West Midlands Doctors Urgent Care - Wolverhampton Urgent Care Centre

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at West Midlands Doctors Urgent Care - Wolverhampton Urgent Care Centre (WUCC) on 21 March 2017. Overall the service is rated as inadequate.

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

- There was an open and transparent approach to safety and an effective system in place for recording and reporting significant events. However an effective process to demonstrate learning was not evident.
- Risks to patients were not always fully assessed and well managed.
- Patients' care needs were assessed but not always delivered in a timely way and according to need. For example, there was the potential risk during the overnight period where paediatric patients (children) could go long periods without an assessment while the doctor on duty was on home visits.
- The service met the National Quality Requirements in some areas, however there was evidence of performance being below the required targets at weekends.
- Although most staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment some of the nurses were not trained to appropriate levels in paediatrics (care of children).
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The service had good facilities and was well equipped to treat patients and meet their needs. The vehicles used for home visits were clean and well equipped.
- There was a clear leadership structure and staff generally felt supported by the management team. However we found improvement was needed in areas of leadership and governance
- The provider was aware of and complied with the requirements of the duty of candour.

Summary of findings

The areas where the provider must make improvements are:

- Ensure effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure all staff providing care to children are competent and appropriately trained.
- Ensure that sufficient staff with the right competencies are on duty at all times.
- Ensure that safe recruitment procedures are consistently followed.
- Ensure the process for reviewing the performance of all staff during the induction period is consistently followed.

The areas where the provider should make improvements are:

- Ensure that a risk assessment is completed to determine whether there is a need for a second thermometer to confirm the accuracy of the temperature of the fridge used to store medicines.
- Ensuring that its vision and values are embedded within the organisation and shared by all staff.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

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?

Inadequate

The service is rated as inadequate for providing safe services.

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, lessons learned were not communicated widely enough to support improvement.
- When things went wrong patients were informed in keeping with the Duty of Candour.They were given an explanation based on facts, an apology if appropriate. They were told about any actions to improve processes to prevent the same thing happening again.
- WUCC had reviewed, its safeguarding systems and processes to ensure patients were safe and safeguarded from abuse across all services.
- When patients could not be contacted at the time of their home visit or if they did not attend for their appointment, there were processes in place to follow up patients who were potentially vulnerable.
- The systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example:
  - We found that safe recruitment procedures were not consistently adhered too.
  - There were no assurances to demonstrate all safety alerts were acted on.
  - There were no assurances to demonstrate that learning from incidents were shared with staff at a local level.
  - Competency checks were not carried out to ensure that staff qualified to care for young children had up to date skills and knowledge.

Are services effective?

Requires improvement

The service is rated as requires improvement for providing effective services, as there are areas where improvements should be made.

- The service was meeting National Quality Requirements (performance standards) for GP out of hours services in some areas however performance was below target at weekends.
- Staff assessed patients' needs, however care was not always delivered in line with current evidence based guidance and patients special notes..

Summary of findings

- Staff had knowledge of national guidelines but evidence of the reference and implementation of the guidelines were not evident.
- There was limited evidence to demonstrate that audit was driving improvement in patient outcomes.
- Most staff had the skills, knowledge and experience to deliver effective care and treatment. However competency checks to ensure that staff qualified to care for young children had up to date skills and knowledge were not carried out.
- A comprehensive induction programme was in place but not always fully completed by all staff.
- There was no evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good 

The service is rated as good for providing caring services.

- Feedback from the majority of patients through our comment cards and feedback collected by the provider was mostly positive.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. An exception was found in reviewing records an elderly patient with special notes notified the service of their palliative care needs, after a delay was sent an ambulance. Their needs may have been best met within their own home.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Patients were kept informed with regard to their care and treatment throughout their visit to the out-of-hours service.

Are services responsive to people's needs?

Requires improvement 

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

- Service staff reviewed the needs of its local population and engaged with its commissioners to secure improvements to services where these were identified.
- The service had good facilities and was equipped to treat patients and meet their needs.
- We found patients were not always treated in a timely way and according to urgency of need.

Summary of findings

- There was insufficient home visiting capacity at weekends resulting in delays to undertake home visits.
- Patients could get information about how to complain in a format they could understand. However, there was no evidence that learning from complaints had been shared with staff.

Are services well-led?

Inadequate

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

- Clinical governance meeting minutes lacked information related to governance arrangements. Governance meetings at a local level to discuss issues were not held.
- There was a lack of systems for the safe triage of walk in patients.
- Appropriate arrangements for identifying, recording and managing risks related to environmental issues were in place. However, implementing mitigating actions related to operational and clinical practice was not always effective.
- There was a lack of recorded information to demonstrate that learning was consistently disseminated to staff and embedded in policy and processes.
- The provider was aware of and complied with the requirements of the duty of candour.
- The service did not have effective methods for communicating with its staff that suited the needs of its workforce.
- Effective systems were not in place to demonstrate that all alerts issued by the Medicines and Healthcare Regulatory Agency about medicines were acted on.
- There was a lack of an effective system to ensure that NICE guidelines and updates were received and actioned in a timely manner.
- Recruitment procedures were not consistently followed.

