Urgent Care Centre North Staffordshire

Inspection 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 location	Good
Are services safe?	**Good**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Overall summary

This service is rated as good overall (previous inspection 04. 2018 – Inadequate).

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection on 22 and 23 April 2018. Our overall rating for the service was inadequate and following discussions with North Staffordshire and Stoke Clinical Commissioning Groups, Vocare and The Royal Stoke Hospital, the provision of the streaming service was transferred to hospital staff until the required improvements could be made. We rated the service to be inadequate for providing safe, effective and well-led services; requires improvement for providing responsive services and good for providing caring services. We served warning notices for breaches in relation to Regulation 12: Safe Care and Treatment and Regulation 17: Good Governance. The hospital management team agreed to provide the service on a temporary basis until the provider could re-commence provision of the service. The transfer of the service back to the Urgent Care Centre North Staffordshire was completed on 10 September 2018.

At this inspection we found:

- Systems to safeguard vulnerable patients had been strengthened.
- There was a consistent approach for identifying risks, issues and implementation of mitigating actions.
- Processes to manage risks relating to shared learning from significant events and incidents were being used effectively.
- Emergency equipment and medicines were easily accessible to staff.
- Staff employed had the appropriate skills to treat patients accepted into the service.
- There was suitable pain relief medicine to treat acute pain.
- Clinicians were working to clear exclusion criteria; no inappropriate patients were found to have been accepted into the service.
- Prescriptions were securely stored and an effective system was in place that monitored their use.
- Patients' care needs were assessed and delivered in a timely way and according to need.
- Systems and processes had been improved to enable the provider to effectively assess, monitor and improve the quality and safety of the services provided.
- The governance arrangements had been strengthened and covered permanent and temporary staff 24 hours a day, seven days a week.

The area where the provider should make improvements are:

- Refresh training for staff on the use of smartcards when using the computer system.

I am taking this service out of special measures. This recognises the significant improvements made to the quality of care provided by the service.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser and a nurse specialist adviser.

Background to Urgent Care Centre North Staffordshire

The Urgent Care Centre (UCC) North Staffordshire is part of the Vocare Group, known locally as Staffordshire Doctors Urgent Care (SDUC). Vocare have approximately 2,000 employees and deliver GP Out -of- Hours (OOH) and urgent care services to approximately 9.2 million patients nationally. Vocare have recently been acquired by Totally Plc. SDUC also provides the OOH service and the NHS 111 service to approximately 1,200,000 patients the whole of Staffordshire. The population of Staffordshire includes the more deprived urban areas in and around Stoke-on-Trent as well as the more affluent areas in south Staffordshire with pockets of deprivation around Cannock, Tamworth and Burton upon Trent.

The service known as UCC North Staffordshire is a streaming (redirecting patients to appropriate care) service provided within the Emergency Department (ED) at The Royal Stoke University Hospital and within a nearby building used to see and treat patients who do not require emergency care. SDUC has provided a GP led urgent care centre service since August 2017, a service aimed at reducing the pressure on the emergency department by treating those patients. This service operates 24 hours a day, 365 days a year, and the local governance is managed within the UCC by a lead nurse and an operations manager and supported from the organisation's headquarters at Staffordshire House, in Stoke-on-Trent. The service receives approximately 3,000 contacts per month from adult patients. Children are streamed by the Children's Emergency Department which is part of the hospital. On 10 September, the service relocated so that consultation rooms, supported by a reception area, are now situated in a separate building near the ED. The service has retained three rooms within the ED, one is a streaming room, one a triage room and one a spare consulting room to be used if the separate building was unavailable and to help with capacity during busy periods.

During our inspection we visited the headquarters of SDUC in Stoke-on-Trent and the ED at The Royal Stoke University Hospital.

Further details can be found by accessing the provider's website at www.sduc.nhs.uk

Good

Are services safe?

