Gloucestershire Out of Hours

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	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

Overall summary

This service is rated as Requires Improvement overall. (Previous inspection September 2018 – Requires Improvement)

We carried out an announced comprehensive inspection at Gloucestershire Out of Hours in September 2018 and rated the provider requires improvement in effective and well led and good in safe, caring and responsive. On the 13 -15 August 2019 we carried out a comprehensive inspection to follow up on breaches of regulations found during the inspection carried out in September 2018.

At this inspection the key questions are rated as:

Are services safe? – Requires Improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires Improvement

At this inspection we found:

- When incidents happened, the service learned from them and improved their processes.
- There were gaps in systems to assess, monitor and manage Health and Safety, such as identifying and managing the deteriorating patient, for non-clinical staff, they were in place and followed by clinical staff
- There were systems in place for the appropriate and safe use of medicines, including medicines optimisation.
- The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Consistent improvements had been made towards meeting performance targets.
- Staff involved and treated people with compassion, kindness, dignity and respect. Patient feedback was positive.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- Complaints were listened and responded to and used to improve the quality of care.
- Whilst clinical staff and staff working at the head office felt there had been improved engagement with the leadership team, many of the non-clinical staff we spoke with and who worked at the bases reported a lack of visibility and support from the management teams.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The areas where the provider **should** make improvements are:

- Continue to improve and sustain performance against targets.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

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

Background to Gloucestershire Out of Hours

Gloucester Out of Hours is the registered location for services provided by Care UK (Urgent Care) limited and provides out-of-hours primary medical services to patients in Gloucestershire when GP practices are closed. The administrative base is located at Unit 10 Highnam Business Centre, Highnam Gloucestershire GL2 8DN.

Gloucestershire is a diverse county. It is mainly rural with two major urban centres, Gloucester and Cheltenham, where nearly 40% of the counties population lives. Although Gloucestershire benefits from a high standard of living, pockets of deprivation exist. Gloucestershire has eight local areas amongst the most deprived 10% of England, which are all located in the Cheltenham and Gloucester districts.

The service is commissioned by Gloucestershire Clinical Commissioning Group and covers a population of approximately 682,000 people across the county of Gloucestershire. Patients access the out-of-hours service via the NHS 111 telephone service. Patients may be seen by a clinician at one of the six primary care centres, receive a telephone consultation or a home visit, depending on their needs The vast majority of patients access the service via NHS 111, however, there were agreements with different services for walk in patients to access the service, including a system to accept walk in patients from other services, such as A&E and the minor injuries units.

The out-of-hours service is provided at six sites:

- Gloucester Royal Hospital, Great Western Road, GL1 3NN (6.30pm to 8am weekdays 24 hours over weekends and bank holidays
- Cheltenham General Hospital, Sandford Road, GL53 7AN (6.30pm to 11pm weekdays and 8am to 11pm over weekends and bank holidays)
- Dilke Hospital, Cinderford, GL14 3HX (6.30pm to 11pm weekdays 10am to 9pm over weekends) and bank holidays.
- Cirencester Community Hospital, Tetbury Road, GL7 1UY (6.30pm to 11pm weekdays 8am to 11pm over weekends and bank holidays)
- Stroud Community Hospital, Trinity Road, GL5 2HY (6.30pm to 11pm weekdays 8am to 11pm over weekends and bank holidays)
- North Cotswolds Hospital, Stow Road, Moreton in the Marsh, GL56 0DS (10am to 9pm over weekends and bank holidays)

During the inspection we visited the sites at, Gloucester, Cheltenham, Stroud, Cirencester and Cinderford.

The provider is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

Requires improvement

Are services safe?

We rated the service as requires improvement for providing safe services because:

- The organisation had policies in place, but these were not always easily accessible to staff.
- Non-clinical staff had not undertaken sepsis awareness training. There was also a lack of guidance and training for identifying and managing the deteriorating patient for non- clinical staff.
- A complete set of risk assessments for each base had not been completed or being monitored by the organisation.
- There was no process in place for regular and ongoing driver assessments.

