to the comments what could be done better.

Within the GP out of hours service staff were offered the opportunity to make their views known directly to the clinical lead, or in the clinical and driver technician meetings or by whistleblowing.

Guidance, risk management and quality measurements

Evening and out of hours (OOH) staff had been involved and engaged in the consultation subgroups on 24 hour care. The trust vision for 24 hour care, and the need for change and keeping people in the community, had been shared with staff.

Are services well-led?

We were provided with a draft business plan for unscheduled care and community hospitals for 2014 to 2015, which demonstrated the trust were considering the overall risks to the service and areas where improvements could be made to reduce the risk.