At the previous inspection we rated the service inadequate for providing safe services. This was because:

- Clinicians were not always working to the exclusion criteria resulting in patients being inappropriately accepted into the service, which resulted in delays to patients in need of emergency treatment.
- Staff employed did not always have the appropriate skills to treat some of the patients accepted into the service.
- Emergency medicines and equipment were not readily accessible to clinical staff.
- There was a lack of suitable pain relief to treat acute pain.
- Patient Group Directions were seen to be contradictory and did not always include the dosage to be used.
- Prescription forms were not monitored by recording individual prescription numbers.
- Adult safeguarding numbers were very low with only two patients having been reported through the Vocare system between August 2017 and March 2018.

At this inspection we rated the service good for providing safe services.

Safety systems and processes

The provider had a safeguarding lead and systems to safeguard children and vulnerable adults from abuse. The service had made two adult safeguarding referrals since taking the service back on 10 September 2018. Staff told us that they were aware of safeguarding leads and knew how to report concerns. The provider had oversight and took appropriate action when required. Children with safeguarding concerns were normally referred to the children's emergency department.

- A review of the two safeguarding referrals showed that when a concern was raised the service worked with other agencies to support patients and protect them from neglect and abuse. For example, social services were contacted when concerns were raised for the safety of a vulnerable adult where there had been allegations of domestic abuse.
- Staff had received up-to-date safeguarding and safety training appropriate to their role. Staff we spoke with knew how to identify concerns. Policies were seen to be up to date and relevant, for example; they included the modern-day definitions for vulnerable adult safeguarding. The service had made two referrals in September 2018. These were followed up by the provider with the local safeguarding team. A quarterly safeguarding newsletter included details of the safeguarding leads, shared learning and information on training events. The provider had liaised with hospital staff to provide a comparison and found the level of safeguarding figures similar (pro rata). To support the overall lead for safeguarding, team leaders and shift leaders acted as a point of contact for safeguarding concerns and there was a safeguarding flowchart in every clinical room that listed responsible individuals.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken on all staff. (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). The provider had implemented a policy to carry out a telephone interview with all agency staff in advance of their first shift.
- There were effective systems to manage infection prevention and control measures. The areas we visited as part of the inspection were clean and tidy; regular audits were carried out at the centre and there were systems for safely managing healthcare waste.
- Emergency medicines and equipment were readily accessible to clinical staff. All equipment and medicines were found to be in date and had been regularly checked. Staff in triaging and streaming rooms could alert the emergency department 'crash team' of an emergency using a buzzer system.

Risks to patients

The provider had implemented effective systems to assess, monitor and manage risks to patient safety. Following the previous inspection, the provider had formulated a new clinical operating model and implemented an action plan to minimise the risks to patients.

- Clinicians were working to the agreed exclusion criteria and we saw examples of when the service directed inappropriate referrals straight into the emergency department. For example, a patient who arrived by ambulance was not accepted into the streaming service but referred to the emergency department. The exclusion criteria consisted of a clear list of conditions and symptoms that should not be treated in the service,

Good

Are services safe?

but referred to the emergency department. A copy of the exclusion criteria was available in each clinical room in a simplified format. Inappropriate referrals were recorded on the 'datix' system and shared with staff from the emergency department (ED).

- Triage was based on a nationally recognised model known as 'Manchester Triage' and the streaming model was a condensed version of the triage model.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups. Previously staff told us that filling rotas at weekends was heavily reliant on agency staff and agency staff were not always given an induction or familiarisation process before starting their first shift. The service had recruited permanent staff and used a regular pool of agency staff, limited to one per shift. The induction process had been overhauled to include a telephone interview prior to booking for their first shift, a dedicated induction including shadowing of experienced staff members and the completion of a competency framework.
- We found positive examples of where risks to patients were managed appropriately: any identified risks were reviewed at a daily risk meeting and safety huddles were held at weekends in the streaming and triage area.
- Training records showed that face to face basic life support training (BLS) had been planned or completed by all staff. Records we reviewed as part of the inspection showed that 82% of mandatory training had been completed.
- Clinical staff we spoke with knew how to identify and manage patients with severe infections, for example sepsis.
- The provider had appropriate safety arrangements, including Control of Substances Hazardous to Health (COSHH) and health & safety within the workplace policies, which were regularly reviewed and communicated to staff.
- Staff received safety information from the provider as part of their induction and refresher training. We found comprehensive risk assessments, for example for fire and lone working.