Safety systems and processes

- The organisation had safety policies, including Control of Substances Hazardous to Health and Health & Safety policies. However these were difficult for staff to find and access on the providers computer system. This meant that staff relied on previous experience rather than working to the organisations own policies.
- Staff received safety information from the provider as part of their induction and refresher training.
- The provider had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to staff although not all staff could locate these so relied on direct contact with head office staff or knowledge gained from other employment. The policies outlined clearly who to go to for further guidance. All staff spoken with knew who to go to for further guidance.
- The service worked with other agencies to support patients and protect them from neglect and abuse, such as the local safeguarding teams. All referrals were logged on the Datix system. (Datix is a web-based patient safety recording system). Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns.
- At the inspection in September 2018 we found gaps in staff checks at the time of recruitment. At this inspection we found that all appropriate checks had been undertaken. Disclosure and Barring Service (DBS) checks were undertaken where required. (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). Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.
- The provider ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions.
- There were systems for safely managing healthcare waste.
- Local monitoring processes were in place to demonstrate whether each site had a health and safety, infection prevention and safeguarding leads who had completed training in these areas of responsibilities. At the time of inspection all sites with their own policies, except for one site whose health and safety lead had recently left.

Risks to patients

There were not always systems in place to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective system in place for dealing with surges in demand.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. Clinical staff knew how to identify and manage patients with severe infections, for example sepsis. In line with available guidance, patients were prioritised appropriately for care and treatment, in accordance with their clinical need. However, non-clinical staff had not undertaken training to support them in identifying those patients who may be suffering from sepsis or a similar deterioration in health. There was also a lack of guidance and training for identifying and managing the deteriorating patient for non- clinical staff. In three of the five bases we visited there was not a clear line of sight of patients in the waiting room. This meant that there was a risk that patients were not able to be prioritised appropriately for care and treatment, in accordance with their clinical need, and there was no risk assessment in place to mitigate these risks. We were

told that local operating policies were being developed but these were not in place at the time of the inspection, and no interim guidance was in place that would support staff. Post inspection we were were sent evidence that demonstrated that a local operating policy had been put in place.

- The provider had a health and safety lead who delegated responsibility to other staff following health and safety training. The representative for the Gloucester out of hours provider had not yet completed their training. High staff turnover meant that a complete set of risk assessments for the bases had not been completed since 2017, and for those that had been undertaken we saw that identified actions had not all been completed. For example, a general environmental risk assessment for the out of hours bases had been completed in May 2018. The results demonstrated 54% compliance. Actions to provide a fire risk assessment and health and safety poster had been completed. However, evidence demonstrating implementation of a first aid risk assessment had not been completed and a review of the overall risk assessment had not been re assessed.
- Systems were in place to manage people who experienced long waits.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.
- When there were changes to services or staff the service assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Appropriate and safe use of medicines

The service had reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, including medical gases, emergency medicines and equipment, and controlled drugs and vaccines, minimised risks. The service kept prescription stationery securely and monitored its use. Arrangements were also in place to ensure medicines and medical gas cylinders carried in vehicles were stored appropriately.
- Regular prescribing audits were undertaken by a pharmacist employed by Care UK Ltd. These included antimicrobial stewardship and individual clinician prescribing audits.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The service had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Processes were in place for checking medicines and staff kept accurate records of medicines.
- Palliative care patients were able to receive prompt access to pain relief and other medication required to control their symptoms.

Track record on safety

The service had a good safety record.

- There were risk assessments in relation to safety issues. However, whilst drivers for the service underwent a risk and driver assessment on joining the service, regular ongoing assessments were not made, and drivers did not have to provide self-declaration that there had been no changes to their health. However post inspection we were sent a policy by the provider that stated that drivers were responsible for informing management if there were any changes in health. The policy also stated that compliance with the policy would be audited regularly. We were told by staff that this had not taken place.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements. This was monitored and reported monthly to the registered manager and once verified, shared with the board and commissioners.

Requires improvement

Are services safe?