Summary of findings

What people who use the service say

We looked at various sources of feedback received from patients about the out-of-hours service they received. Patient feedback was obtained by the provider on an ongoing basis via the Friends and Family Test and included in their contract monitoring reports. Data from the provider for West Midlands Doctors Urgent Care - Wolverhampton Urgent Care Centre for the period of late March 2016 to February 2017 showed that 97% of patients surveyed were likely or extremely likely to recommend the centre. The provider informed us that their aim was to survey 20% of patients as determined by their contract. At the time of the inspection staff said they had achieved approximately 10%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 32 comment cards of which 20 were positive about the standard of care received and 12 provided negative feedback. Positive comments included, the cleanliness of the service and the caring approach of the staff. Of the 12 negative, six related to waiting time delays and three related to staff attitudes, described as rude.

We spoke with five patients during the inspection. All five patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

The service had documented four compliments in respect of the care and treatment received onto their electronic spreadsheet between October 2016 and February 2017.

Areas for improvement

Action the service MUST take to improve

- Ensure effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure all staff providing care to children are competent and appropriately trained.
- Ensure that sufficient staff with the right competencies are on duty at all times.
- Ensure that safe recruitment procedures are consistently followed.
- Ensure the process for reviewing the performance of all staff during the induction period is consistently followed.

Action the service SHOULD take to improve

- Ensure that a risk assessment is completed to determine whether there is a need for a second thermometer to confirm the accuracy of the temperature of the fridge used to store medicines.
- Ensuring that its vision and values are embedded within the organisation and shared by all staff.

West Midlands Doctors Urgent Care - Wolverhampton Urgent Care Centre

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, a GP specialist adviser, and a nurse specialist adviser.

Background to West Midlands Doctors Urgent Care - Wolverhampton Urgent Care Centre

West Midlands Doctors Urgent Care – Wolverhampton Urgent Care Centre (WUCC) is part of the Vocare group, which began in 1996 in the North East of England as a co-operative of local GPs providing healthcare to local people. Vocare Limited is a private limited company. WUCC has been operating since April 2016 and is commissioned by NHS Wolverhampton CCG under a single contract to provide an integrated approach to urgent health care which include all the elements of out of hours (OOHs), urgent care and walk-in services from one location. The services are organised and delivered in a co-ordinated way.

Policies and protocols cover all services and the provider Vocare provides centralised governance for its services which are co-ordinated locally by service managers and senior clinicians.

WUCC is located on the first floor of the Urgent and Emergency Care Centre at New Cross Hospital, Wolverhampton. An integrated model of urgent health services is available for the whole of Wolverhampton (Population, 262,000). The total activity covering all services for the period April 2016 to February 2017 is 54,259. WUCC provides services to one of the more deprived areas of the West Midlands. People living in more deprived areas tend to have a greater need for health services. There is a lower practice value for income deprivation affecting children and older people in comparison to the practice average across England. The OOHs service is extended to patients registered at seven named practices in Seisdon:

- Claverley Surgery
- Dale Medical Practice
- Featherstone Family Health Centre
- Lakeside Medical Centre
- Moss Grove Surgery
- Russell House Surgery
- Tamar Medical Centre

WUCC is led by a local clinical director, service manager, and a clinical services manager who have oversight of the out of hours (OOHs), urgent care and walk-in services.

Detailed findings

WUCC is open 24 hours a day, seven days a week for people who walk in, patients referred after being triaged in the emergency department or referred following contact with the NHS 111 service. The services provided include an out of hours service between the hours of 5.30pm and 9am on weekdays and 24 hours a day at weekends and bank holidays. All services are provided from one location. WUCC provides access to patients to the services in the following ways:

- Walk-in, any patient can walk directly into WUCC and ask to be seen. These patients are asked to complete a form for themselves or their child by non clinical staff at the reception desk. The form is handed back to reception staff who document the patients' responses. Patients' names are then entered onto the patients list without an initial clinical assessment or timed appointment given. The service does not routinely order blood tests or x-rays for walk in patients. If a test is required, patients are referred back to their own GP.
- Following contact with the NHS 111 service and an initial assessment patients could be given an appointment to attend WUCC or receive a home visit from a GP as part of the OOHs.
- WUCC forms part of the urgent and emergency care centre at New Cross Hospital and is commissioned to provide treatment for identified minor injuries and illness for patients who do not require A&E treatment but who cannot wait until the next available appointment with their registered GP. Patients within this category undergo a triage assessment by a nurse employed by WUCC and/or a nurse employed by the hospital and if clinically assessed as appropriate are given an appointment to attend WUCC.

All patients are entered onto one patient list, which includes the walk-in patients who have no timed appointment. All the services are staffed by the same group of doctors, nurses and reception staff. This includes a GP on shift carrying out home visits during the period when the patients registered GP is closed.