Information to deliver safe care and treatment

Exclusion criteria was provided to inform clinicians which patients should not be accepted into the service. Copies of streaming pathways were available in an easy to read format in every clinical room. Clinical staff we spoke with were aware of the exclusion criteria and examples of case notes we reviewed showed that all patients accepted into the service were appropriate. A new clinical operating model had been developed and this included simplified exclusion criteria that was available in each consulting room. This had been agreed with the North Staffordshire and Stoke Clinical Commissioning Groups (CCG) and with the Royal Stoke University Hospital and had been signed off at board level within each organisation.

We saw that the service met with hospital staff to share information, in particular to review incidents and inappropriate patients who had been accepted into the service. A weekly meeting was held and staff told us informal conversations took place daily.

Safe and appropriate use of medicines

There were effective processes in place for checking medicines:

- Blank prescription forms and pads were securely stored and there was a system in place to monitor their use.
- Patient Group Directions (PGDs) used had been ratified in accordance with the Medicines and Healthcare products Regulatory Agency guidance. For example, the provider worked with the CCGs and included a microbiologist who had been involved in the development of antimicrobial PGDS (policies were in the process of being updated to include this).
- We found that since the last inspection, PGDs had been updated to include details of the appropriate dosage.

Track record on safety

The service had extended the governance arrangements on safety in place for its Out of Hours (OOH) service to include the Urgent Care Centre (UCC) North Staffordshire:

- The provider had written health and safety policies and a health and safety committee was made of Vocare staff from across the group; staff 'ambassadors' had written up terms of reference for this group supported by the management team. There were risk assessments in relation to safety issues. An independent health and safety risk assessment had been carried out and a 'health and wellbeing' schedule was in place, managed within the human resources department.
- A fire risk assessment had been carried out in January 2018. Staff had completed fire safety training; team

leaders and managers were trained as fire marshals. Annual service plans were in place to maintain the fire extinguishers and the fire alarm. The fire alarm and emergency lighting were tested weekly and fire evacuation drills carried out every six months. These included a review of any areas of improvement identified.

- Joint reviews of incidents were carried out with partner organisations and communicated to the quality team that represented the Staffordshire CCGs. Incidents when appropriate had been reported to the hospital governance team and had been shared with hospital staff within the ED.

Lessons learned and improvements made

- The provider had processes for reviewing and investigating when things went wrong. The Staffordshire Doctors Urgent Care (SDUC) governance team led on the process of recording, reporting and learning from incidents. Staff had access to an electronic system (Datix, an electronic system that allows learning from incidents to be shared). SDUC had adopted this as their system of choice for recording all incidents.
- There was an 'adverse event' policy that included an action plan that provided a flow chart detailing what to do having identified an incident. This included reference to the duty of candour principles.
- There was a process in place for sharing any learning with staff following an incident or complaint to improve the service. Staff newsletters were circulated monthly and a central website allowed learning to be shared within the Vocare Group. The clinical leadership team discussed clinical incidents at monthly meetings. Operational incidents were discussed at daily meetings and reviewed at weekly governance meetings. All staff had access to a central website. Staff we spoke with understood their duty to raise concerns and report incidents and near misses.
- The provider analysed incidents monthly and this included a review of the level of harm caused.
- There was a document that tracked each incident including any action taken and noted when the incident was closed.
- There had been no 'serious incidents' (SI) reported since the service has been returned to UCC North Staffordshire on 10th September 2018.

Good

Are services effective?

At our last inspection we rated the service inadequate for providing effective services. This was because:

- Although access was available, not all clinical staff were aware of where to find guidelines from the National Institute for Health and Care Excellence (NICE) for information to help ensure that people's needs were met.
- Some patients, when streamed for a further assessment, were delayed urgent treatment.
- The service was not achieving the indicator for returning patients back to the emergency department when emergency treatment was required.
- Staff did not always have the skills, knowledge and experience to treat some of the patients accepted into the service.
- There was no clear structure in place for staff to work with colleagues from the hospital team.