- There was a system for receiving and acting on safety alerts. This included a log of action taken and email correspondence to communicate any actions or alerts with relevant staff.
- Joint reviews of incidents were carried out with partner organisations. including the local A&E department, other parts of the Care UK organisation and the NHS 111 service.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a failsafe system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. Audits were in the process of being tested and implemented to evaluate staff understanding of this process and ensure the system used was correctly completed.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes, and took action to improve safety in the service. There was a structured process which showed actions had been completed, statutory notifications and leaning shared with appropriate staff, other regions of the organisation and external organisations, including CQC, NHS 111 services and GP practices. An incident occurred where mouth to mouth masks had been difficult to quickly locate within a car sent to deal with an emergency. Actions taken to minimise reoccurrence included: updated information circulated to the staff team, images of where the masks were located within the kit; check added to start of shift checklist for staff to ensure they were aware of location of equipment within the cars; a review to optimise the emergency equipment carried on mobile cars and to ensure its accessibility.
- The service learned from external safety events and patient safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff. This was usually by email or in the monthly 'reflect' newsletter and included use of photographs, sharing of clinical assessment tools and national guidance.
- The provider took part in end to end reviews with other organisations. Learning was used to make improvements to the service. A root cause analysis investigation was carried out in conjunction with the NHS111 service following a serious incident to identify care or service delivery problems and improvements that could be made to minimise the likelihood of reoccurrence. As a result of the investigation, findings and improvements were shared with the local clinical commissioning group and NHS digital in relation to the NHS pathway (an approved triage tool used by NHS 111) that had been used on this occasion. Learning points were also shared with the OOH clinicians to improve the quality and consistency of care delivered.

Good

Are services effective?

At the inspection in 2018 we rated the provider requires improvement for providing effective services because the provider had not ensured that:

- Suitable numbers of appropriately qualified staff were deployed to ensure that peoples care, and treatment needs were met.
- National quality requirements standards of care were met or were in line with national achievements.
- All staff had received appropriate training, and appraisal as is necessary to enable them to carry out the duties they were employed to perform.

Following the inspection, the provider sent us an action plan that detailed how improvements were to be made and at this inspection we found that these improvements had been made.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence-based practice. Examples of this were monthly clinical meetings, a newsletter sent to all staff and regular communications on updates to guidelines. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed by notes reviews and prescribing audits.
- Clinical assessments were carried out using structured assessment tools such as the National Early Warning Score (NEWS2) to identify those who were at risk of
- developing Sepsis.
- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- Care and treatment was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. For example, management plans for vulnerable people and child protection alerts were documented within enhanced
- summary care records.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients and information was inputted to the special notes section of the computer system to ensure coordinated care and that all staff had up to date information.
- We saw no evidence of discrimination when making care and treatment decisions.
- When staff were not able to make a direct appointment on behalf of the patient clear referral processes were in place. These were agreed with senior staff and clear explanation was given to the patient or person calling on their behalf.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

- From 1 January 2005, all providers of out-of-hours services were required to comply with the National Quality Requirements (NQR) for out-of-hours providers. The NQR are used to show the service is safe, clinically effective and responsive. Providers are required to report monthly to their clinical commissioning group (CCG) on their performance against the standards which includes: audits; response times to phone calls: whether telephone and face to face assessments happened within the required timescales: seeking patient feedback: and, actions taken to improve quality.

When we inspected the service in 2018 we found that the service was not meeting the required standards. On this inspection we reviewed data from September 2018 to June 2019. Data over this period showed that whilst targets weren't always being achieved, there had been significant and consistent improvements over the last 12months. We also saw that activity volumes had increased over the previous year.

- The percentage of urgent calls triaged within 20 minutes of arrival ranged from 64% in September 2018 to 86% in June 2019, against a target of 95%. There had been consistent monthly improvement during this period.
- The percentage of urgent and routine calls triaged within 60 minutes of arrival: Percentage achievements ranged from 79% in September 2018 to 95% in June 2019 against a target of 95%. There had been consistent monthly improvement during this period.

Good

Are services effective?

- The percentage of routine calls triaged within two hours of arrival: Percentage achievements ranged from 81% in September 2018 to 97% in June 2019, against a target of 95%. There had been consistent monthly improvement during this period.
- The percentage of urgent patients consulted within two hours ranged from 74% in September 2018 to 86% in June 2019 against a target of 95%. Whilst the target had not been achieved in any month during this period we did see that performance was stable. We also saw that the highest average time to an urgent base appointment was two hours and twenty-nine minutes.
- The percentage of routine patients consulted within six hours, was 99% for each month within the period, against a target of 95%.
- The percentage of urgent patients visited within one hour was 100% for the previous six months.
- The percentage of urgent patients visited within two hours ranged from 83% to 91% from September 2018 to June 2019 against a target of 95%, with the highest achievement being in December 2018.
- The percentage routines visited within six hours, ranged from 91% to 99% from September 2018 to June 2019 against a target of 95%, with the highest achievement being in October 2018 and April 2019.