There are a total of 90 staff working at WUCC. This number includes sessional GPs who are self- employed contractors. The organisational structure at WUCC include a Regional Director, an Assistant Regional Director, a Clinical Support Manager and a Local Clinical Director, who also works part-time as a salaried GP. The combined role of the local clinical director as a salaried GP would bring the number of staff roles employed at WUCC to 91. The number of staff employed and staff roles include:

- 1 Salaried GP (Also has the role of the Local Clinical Director)
- 29 Sessional GPs
- 1 Clinical Support Manager
- 6 Advanced Nurse Practitioners
- 2 Emergency Care Practitioners
- 10 Nurse Practitioners
- 7 Junior Nurse Practitioners
- 1 Healthcare Assistant
- 2 Despatchers
- 11 Drivers
- 15 Receptionists
- 1 Rota Assistant
- 1 Senior Team Leader
- 2 Team Leaders

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is 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. The inspection also checked on concerns raised by Wolverhampton Clinical Commissioning Group (CCG) and two whistle blowers to the CQC before the inspection.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew. We carried out an announced visit on 21 March 2017. During our visit we:

- Spoke with a range of staff, which included, the Regional Director, the Assistant Regional Director, Local Clinical

Detailed findings

Director, Clinical Support Manager, the Senior Team Leader and a Team Leader, Nurse Practitioner, Advanced Nurse Practitioners, driver and receptionist, despatchers.

- We spoke with five patients who used the service.
- Observed how patients were provided with care and talked with carers and/or family members
- Inspected the out of hours premises, looked at cleanliness and the arrangements in place to manage the risks associated with healthcare related infections.
- Looked at one of 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.
- Reviewed 32 comment cards where patients and members of the public shared their views and experiences of the service.

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?

Please note that when referring to information throughout this report, for example any reference to the National Quality Requirements data, this relates to the most recent information available to the CQC at that time.

Inadequate

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events. The system covered all the integrated urgent health care services of out of hours (OOHs), urgent care and walk-in services.

- Staff told us they would inform the team leader or service manager of any incidents. All staff could report significant events, however only the team leaders entered the information onto a shared electronic system. West Midlands Doctors Urgent Care - Wolverhampton Urgent Care Centre (WUCC) could not be sure that staff would not feel prohibited from appropriately reporting incidents, which included complaints or that incidents were accurately recorded. Staff we spoke with demonstrated a lack of awareness of incidents that had occurred.
- The local governance team received electronic notification of all events, which included incidents and complaints. Incidents that were identified as serious and requiring further investigation were written up in more detail by the regional clinical governance lead and forwarded to the Vocare central assurance team for classification and further investigation if appropriate.
- The incident recording form used by the provider supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received support; an explanation based on facts, an apology where appropriate and were told about any actions to improve processes to prevent the same thing happening again. We saw that these outcomes were discussed and shared with the management team at a regional level. However there was no assurances to demonstrate learning from incidents were shared with staff at a local level.
- The total number of incidents between April 2016 and February 2017 across all services was 131 (0.24% of contacts) and the number of serious incidents identified and investigated by the Vocare central assurance team was eight (0.01% of contacts).
- Data in a quality report for WUCC, dated January 2017 showed that a total of 13 incidents were reported. Incidents identified in the report were related to clinical care, security, medicine errors, delays in care and the referral process. Details of incidents recorded highlighted delays in the verifications of deaths on four occasions. Where a GP visited a patient at their home to verify a death as part of their role, it resulted in the absence of GPs on shift at WUCC to see other patients. In response, the provider was pursuing plans to gain agreement with the commissioners for nurse practitioners to verify death.

The management team told us that learning was shared at local and regional governance meetings. We looked at the minutes for regional meetings these showed that learning had been discussed at a regional level. We looked at three local newsletters dated June 2016, November 2016 and March 2017. The November and March issues contained the same information for staff on medicine management improvements needed. The March newsletter shared learning with all staff, which included sessional GPs, on the management of patients experiencing mental health problems. However there was a lack of recorded information to demonstrate that learning was consistently disseminated to staff and embedded in policy and processes. The local Clinical Commissioning Group (CCG) found that the provider did not have a strong culture for reporting incidents.

Medicines and Healthcare products Regulatory Agency (MHRA) and Central Alerting System (CAS) alerts were managed centrally by the Head of Assurance for Vocare, and locally by the Clinical Support Manager who then shared these via email with clinicians. However there were no assurances to demonstrate all alerts were acted on or searches undertaken or shared at a local level. GPs and nurses spoken with demonstrated a lack of awareness of safety alerts.

Overview of safety systems and processes

The provider held regular meetings with Wolverhampton Clinical Commissioning Group (CCG). We saw the minutes of a contract review meeting held on 27 January 2017 with the provider, Vocare Limited to discuss issues related to safety systems and processes. The CCG had identified a number of concerns in respect of safeguarding related to the processes in place and staff training. The provider had

provided a remedial action plan to Wolverhampton CCG in order to address the issues raised. The provider and Wolverhampton CCG notified the Care Quality Commission of the action taken.