At this inspection we rated the service good for providing effective services.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice. Staff we spoke with were aware how to access the guidelines, clinical pathways and protocols.

- Clinical staff had awareness of the access to guidelines from the National Institute for Health and Care Excellence (NICE) for information to help ensure that people's needs were met. The provider monitored that these guidelines were followed; for example, through clinical consultation reviews.
- There was suitable pain relief medicine to treat acute pain. At the last inspection, the protocol for pain relief contradicted the clinical and operational model. The protocol stated that the only urgent medicines that could be given were ibuprofen and paracetamol but the clinical and operational model stated that the service may include the provision of stronger analgesia. The provider acted immediately after the last inspection to ensure suitable pain relief was available. Tramadol, diclofenac injections and codeine were available in the urgent care centre.
- Care and treatment was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable. For example, the patient record system had special notes for those patients requiring specific care.
- There was a system in place to identify frequent callers and patients with particular needs, for example, patients experiencing poor mental health were triaged to assess their mental capacity.

Monitoring care and treatment

We looked at the key performance indicators (KPIs), which provide a clear and consistent way of assessing performance as they help inform our decisions about the quality of care. There was a data set of KPIs used to monitor performance of the service. The streaming figures (clinical assessment used to navigate patients to the most appropriate department) for September 2018 showed that the service was now meeting contractual targets:

- 99% of patients had been streamed within 15 minutes of their arrival compared to December 2017, when the service performance was 63%. The contractual target was 95%.
- 100% of patients had been streamed within 60 minutes of their arrival compared to December 2017 when the performance level was 89%. The contractual target was 99%.
- 100% of all patients streamed had a post event message regarding each episode of care sent to the patient's registered GP by 8am the following day. The contractual target was 100%.

Since 10 September 2018, when the provision of the streaming service had returned to Urgent Care Centre North Staffordshire, the number of patients seen per day has averaged 40. A total of 99.7% of patients were seen, treated and discharged within the four-hour target time and no patients had left without being seen.

Effective staffing

Staff were seen to be working within their capabilities and had the skills, knowledge and experience to treat patients accepted into the service.

- The provider had an induction programme for all newly appointed staff. Clinicians we spoke with had completed

an induction or familiarisation process prior to their first shift. All staff were required to complete a telephone interview with the head of nursing in advance of working their first shift.

- The provider had an effective system for monitoring training requirements by individual staff members. Electronic records were kept for each staff member and contained up to date records of training completed and dates when refresher training was due. Training needs had been identified for each role. SDUC had amended its recruitment policy to improve the number of GPs who provided evidence of completed training.
- The provider had a clear process to provide staff with ongoing support; this included appraisal. There was a clear approach for supporting and managing staff when their performance was poor or variable. Quarterly reviews were completed and a red/amber/green (RAG) rated process was in place to manage any performance issues, for example, serious concerns, rated as red, would result in the clinician being stopped from working any further shifts until a formal assessment has been completed. If appropriate to continue, close supervision would be used until performance is satisfactory.
- The provider could demonstrate how it ensured the competence of staff employed in advanced roles by audit of their clinical decision making. For the first four weeks, all clinical streaming and triage case notes were reviewed by a service medical lead who was a doctor.
- Staff were made aware of external training opportunities provided free by the local hospital and distance learning courses provided by a local college. Staff were given the information to enrol and the opportunity to complete training if they left SDUC's employment.
- For the first four weeks, weekly audits had been carried out on streaming, triage and see and treat to assess that appropriate patients were being seen. Live audits were being done by the medical leads to give immediate feedback.

Coordinating care and treatment

A clear structure had been implemented for staff to work with colleagues from the hospital team. There was a weekly meeting with the matrons from the emergency department and the medical lead. Staff told us that informal meetings were held daily. The provider shared safety incidents and emailed the hospital governance team weekly to request any incidents reported through the hospital system that involved the urgent care centre.

All patients streamed had a post event message regarding each episode of care sent to the patient's registered GP by 8am the following day. Team leaders contacted GP practices when concerns and risk factors such as high blood pressure were identified.