Where the service was outside of the target range for an indicator the provider was aware of these areas and we saw evidence that attempts were being made to address them. We saw that all clinical breaches against targets were investigated and improvements put into place to minimise recurrence.

The service was also generally meeting its locally agreed targets as set by its commissioner.

- Timely call back to patients on weekdays and weekends and bank holidays were consistently above the target of 95%
- Timely call backs to health professionals ranged between 87% and 98% against a target of 95%.

The service made improvements through the use of completed audits. Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality.

- An audit was undertaken to ascertain an increase and consistency in the usage of a NEWS2 score for each by OOH clinicians. (The NEWS2 score is the National Early Warning Score which determines the degree of illness of a patient and prompts critical care intervention where appropriate). Following interventions to increase awareness the standards set were an increase of 5% in usage. Monthly audit demonstrated that this had been achieved, however it was noted that clinicians needed to improve coding the assessment within medical records. Further interventions were actioned to achieve this, and it was hoped that future audits would show further improvements.
- Concerns had been raised about the appropriateness of emergency department (ED) referrals to the OOH service. An audit was undertaken to establish whether referrals over the period January 2019 to April 2019 were in line with what could be expected and how many had needed to be referred back to the ED. The audit demonstrated that re-referrals were low and consistent with previous levels. However, there were areas identified that could be improved and a meeting was held between the ED, OOH service and commissioners of the service to discuss and action these. For example, an improved escalation procedure for the OOH service to cope with surges in demand related to ED referrals.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. The provider had an induction programme for all clinical and non-clinical newly appointed staff. The induction programme for non-clinical staff had recently been redesigned and was more comprehensive. We were told that each member of staff had a bespoke induction and there was no set length of time that induction lasted and that this depended on individual staff and competencies being achieved. The service had found that new members of staff who had received the new induction had progressed well.
- The lead nurse ensured that all Advanced nurse practitioners and emergency care practitioners worked within their scope of practice and had access to clinical support when required.

The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. At the previous inspection we saw that not all staff had undertaken refresher training. At this inspection

we saw that compliance for mandatory training had increased from 85% to 96%, and for those that were not compliant there was a rationale, such as long-term sickness. There were new processes in place to follow up on the completion of staff training.

- The provider provided staff with ongoing support. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The provider could demonstrate how it ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable. For example, the organisation completed call back audits on 1% of all
- calls. These had been used for identification of training needs and poor performance. We were given examples to demonstrate appropriate action had been taken.

Coordinating care and treatment

Staff worked togethe and worked well with other organisations to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. Care and treatment for patients in vulnerable circumstances was coordinated with other services. Staff communicated promptly with patient's registered GP's so that the GP was aware of the need for further action. Staff also referred patients back to their own GP to ensure continuity of care, where necessary. There were established pathways for staff to follow to ensure callers were referred to other services for support as required. The service worked with patients to develop personal care plans that were shared with relevant agencies.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- The service had formalised systems with the NHS 111 service with specific referral protocols for patients referred to the service. An electronic record of all consultations was sent to patients' own GPs.
- The service ensured that care was delivered in a coordinated way and took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that require them. Staff were empowered to make direct referrals and/or appointments for patients with other services.

Helping patients to live healthier lives

Staff were consistent and proactive in empowering patients and supporting them to manage their own health and maximise their independence.

- The service identified patients who may be in need of extra support, such as patients who were carers or those who needed translation services.
- Where appropriate, staff gave people advice so they could self-care. Systems were available to facilitate this. Patients were given a "treating your infection leaflet which supported patients when the clinician had recommended self-care for self-limiting infections. This also supported improved antibiotic guardianship.
- Risk factors, where identified, were highlighted to patients and their normal care providers so additional support could be given.
- Where patients need's 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.
- The provider monitored the process for seeking consent appropriately.

Good

Are services caring?