- We found that arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements and there was a safeguarding strategy and policy in place. The policy was accessible to all staff and clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. We saw that contact details for the local safeguarding team was available to staff in clinical rooms. There was a lead member of staff for safeguarding. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs and nurses were trained to child safeguarding level 3. We saw evidence of three safe guarding concerns that had been referred to the safeguarding team.
- A notice in the waiting room and in consulting rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Appropriate standards of cleanliness and hygiene were maintained at the centre. We observed the premises to be clean and tidy. There was an infection control lead and an infection control protocol in place. All staff had received up to date training. The clinical support manager for WUCC had carried out an infection control audit in January 2017. We saw evidence that action was taken to address any improvements identified as a result.
- There was a system in place to ensure equipment was maintained to an appropriate standard and in line with manufacturers' guidance. This included, annual servicing and maintenance of medical equipment for example the servicing of fridges, weighing scales and emergency equipment including calibration where relevant.
- The provider had comprehensive recruitment systems in place but the five personnel files we reviewed demonstrated recruitment policies and procedures were not consistently adhered too. For example, references and the appropriate checks through the Disclosure and Barring Service were not completed for a GP. There was also no employment history in one staff file and no references in two other staff files.
- WUCC had two cars to support the out of hours service. We saw that systems were in place to ensure the safety of the staff team carrying out home visits and the cars. The vehicles were equipped with integrated IT systems for communication and a GPS tracking system. The cars were checked before and after each home visit and the findings recorded by staff on a vehicle log form. Safety checks made included the tyres and lights. Records also showed that maintenance checks had been completed. Copies of the tax, insurance and breakdown cover for the cars were shared with us.

Medicines Management

- The arrangements for managing medicines at the service, including emergency medicines and vaccines, kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Vocare had an organisation wide policy and procedure which detailed how medicines should be safely managed for all of the services provided at WUCC. For example, medicines used for home visits were provided in secure boxes, which were numbered, tagged and sealed. All medicines for home visits were recorded and signed out by the GP the medicines were issued to. All medicines returned were then rechecked and a record maintained of medicines used. The policy and procedure was accessible to all staff via the organisation's electronic library.
- We saw that the temperature of the fridge used to store medicines at WUCC was recorded daily and was within the accepted range. There was no data logger, or second check thermometer independent of the electricity supply inside the fridge to ensure the temperature was maintained within the accepted range at all times. (In the event of a power loss a data logger would continue to record and store the temperature and this information could be downloaded for reference).
- The service carried out regular medicines audits, with the support of the local CCG medicines management

team, to ensure prescribing was in accordance with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.

- Patient Group Directions were used by nurses and paramedics to supply or administer medicines without a prescription. PGDs in use had been ratified in accordance with the Medicines and Healthcare products Regulatory Agency guidance.
- WUCC held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had standard operating procedures in place that set out how controlled drugs were managed in accordance with the law and NHS England regulations. Records and documents we looked at showed appropriate arrangements for the ordering and receipt of controlled drugs. Arrangements were in place for the safe destruction of controlled drugs. Auditing and monitoring of controlled drugs took place and staff were aware of the mechanisms for reporting and investigating discrepancies. We saw that these medicines were securely and appropriately stored.
- Processes were in place for checking medicines, including those held at the service and also medicines bags for the out of hours vehicles. Arrangements were in place to ensure medicines and medical gas cylinders carried in the out of hours vehicles were stored appropriately. An extreme weather protocol had been implemented to ensure that medicines and medical gas cylinders were transported and stored safely. All staff had access to detailed and up-to-date policies and procedures which supported the safe management of medicines.

Monitoring risks to patients

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in areas accessible to all staff that identified local health and safety representatives. The service had up to date fire risk assessments and took part in the hospital led fire drills.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. Clinical equipment that required calibration was calibrated according to the manufacturer's guidance. The service had a variety of other risk assessments in place to monitor the safety of the premises such as control of substances hazardous to health, infection control and legionella (Legionella are bacteria which can contaminate water systems in buildings).
- WUCC used a computerised rota system (Rotamaster) for all the different staffing groups to ensure that sufficient and the appropriate mix of staff were on duty. There were exceptions to the effectiveness of the rota system in ensuring that there were enough staff on duty to meet expected demand, at weekends. We saw evidence of breaches in the length of time taken to see patients' and insufficient home visiting capacity for the out of hours service, resulting in patients being re-triaged and visits deferred until the next day with no documented or clear reason indicated for this.
- The local CCG had shared concerns about inconsistencies in performance data produced by the provider. To address this the provider had reviewed the format in which the data was presented to ensure that it accurately reflected the performance of all services provided from the WUCC location and would address the requirements of the CCG.
- The management team told us that at times of staff shortage the Vocare national triage service was used and staff absences filled by sourcing the availability of staff working throughout the organisation. Plans to address staffing shortages also included extending the role of qualified staff, for example, training qualified staff to undertake home visits to verify death.

Arrangements to deal with emergencies and major incidents

There were arrangements in place to respond to emergencies and major incidents.

- The service had a comprehensive business continuity plan in place for major incidents such as power failure and severe weather conditions. The plan included emergency contact numbers for staff. There was a continuity planning checklist to direct staff through the appropriate actions they should take in the event of an incident.
- The provider had standard operating procedures in place advising staff how to respond in an emergency situation. We looked at the standard operating procedure on how to manage in the event of a collapsed

patient. The procedure detailed the assessments that should be carried out, the treatment to be given including medication and the dosing details for the different age groups.