We heard how the service supported a patient with mental health by visiting the GP practice to discuss how care could be better coordinated. A weekly email was sent to the hospital governance team asking if issues had been raised regarding the urgent care centre.

Helping patients to live healthier lives

Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- At the last inspection, it was not clear to patients when they arrived at the emergency department reception as to who treated them, therefore it was not clear that they had given informed consent to be treated by a streaming service rather than the emergency department. However, the provider had provided information leaflets to support patient choice. The service had been relocated into a separate building, away from the emergency department and the reception desk within the emergency department now provided a single point of access.

Good

Are services caring?

At the previous inspection we rated the service as good for providing caring services. At this inspection, we continued to rate the service good for providing caring services.

Kindness, respect and compassion

Staff we observed treated patients with kindness, respect and compassion. Staff displayed an understanding and non-judgmental attitude to all patients. For example, towards patients experiencing poor mental health.

A total of 42 Care Quality Commission comment cards were received. A total of 38 comments were positive about the service received, 12 of the comments complimented the timely access to treatment and 10 complimented the caring and compassionate staff. Of the negative comments, only one applied to the urgent care centre.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- The service was aware of the requirements under the Accessible Information Standard. There was a hearing loop system for people with a hearing impairment. There were facilities for those that required sign language interpretation. British sign language interpreters required advanced booking.
- Patient information leaflets were available. For example; there was a booklet for patients that detailed the options for where patients could attend giving guidance of when each was appropriate.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- In addition to the friend and family test, a postal survey was used to capture patient feedback on the service.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- 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.

Good

Are services responsive to people's needs?

At the previous inspection we rated the service requires improvement for providing responsive services. This was because:

- Healthcare professionals caring for vulnerable people did not always raise safeguarding concerns for vulnerable adults.
- Patients did not always have timely access to clinical diagnosis and treatment.
- Comments from patients were generally negative about the waiting times to receive treatment.

At this inspection we found that improvements had been made.

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.

- There were accessible facilities, baby-changing facilities, a hearing loop and translation services available (to be provided within 15 minutes of the initial contact).
- The service could access the mental health crisis team or single point access for rapid response community matrons. There were direct referral pathways in place for patients experiencing poor mental health who attended the urgent care centre.
- The facilities and premises were appropriate for the services delivered. There was a marked pathway and maps for patients sent to the urgent care centre building following initial assessment within the emergency department. There was an alternative route for wheelchair users that avoided ramps.
- The streaming clinician observed the waiting area between patients (approximately every three minutes) to identify any patients who may need prioritising.

Timely access to the service

The service was open 24 hours a day, seven days a week, and 365 days a year. The provider operated a model that moved clinicians between centres dependent on demand. Data for the last month showed that at least one GP and an advanced nurse practitioner was always available at the centre.

Patients could access the service via NHS 111 (NHS 111 is a telephone-based service where callers are assessed, given advice and directed to a local service that most appropriately meets their needs). The service also saw 'walk in' patients but not patients who arrived at the hospital by ambulance.

Data for September 2018 showed patients had timely access to clinical diagnosis and treatment. Data obtained from the service regarding timescales for streaming, treating and discharging patients was at 99.7%.

Listening and learning from concerns and complaints

Information about how to make a complaint or raise concerns was accessible and easy to understand. The complaint policy and procedures were in line with recognised guidance. The governance team managed the complaints process and spoke to all complainants upon receipt of a complaint. We looked at the complaint system provided to us at the inspection that included a copy of complaints that dated back to when the service had recommenced on 10 September 2018.

- A total of two complaints received since the service had been handed over, this represented approximately 0.1% of total contacts.
- We reviewed the two complaints, one was through the patient advisory liaison service (PALS) for a service user who felt not listened to during a streaming assessment. The patient was contacted in writing and the clinician had reflected and explained to the PALS office about streaming and explained that the patient needed a further explanation of the process and that they had been quickly moved through for further assessment in triage.
- The provider analysed the complaints and identified any themes to be used at future workshops and shared learning events. The second complaint was still under investigation as the patient felt that a referral to a specific service should have been made. The service medical lead had reviewed the complaint and felt that further pain relief should have been administered but the referral was not necessary.
- The response time to complaints was timely, the longest response time had been 10 days.
- The provider had implemented a two-tier approach to managing complaints. This consisted of formal complaints that were taken through the formal process and informal complaints that could be closed without the need for a formal investigation.