We rated the service as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information. Call handlers gave people who phoned into the service clear information. There were arrangements and systems in place to support staff to respond to people with specific health care needs such as end of life care and those who had mental health needs. For example, the service worked collaboratively with a local and external End of Life Implementation and Education Group.
- Comfort calls were carried out by receptionists and drivers to check patients' conditions and to inform them how long it would be before they would receive a home visit or telephone consultation.
- Of the 63 patient Care Quality Commission comment cards we received, 61 were positive about the service experienced. There were two negative comments about waiting times at the Gloucester base.
- The service engaged with patients and regularly reviewed patient feedback. Results showed that for the year June 2018 to June 2019 out of 788 responses 94% were extremely likely or likely to recommend the service to friends and family.

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.
- Patients told us through comment cards, that 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.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Staff always respected confidentiality.
- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The service monitored the process for seeking consent appropriately.

Good

Are services responsive to people's needs?

We rated the service as good for providing responsive services.

Responding to and meeting people's needs

The provider organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The provider understood the needs of its population and tailored services in response to those needs, such as, collaborative working with Rapid Response teams to optimise care and utilisation of capacity.
- The provider engaged with commissioners to secure improvements to services where these were identified. For example, improved anticipatory care planning especially in Nursing Homes.
- The provider improved services where possible in response to unmet needs. The service provided out of hours support for eight community hospitals and co-located minor injuries units to ensure patients received the most appropriate care within a reasonable timescale.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service. Staff had access to 'special notes', additional notes about the patients' health, social situation, past medical history and medicines. Care pathways were appropriate for patients with specific needs, for example those at the end of their life, babies, children and young people.
- The facilities and premises were appropriate for the services delivered.
- The service made reasonable adjustments when people found it hard to access the service. Sunflower Lanyards had been introduced. People with hidden conditions such as autism, dementia or anxiety can ask for special sunflower lanyards to support the discreet identifying of patients who may have hidden additional needs
- We were told that patients who found waiting rooms difficult environments to be in, were prioritised where possible.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

Patients were able to access care and treatment at a time to suit them. The service operated from 6.30pm to 8am Monday to Friday and 24hours a day on weekends and bank holidays.

- The service did not see walk-in patients and a 'Walk-in' policy was in place which clearly outlined what approach should be taken when patients arrived without having first made an appointment, for example, patients were told to call NHS 111 or referred onwards if they needed urgent care. Staff were aware of the policy and understood their role with regards to it, including ensuring that patient safety was a priority.
- Patients were allocated an appointment, although the service had a system in place to facilitate prioritisation according to clinical need where more serious cases or young children could be prioritised as they arrived. The receptionists informed patients about anticipated waiting times.
- There were areas where the provider was outside of the target range for an indicator, however where the service was not meeting the target, there was an awareness of
- this and we saw evidence that attempts were being made to address them and were detailed within the recovery plan. Rota calls were held twice a week to monitor rota fill to ensure safe staffing levels across the service. To improve rota fill shift, timings had been adjusted to suit clinicians where appropriate, and incentives were offered for key dates which historically had proved difficult to fill. We looked at the rota fill for a sample of shifts during the inspection and saw that these were within acceptable parameters. A system to monitor performance on a three hourly basis had been introduced which meant that regional support could be sought at the earliest opportunity if required.
- Data that we saw showed that there had been a consistent improvement towards targets.
- There were systems in place to manage waiting times and delays. For example, patients could be contacted, and their appointment transferred to a site where there was better capacity. Where people were waiting a long time for an assessment or treatment the centre's reception staff we spoke with demonstrated how they would inform patients of waiting times.
- The service engaged with people who are in vulnerable circumstances and took actions to remove barriers when people found it hard to access or use services. "Fidget packs" (finger activities that may help alleviate

agitation and restlessness) were being introduced to provide comfort to patients accessing the service who found it difficult to wait in a busy waiting room or those with sensory sensitivity.
- Patients with the most urgent needs had their care and treatment prioritised.
- Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.
- The appointment system was easy to use.
- Referrals and transfers to other services were undertaken in a timely way. Operating policies were in place for the transference of patients between the emergency department and the OOH service in the two bases where they were co-located.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The company took complaints and concerns seriously and responded to them appropriately to improve the quality of care. The complaint policy and procedures were in line with recognised guidance. The company learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care.
- Issues were investigated across relevant providers, and staff were able to feedback to other parts of the patient pathway where relevant.
- The service learned lessons from individual concerns and complaints and from analysis of trends. It acted as a result to improve the quality of care. For example, a patient had written to the service to complain about receiving a feedback questionnaire and concerns that information was being shared with a third party. The patient was given reassurance and the service looked at the information governance of how consent to ask for feedback was recorded. Changes were made to records and letters sent to the patient.