- All staff received annual basic life support training, including the use of an automated external defibrillator.
- WUCC had access to an emergency trolley located on an adjacent ward. Access were through double doors which could be easily and quickly accessed by staff to ensure immediate access to appropriate resuscitation equipment and drugs to facilitate rapid resuscitation of the patient in cardiorespiratory arrest.
- Emergency medicines were also easily accessible onsite and all staff knew of their location. All the medicines we checked were in date and stored securely.
- A first aid kit and electronic accident book were available.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We were told that staff had access to guidelines from National Institute for Health and Care Excellence (NICE) best service guidelines and used this information to deliver care and treatment that met patients' needs. We looked at a copy of the minutes for a meeting of the NICE Clinical Commissioning Assurance Group (NCAG) held by Wolverhampton Clinical Commissioning Group (CCG). These meetings were held every three months and attended by a representative from West Midlands Doctors Urgent Care - Wolverhampton Urgent Care Centre (WUCC). However there were no mechanisms in place to assure us that NICE guidelines and updates were received locally and actioned where appropriate in a timely manner. For example, medicines included in the WUCC formulary showed that prednisolone was used in children as opposed to dexamethasone (Prednisolone and dexamethasone were used to control the body's response to inflammation and treat conditions such allergic disorders, skin conditions and breathing disorders). NICE treatment recommendation for treating a child with croup states that 'Providers of urgent care services should ensure that dexamethasone is available'. We found at the inspection that there was no evidence of a risk assessment or discussion to demonstrate the decision for using this second line treatment.

Following discussion with the Head of Assurance about the factual inaccuracy comments we received they recalled an email that would verify Vocare's reasoning to use prednisolone. The email showed that the Deputy Organisational Medical Director, had carried out a review in November 2015 and sought specific respiratory advice from a local respiratory physician. However the outcome of this review did not comply with NICE guidance. It should also be noted that clinical staff at WUCC were not aware of this decision.

Management, monitoring and improving outcomes for people

WUCC used information collected as part of the National Quality Requirements (NQRs) and other quality indicators to monitor the quality of its service. NQRs were set out by the Department of Health to ensure that GP out of hours services operated safely, were clinically effective and responsive. This included audits, whether face to face assessments happened within the required timescales, patient feedback and actions taken to improve quality. WUCC was contractually required to meet a range of national and local quality and performance indicators and provide monthly performance reports to the clinical commissioning group. Concerns had been raised by the local commissioning group about the quality and format of the data and information produced by WUCC. Performance against the NQR for out-of-hours providers for the last three months showed the following:

NQR Four states that providers must regularly audit a random sample of patient contacts focussed on the quality of triage, telephone consultations and face-to-face consultations for the out of hours service. Appropriate action should be taken on the results of the audits. Regular reports of these audits must be made available to the appropriate contracting commissioning body.

- The provider had a clinical audit policy to regularly audit a random sample of patient contacts and take appropriate action on the results of those audits.
- We reviewed records for home visits completed on 4 February 2017 following concerns raised by a whistle blower to the Care Quality Commission (CQC). We found examples of when appropriate action had not been taken where audits identified issues related to the competence of a GP due to insufficient details recorded in notes to demonstrate appropriate clinical assessments had been carried out. We reviewed six further records in relation to documentation by this triage GP and found other deficiencies. We saw that the GP's record and triage notes from home visits were poorly documented. An example of written documentation on a home visit was 'off legs' with no other clinical indicators stated.
- The management team which included the Vocare local clinical director for WUCC told us that they had identified some concerns with a GP's performance. They said the GP's performance was being reviewed and they had been removed from completing telephone triage consultations. We found that although the provider had concerns, only six patient records had been reviewed and the GP had continued carrying out home visits. There was no evidence to demonstrate that the provider had provided training for the GP. Immediately after the

Requires improvement

Are services effective?

(for example, treatment is effective)

inspection, their employment was terminated and the GP was referred to their responsible officer for advice on any further action required to mitigate the level of risk if the GP worked elsewhere.

- WUCC had been operating since April 2016. We therefore looked at the NQR 12 performance for the period April 2016 to March 2017. NQR 12 requires that face-to-face consultations (whether in a centre or in the patient's place of residence) must be started within the following timescales, after the definitive clinical assessment has been completed:

Emergency: Within 1 hour

The provider did not record their performance for the emergency category or for NQR 10. (Face to face clinical assessment (for patients presenting to clinic). The reason given for this was that due to the co-location with Wolverhampton A&E department they did not provide an emergency service.

Urgent: Within 2 hours

For the period April 2016 to March 2017 the provider saw 64% of all urgent consultations within two hours. The target was 95%.

Less Urgent: Within 6 hours

For the period April 2016 to March 2017 the provider saw 91% of all less urgent consultations within two to six hours. The target was 95%.

The data showed that the service performance between April 2016 and February 2017 for non-urgent cases although below the required target showed improvement over the 10 month period. This ranged between 86% and 93%. However, the data showed that urgent cases were not always meeting the contractual targets. For example for the month of February 2017:

WUCC was contractually required to meet a range of local quality and performance indicators set by the local clinical commissioning group.