Good

Are services responsive to people's needs?

- Any themes and trends around complaints were reported to the clinical commissioning groups at a monthly combined quality review meeting (CQRM).
- The service shared learning by dedicating one in four of the weekly governance meetings to discuss lessons learnt and share good practice. These meetings were open to all staff who worked within the service. Issues that stemmed from complaints were discussed at the monthly quality and safety meeting and included on staff newsletters.
- Lessons were learnt from other services within the Vocare Group. For example, a child who had presented with soiled pyjamas had led the service to recognise that having disposable garments and nappies available to maintain the patient dignity.

Good

Are services well-led?

At the previous inspection we rated the service inadequate for providing well-led services. This was because:

- Systems and processes failed to enable the provider to effectively assess, monitor and improve the quality and safety of the services provided.
- There was an inconsistent approach for identifying risks, issues and implementation of mitigating actions.
- Systems for the management of emergency medicines and equipment were not effective.
- Staff had stopped reporting on significant events and incidents.
- The governance arrangements were not sufficient for permanent and temporary staff recruitment and training.

At this inspection we found that improvements had been made.

Leadership capacity and capability

Leaders demonstrated the skills and the capacity to run the service and could demonstrate awareness and oversight of the issues and how they ensured safe care and treatment was being provided by all staff.

- The clinical leadership management structure showed clear lines of accountability. The service had added to the leadership team and introduced an on-call rota that included clinical and operational support at all times. The rota for the clinical leadership ensured that there was presence at weekends. The first port of call was the senior team leader at Staffordshire House and a white board detailed who was the clinician in charge on each shift. This was communicated at a 'daily safety briefing'. An email had been sent out to all staff to communicate the new roles and names.
- An operations manager had been appointed in the weeks leading up to the previous inspection. A team leader and a lead nurse had been appointed into dedicated roles for the urgent care centre (UCC). A clinical lead had been recruited with experience across emergency department and primary care. The regional clinical leadership for the Vocare central region had been strengthened with the appointment of a regional clinical director, a regional director and a regional medical director.

Vision and strategy

- Vocare had a corporate vision and defined its role to be 'the urgent healthcare provider and partner of choice for the NHS which will allow them to provide better clinically led, evidenced based, innovative and sustainable services for patients'. This was accessible on the provider's website.
- The senior management team had formalised a localised strategy to develop an integrated urgent care model, especially with the NHS111 service. Staff worked across both services and urgent care practitioners were being multi-trained; for example, paramedics were trained as urgent care practitioners, able to work in all areas of the urgent care system.
- The strategy and vision was under review at senior management level to focus more on the local plans and aspirations rather than the overarching corporate strategy. Staff we spoke with were aware of the vision, values and strategy and their role in achieving them.

Culture

The provider had strengthened the leadership and governance arrangements at the regional SDUC headquarters. The management team had clinical oversight of the service.

- Staff felt respected, supported and valued, and were positive about the improvements made since the last inspection.
- They told us they could raise concerns and had received additional training in the incident reporting system.
- The provider was aware of and had systems in place around 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).
- There were organisational policies for providing employed staff with the development they needed, for example; support with revalidation.
- Shared learning events and workshops had been held to encourage a learning culture. Recent workshops had included a review of a significant event, a review of how effective comfort calls were and the induction and appraisal process. Shared learning events held monthly included information governance and learning from complaints. The significant event had become the subject for a training event. Communication improvements resulting from the workshops included the use of a new 'Q-mail' function that communicated

through an application direct to clinicians to advise of rota gaps that could be accepted with a single press of a button. The provider used 'zoom' a system that used an internet link to share meetings so attendees could dial in remotely.
- Since the last inspection, the culture of working together with hospital staff had improved. We spoke with hospital staff as part of the inspection and the relationship between the services was cohesive and regular meetings were held.