Requires improvement

Are services well-led?

We rated the service as Requires Improvement for leadership.

At the previous inspection in September 2018 we found the service to be requires improvement for being well led because:

- We identified concerns about how govenrnace had been developed and embedded. We noted that at that time a new leadership was in place and working to improve this
- The provider had not ensured that all staff who worked away from the main base felt engaged in the delivery of the provider's vision and values.
- Staff we spoke with did not feel felt respected, supported and valued and did not have confidence that issues and concerns would be addressed by the leaders.

At this inspection we found that the service had not made sufficient improvements and the rating for well led remains as Requires Improvement. Specifically:

- High turnover of middle management staffing had led to gaps in the oversight of governance processes.
- Whilst clinical staff and staff working at the head office felt there had been improved engagement with the leadership team, many of the non-clinical staff we spoke with and who worked at the bases reported lack of visibility and support from the management teams.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Some members of the middle management team did not always have the experience or capacity to deliver the service strategy and address risks to it. A high turnover of staff within middle management meant that there was sometimes a lack of capacity to address all risks. However, we also saw that additional roles were being introduced to support the administrative operations team. Exit interviews had been undertaken and we were told that no common themes had been identified.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them except for engagement with non clinical staff .
- Leaders at all levels were not always visible and approachable. They worked closely with some, but not all the staff groups, to make sure they prioritised compassionate and inclusive leadership.
- Senior management was accessible throughout the operational period, with an effective on-call system that staff were able to use.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service. We saw that head office staff had been developed and gained promotion to roles where there were staffing gaps.

Vision and strategy

The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The service had a strategy and supporting business plans to achieve priorities. For example, ongoing recruitment programmes to ensure sufficient appropriately qualified staff were deployed to meet the demands of the business had been successful and work to improve this further was ongoing.
- We were not assured that all staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The provider planned the service to meet the needs of the local population and worked collaboratively with the commissioners of the service to achieve this.
- The provider monitored progress against delivery of the strategy.
- The provider did not ensure that all staff who worked away from the main base felt engaged in the delivery of the provider's vision and values.

Culture

The service had a culture of high-quality sustainable care.

- Not all staff felt respected, supported and valued. Clinical staff and staff who worked at head office told us that there had been improvements over the past 12 months. Most non-clinical staff who worked at the bases told us that there had been a number of changes in line management over the previous 12 months and this had led to inconsistencies and a lack of engagement with

them from line managers. Some staff were unsure who their line manager was, and most of those we spoke with, told us that they had never met a member of the senior leadership team.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values. We saw that regular call and notes audits were undertaken and if an individual fell below expected standards, performance management processes were implemented.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. From the incidents and complaints we looked at, in all instances those affected were contacted and kept informed of outcomes. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. We saw instances where issues raised had been addressed promptly but we were also told by some that they did not always have confidence that these would be addressed.
- There were processes for providing all staff with the development they need. At the previous inspection we found that not all staff had received regular annual appraisals. At this inspection we found that all staff had received an annual review but, non-clinical staff at the bases told us that these were often conducted over the telephone, which was not in line with the providers policy, and provided little value to them We looked at a sample of appraisal forms completed for drivers and receptionists and saw these did not demonstrate detailed or individualised discussions. For example, examples seen were brief and the wording the same for each staff member and that there were two objectives which were to give out survey forms and complete manadatory training. The sample of forms we looked at for the administrative staff based at head office were more comprehensive and had personal objectives detailed.
- Clinical staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional time for professional development and evaluation of their clinical work.
- There was not always a strong emphasis on the safety and well-being of all staff. The provider had taken some steps to improve the safety of staff. For example, following feedback from staff, the latest appointment at one of the bases had been amended to ensure staff were able to leave the premises at the same time as other departments were closing. However, we also saw at this base that the alarm button that staff could use to call for help, was inactivated.
- Attempts had been made to improve wellbeing. A staff rewards system was in place, for which staff were nominated and voted for by staff, but staff we spoke with at the bases, felt disengaged with this, as they felt that it was usually staff from head office that won the award.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.