- Over the first three quarters of the year the percentage of patients registered at the Urgent Care Centre that were seen and treated, admitted, discharged or referred to another provider within 1 hour (60 minutes) of arrival averaged between 60% and 66%. The target was 80%.
- Data showed that 80% to 97% of patients registered at the Urgent Care Centre were seen and treated, admitted, discharged or referred to another provider within 2 hours (120 minutes) of arrival.
- The percentage of patients returning to WUCC within 48 hours for the same condition was 0.93% to 1.6%. This was consistently below the threshold of less than 5%

The provider told us that performance had been impacted by the development of the integrated services, following its inception in April 2016. Although performance for urgent cases were poor, data showed improvement over time. The service had also experienced periods of instability with staffing. This was related to changes to the management team and recruiting a stable clinical and non-clinical staff team.

There was a lack of evidence to confirm that two cycle clinical audits were carried out. There was evidence that prescribing and medicine audits had been completed at a national level to promote quality improvements throughout Vocare Limited. These included audits completed on antibiotic prescribing, controlled drug prescribing and large volume prescribing of medications of potential abuse (those that would have a street value on the black market). Information from the Vocare central offices suggested regular quality assurance audits were taking place for example, audits had been carried out on nursing staff and GP triage calls. However, of the 39 GPs only eight had had six cases reviewed and completed to date.

Effective staffing

- The service had an induction programme for all newly appointed staff which included sessional staff. We found that the induction material provided for staff was comprehensive. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. New staff were supported to work alongside other staff. We found that the process for regularly reviewing performance during the induction period was not consistently followed for all staff.
- The service could demonstrate how they ensured role-specific training and updating for relevant staff. For example, nurses were supported with their revalidation requirements. Nurses were able to share with us training they had completed, which included wound care, end of life care and independent and supplementary

Requires improvement

Are services effective?

(for example, treatment is effective)

prescribing courses. However there was no evidence to show that Advanced Nurse Practitioners (ANP) who undertook this role had received appropriate supervision.

- We found that there was an inconsistent approach towards the management of children and some nurse practitioners were not trained in the clinical assessment of children under the age of one year. The provider had introduced a course for nurses in paediatric care. However, staff told us that the three day course was not considered sufficient to impart the knowledge required. We found that there was no evidence of a competency check on staff. and there was no clear guidance for nursing staff to follow. This could potentially lead to young patients (children) waiting for long periods when the GP was carrying out home visits at night.
- We found that Vocare had developed systems for identifying the learning needs of staff. These included appraisals, meetings and reviews of service development needs. However these systems had not been fully and consistently implemented at WUCC. The management team could not confirm that formal one-to-one meetings, coaching and mentoring, clinical supervision and appraisals had taken place. Staff told us that they had no problems seeking clinical advice and ongoing support when needed.
- Records we examined showed that training received by staff included: equality and diversity, safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the service's patient record system and their intranet system.

- The service shared relevant information with other services in a timely way, for example when referring patients to other services. The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the service's patient record system and their intranet system. This included access to required 'special notes' which detailed information provided by the person's GP. This helped the out of hours staff in understanding a person's needs.
- WUCC worked with other service providers to meet patients' needs and manage patients with complex needs. Notes related to the out-of-hours services provided to patients were sent to the registered GP services electronically by 8am the next morning. This was monitored on a monthly basis and data from the provider showed that they had achieved 100% transfer of notes in the last 12 months.
- Patients who could be more appropriately seen by their registered GP or an emergency department were referred. The out-of-hours service had access to the mental health team and district nursing team if they needed support during the out-of-hours period.
- We saw that information was received daily for patients receiving palliative care. These were added to the electronic system each day to allow access for the local palliative care coordination team. However, one of the whistle blowing concerns we received and verified as accurate showed that the special notes for palliative care patients' were not always appropriately acted on.
- The service worked with other service providers to meet patients' needs and manage patients with complex needs. It sent out-of-hours notes to the registered GP services electronically by 8am the next morning. This was monitored on a monthly basis and data from the provider showed that they had achieved 100% transfer of notes in the last 10 months.

Consent to care and treatment

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.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear clinical staff assessed the patient's capacity and, recorded the outcome of the assessment.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We saw that patients who attended WUCC for an appointment or walked in were treated with dignity and respect. We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms 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.

Thirty-two patient Care Quality Commission comment cards were received, 20 of which were positive about the service experienced. Patients said they felt the service offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required. Twelve patient comment cards contained negative feedback about the service, six related to waiting time delays and three to staff attitude.

Results from the provider's own survey were not made available to the inspection team. The expectation was that 1% of patients seen would be surveyed each year, however it was noted that this provider location was only 11 months into its contract period.

Care planning and involvement in decisions about care and treatment

Patients we spoke with at WUCC told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received showed that 62.5% of respondents were aligned with these views. The service provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas such as how to complain were available in a number of languages and reception staff informed patients that translation services were available. Reception and despatch staff for walk in patients had access to a Red Cross translation folder which assisted patients to answer some basic questions such as name, date of birth and address.
- Information leaflets were available in easy read format should these be required as clinical staff could access appropriate patient information literature via their electronic systems.
- Facilities for people with hearing impairment were available this included a hearing aid loop.
- As an out of hours provider staff could book a translation service with advance notice and signpost patients to resources such as the signed videos on NHS Choices.
- Special notes forwarded by patients' GPs to the out of hours service were used to identify patients who may be vulnerable, receiving end of life or palliative care and for patients with specific needs or requirements, such as patients with dementia, learning disability or mental ill health. We found in reviewing records that an elderly patient with special notes which notified the service of their palliative care needs, after a delay was sent an ambulance. Their needs may have been best met within their own home.