Governance arrangements

Structures, processes and systems to support good governance and management had been strengthened. Some staff we spoke with told us that the information available to staff had improved and there was an effective system to determine which patients should be accepted into the service.

- There was a clear staffing structure at the regional head office, staff were aware of their own roles and responsibilities. The governance structure had been extended to incorporate the service provided at the hospital.
- The provider had a good understanding of their performance against local key performance indicators. These were discussed at senior management and board level. Performance was shared with staff and the local clinical commissioning group as part of contract monitoring arrangements.
- The governance structure had been strengthened to include a point of contact 24 hours a day, seven days a week. A regional on-call system had been introduced to provide round the clock cover. The on-call team always included a regional manager or director who was a clinician.
- There was a dedicated management team for the streaming service whereas at the previous inspection the management team spanned the GP Out of Hours (OOH) and the NHS 111 service provided in Staffordshire by Staffordshire Doctors Urgent Care (SDUC).

Managing risks, issues and performance

The governance systems and processes to identify and manage risks had been improved. When risks had been identified, the provider had effective systems and processes to assess, monitor and improve the quality and safety of the services. Examples were discussed in a daily risk meeting and fed into the weekly governance meeting. Any incident mentioned at the weekly meeting was discussed at the monthly quality and safety meeting. Incidents are discussed with the clinical commissioning group (CCG) at monthly combined quality reporting meeting (CQRM).

The communication between the lead nurse for the UCC and the matrons in the emergency department had improved and a three-step process had been implemented to resolve incidents raised. A dedicated link clinician had been appointed for incident and risk management.

The service had achieved compliance with the local indicators that monitored the streaming of patients in a timely manner.

Leaders understood service performance against the national and local key performance indicators. Performance was regularly discussed with the local CCGs as part of contract monitoring arrangements.

The service monitored who was reporting and checked daily informally and weekly formally with the hospital to check if any incidents reported related to the UCC. The governance team ran workshops to educate staff in the use of Datix, refreshed training to ensure staff could use datix (included discussion around why to report through the correct system) and appointed a 'Datix Champion' from the clinical team who worked with the governance team to gain an understanding of how the information is used. The 'Datix Champion' provided that part of the induction for new starters. The governance team monitored which staff group reported incidents for an assurance that all staff groups are using the system.

Appropriate and accurate information

The service reported on appropriate and accurate information. The data provided an effective monitor on performance.

- The service used a set of local indicators to monitor performance and the delivery of quality care which they reported on monthly.
- The service submitted data or notifications to external organisations such as CCGs as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Good

Are services well-led?

Engagement with patients, the public, staff and external partners

- Systems were in place for staff to give feedback and be involved in service development.
- We saw there was a locally produced monthly newsletter and a monthly clinicians' newsletter.
- Staffordshire Doctors Urgent Care (SDUC) engaged with other urgent care services such as the ambulance service.
- Engagement with staff had been improved, most notably at weekends. Clinical staff we spoke with were aware of the management team and knew who to contact for support.
- The provider was seen to be recruiting service users to form a patient forum.
- Complainants were seen to have been invited when relevant to gain a greater understanding of the feedback since improvements had been made. There were plans to include patients in shared learning events and workshops where patient identifiable data was not a barrier.
- SDUC had developed links with the local Healthwatch team in Stoke-on-Trent to provide patient feedback on the service.

Continuous improvement and innovation

SDUC planned to improve the flow of information through a project named 'black pear'. This involved a piece of software to perform system inter-operability allowing different clinical systems to be accessible from the OOH service. The project aimed to link in with GP practices and the community healthcare team. The service planned to explore how the navigator role could support the emergency department with patients for example with minor injuries. The service had the facilities and the potential to look at supporting the emergency department by carrying out near patient testing. The provider saw potential of how to incorporate the paramedic workforce into the system and in doing so build up resilience with a mobile workforce. Two paramedics had been enrolled on advanced health assessment course and independent prescribing courses.