Governance arrangements

There were responsibilities, roles and systems of accountability to support good governance and management. Structures, processes and systems to support governance and management were mixed.

- We saw embedded governance processes included processes for communicating changes in national guidelines, patient feedback, clinical audit, root cause analysis processes, risk management and regular programme of meetings.

Developments and improvements had been made during the previous year in the management of:

- Complaints and investigations: The service now held Datix working parties to review the system effectiveness and identify where improvements or attention was required.
- Information Governance: The service had aligned staff training and patient experience correspondence to become compliant with GDPR requirements.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and significant event reporting and recording compliance audits had been introduced.
- We saw examples that demonstrated good governance and management of partnerships, joint working

arrangements and shared services promoted interactive and co-ordinated person-centred care, which included those with local emergency departments, community hospitals and commissioners.

However, we saw other examples which had resulted in gaps in governance processes. For example:

- The absence of a health and safety lead at the service had resulted in incomplete risk assessments and a lack of oversight or assurances that health and safety checks and actions had been completed.
- Leaders had established policies, procedures and activities but had not assured themselves that they were operating as intended. Staff told us that they were difficult to access quickly, and it was hard to identify which policies related to their role. We were shown the policies on the providers computer system and saw that a number of policies related to other areas of the providers business. For example, there were OOH spillage policies available. However, we saw that these were very difficult for staff to find.

Managing risks, issues and performance

There were not always clear and effective processes for managing risks, issues and performance.

- There were not always effective processes to identify, understand, monitor and address current and future risks to patient safety. Examples of this were; the identification and guidance to support non-clinical staff for the management of the deteriorating patient, and the absence of regular driver assessments.
- The provider had processes to manage current and future performance of the service. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of MHRA alerts, incidents, and complaints. Leaders also had a good understanding of service performance against the national and local key performance indicators. Performance was regularly discussed at senior management and board level. Performance was shared the local CCG as part of contract monitoring arrangements.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality. For example, in relation to referrals from the emergency department.
- The providers had plans in place and had trained staff for major incidents.
- The provider implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Actions had been taken during the previous 12 months which had resulted in improved performance against targets.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service used information technology systems to monitor and improve the quality of care. For example, mobile phone applications used by clinicians to support evidence-based care.
- The service submitted data or notifications to external organisations 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.

Engagement with patients, the public, staff and external partners

- Patient feedback was collated monthly and reported to the commissioners and used to identify areas for improvement. Patient feedback from the surveys and from the CQC comment cards received, demonstrated positive feedback from patients.

Requires improvement

Are services well-led?

- A range of external partners' views and concerns were encouraged, heard and acted on to shape services and culture. Monthly meetings were held with for example, Emergency Departments, the commissioners medicine management team to improve ways of working. Members of staff from the OOH service attended GP practices to give talks and understand and improve relationships within primary care.
- We spoke to the commissioners of the service who told us that the provider had been central to the collaborative working of several transformational projects to improve care and pathways such as introducing a GP in to the Single Point of Clinical Access.
- Staff were able to describe to us the systems in place to give feedback. A staff survey had been undertaken in January 2019. There was a low response rate of 18%. Responses included:
- 5% agreed and 39% disagreed that they were kept informed about important company matters and changes that affected them.
- 0% agreed and 67% disagreed that their line manager talked to them clearly and regularly.
- 0% agreed and 78% disagreed that managers told them when they performed well
- The results of the survey had not been shared with staff and we were not shown an action plan to address the results. We were told the survey would be repeated on an annual basis.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- The service had developed two new audit tools to monitor- staff awareness of the incident reporting process and how well staff completed the Datix incident records. These were in the process of being tested but were due to be shared with other Care UK regions. Testing had highlighted the need for DATIX training which was currently being discussed.
- Electronic prescribing was shortly to be introduced in line with NHS England digital strategy.
- The service had undertaken a pilot on the effectiveness of using a GP in the local Single Point of Clinical Access Hub.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Transport services, triage Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met… • There was a lack of guidance and training for identifying and managing the deteriorating patient for non-clinical staff. • There were policies and procedures in place, but leaders lacked oversight and had not assured themselves that they were operating as intended. • There were gaps in local operating policies and interim risk assessments had not been completed. • Processes to ensure regular driver assessments were undertaken were not in place. • Non-clinical staff who worked at the bases reported lack of visibility and support from the management teams.