We reviewed the Friends and Family Test responses received by WUCC between November and January 2017.

- 25 responses in November 2016 showed that 100% of those who responded were likely or extremely likely to recommend the service.
- 31 responses in December 2016 showed that 100% of those who responded were likely or extremely likely to recommend the service.
- 70 responses in January 2017 showed that 97% of those who responded were likely or extremely likely to recommend the service.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The service reviewed the needs of its local population and engaged with its commissioners to secure improvements to services where these were identified. For example, the service was aware of Public Health England data on population health in Wolverhampton as well as information shared by local Healthwatch and the local Clinical Commissioning Group.

- West Midlands Doctors Urgent Care – Wolverhampton Urgent Care Centre (WUCC) was situated on the first floor of the Urgent and Emergency Care Centre at the New Cross Hospital in Wolverhampton. Patient access was via a lift or stairs to the first floor. The facilities were accessible to children.
- The facilities were suitable for people with disabilities and patients with young children. There were electronic opening doors and wide corridors to manoeuvre wheelchairs and pushchairs. A lowered area at the reception desk made it easier for patients in wheelchairs to communicate with the reception staff. A hearing loop was also available. There was access to disabled toilets and baby changing facilities. Translation services were available for patients who could not speak English and some staff were multi-lingual.
- The service had introduced an Accessible Information Standards Policy. The Accessible Information Standard aimed to make sure that people who have a disability, impairment or sensory loss were provided with information that they could easily read or understand and with support communicate effectively with health and social care services. Vocare Limited had implemented approaches to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs related to a disability, impairment or sensory loss. Training was being implemented so that staff asked the right questions in the most appropriate manner. Vocare additionally had close liaison with local British Sign Language provision via the National Register of Communication Professionals working with Deaf & Blind People.

Access to the service

WUCC was open 24 hours a day, seven days a week for people who walked in, or were referred following contact with the NHS 111 service. The services provided include an out of hours service between the hours of 5.30pm and 9am on weekdays and 24 hours a day at weekends and bank holidays. All services were provided from one location. Following an assessment patients could be given an appointment at WUCC, receive a home visit from a GP or be referred to WUCC following joint triage in the Wolverhampton A&E department. All the services were staffed by the same group of doctors, nurses and reception staff. This included the GP on shift carrying out home visits during the period when the patients registered GP was closed.

Feedback received from six patient CQC comment cards suggested that they were not always seen in a timely manner.

Where patient numbers and demand was high for the service there were systems such as 'comfort calls' in place. Staff utilised prompts for comfort calling for example when the service may not meet the anticipated response time given to the patient by the NHS 111 service. This included ascertaining whether there had been any change in the patient's symptoms. If there was no change patients were encouraged to contact the service should their symptoms change or worsen either via NHS 111 or contacting emergency services such as an ambulance.

Care Quality Commission findings in reference to the concerns received prior to the inspection verified that demand had exceeded staff capacity and had impacted on all services provided on varied dates over the weekends. This had led to breaches in service level agreed time limits, patients being re-triaged by clinical staff.

- Examination of records confirmed a number of occasions in September and October 2016 when there were delays in seeing patients. This included children and other vulnerable patients.
- We also verified the concerns highlighted for a Saturday in February 2017. These involved delays of up to 10 hours, patients being diverted to hospital and home visits being passed through to the next day with no recorded clear rationale as to why this had occurred.

Following the review of the findings, we found there was insufficient home visiting capacity built into staff rotas for the population size. This pattern was also recognised and

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

acknowledged by the clinical director for WUCC who told us that they had started to take action to address this. This included the purchase of an additional car and training advanced nurse practitioners to undertake home visits.

Listening and learning from concerns and complaints

The service had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with the NHS England guidance and their contractual obligations.
- There was a designated responsible person who co-ordinated the handling of all complaints in the service.
- We saw that information was available to help patients understand the complaints system with posters available in the reception waiting area in two languages.

All complaints are recorded electronically. Information available showed that 58 incidents had been logged between 4 April 2016 and 1 March 2017. We looked at three complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way and with openness and transparency when dealing with the complaint. Lessons were learnt from individual concerns and complaints and also from the analysis of trends and action was taken as a result to improve the quality of care. For example, a walk in patient with breathing difficulty had presented at the reception area. The patient had been informed of a five hour walk in patient waiting time and was advised to contact NHS 111, who would assess their symptoms. This offered the patient the potential to have a pre-arranged appointment time which could shorten their wait. Staff did not take any details from the patient and they chose to leave, and subsequently complained. The complaint was investigated and action taken to reduce the risk of reoccurrence. The lessons learnt were communicated locally to all staff to ensure that appropriate procedures were followed. However, the mechanism for sharing lessons learnt from complaints with all staff, was not effective as it was not always consistently applied to all staff.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The service had written vision and values but these were not fully embedded and there was no evidence of a whole staff approach and involvement in the improvement of the service. The service opened in April 2016 and during this time there had been staffing changes which included recent changes in the management team.

Governance arrangements

Governance arrangements were mixed. The WUCC had effective processes in place in a number of areas, for example:

- There was a clear staffing structure and staff were aware of their own roles, their level of competence and responsibilities.
- Service specific policies were implemented and were available to all staff. These were updated and reviewed regularly by Vocare head of assurance.
- The clinical services manager, assistant regional director and local clinical director for WUCC met with the local clinical commissioning group (CCG) monthly as part of contract monitoring arrangements to discuss performance.

There were a number of areas where governance arrangements were not in place and needed reviewing and or strengthening. These included:

- A lack of systems for the safe triage of walk in patients. There was one electronic patient list. The list included patients triaged through NHS 111, A&E streamed patients who all had appointments to attend WUCC. The list also included the walk in patients who were not given an appointment. The provider advised that this approach to appointments for walk in patients was requested by and agreed with the CCG.
- A reliance on clinical staff 'spotting' whether walk-in patients were a higher priority patient from their electronic list or observation in the waiting room should they have the opportunity to do this in between seeing patients. This could lead to a potential conflict if the time in which a patient should be seen would be breached versus clinical priority.
- Although arrangements were in place for identifying, recording and managing some risks related to environmental issues such as infection control, implementing mitigating actions related to operational and clinical practice was not always effective. For example;
  - Systems and processes for the auditing of GP clinical assessments were not effective to ensure that appropriate action was taken in a timely manner when concerns were identified and in accordance with Vocare policy.
  - There was a lack of effective mechanisms and recorded information to demonstrate that the learning outcomes from significant events, complaints and incidents were shared with all staff.
  - The service did not hold regular governance meetings at a local level to discuss issues and there were no regular local staff team meetings to include all staff.
- Effective systems were not in place to demonstrate that all alerts issued by the Medicines and Healthcare Regulatory Agency about medicines were acted on.
- There was a lack of an effective system to ensure that NICE guidelines and updates were received and actioned in a timely manner.
- Recruitment procedures were not consistently followed.

Leadership and culture

There was a clear leadership structure in place. Staff told us they had the opportunity to raise any issues and felt confident in doing so. There were some arrangements in place for staff to be kept informed and up-to-date. These included newsletters, a shared intranet platform and emailed communication. However these arrangements were not always effective for example, at the inspection we found that staff lacked awareness of learning from significant events that had occurred. We found that regular local staff meetings were not held.

We saw that the minutes of governance meetings held nationally lacked information related to governance arrangements. We looked at the minutes for January 2017, which only detailed discussions about significant incidents that had occurred across the region. A copy of the minutes for a meeting held in February 2017 showed that the format of the meeting was under review. The provider planned to focus the structure of the meeting on patient safety, and the effectiveness and outcome of clinical and patient related outcomes.

Are services well-led?

Inadequate

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

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The service had systems in place to ensure that when things went wrong with care and treatment:

- The service gave affected people an explanation based on facts and an apology where appropriate, in compliance with the NHS England guidance on handling complaints.
- The service kept written records of verbal interactions as well as written correspondence.

Seeking and acting on feedback from patients, the public and staff

The service encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The service had gathered feedback from patients through surveys and complaints received. For example, the NHS Friends and Family Test.
- The provider, Vocare held annual management away days, both for the executive and the regional teams. The provider told us that these days were used to learn lessons from internal reflection and develop future plans. We found that formal arrangements to ensure staff had access to regular staff meetings, effective communication and up to date information at a local level to support staff feedback were not in place.
- The management team told us that they had received whistle blowing/grievance concerns which they were acting on.

Continuous improvement

Vocare were exploring opportunities for closer working with health and academic colleagues to enable greater development of the workforce. Other planned developments included addressing concerns regarding the role of despatches and whether the despatches team would be best located at a regional location.

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 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** • The provider had not ensured that there were sufficient staff at all times to meet the changing demands of the service. • The provider had not ensured that its induction process were fully completed by all staff. • The provider had not ensured that all staff received appropriate support, training, supervision and appraisals to enable them to undertake all their duties.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** • The provider had not ensured that recruitment procedures were consistently followed.

This section is primarily information for the provider

Enforcement actions

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:** • Appropriate arrangements were not in place to ensure the timely and safe triage of patients resulting in delays in seeing patients, delays in home visits, delays in seeing children and the absence of triage for walk in patients. • Appropriate action had not been taken to follow up on failed audits of the documentation of GP clinical assessments. • The provider did not operate an effective system to demonstrate that all alerts issued by the Medicines and Healthcare Regulatory Agency about medicines were acted on.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** • The provider did not have effective systems in place for recording and managing risks in all areas. • There was a lack of an effective system to ensure that NICE guidelines and updates were received and actioned in a timely manner. • There were a lack of effective mechanisms to ensure that the learning outcomes from significant events such as serious incidents and complaints were shared with staff locally. • There were no mechanisms in place to ensure that clinical staff were aware of and take appropriate action on alerts issued by the Medicines and Healthcare Regulatory about medicines.

This section is primarily information for the provider

Enforcement actions

- There was an inconsistent approach towards the management of children. There was no clear guidance for nursing staff to follow and competency checks to ensure that staff qualified to care for young children had up to date skills and knowledge were not carried out.
- The outcome of audits on the clinical performance of staff were not acted on.