# Gloucestershire Out of Hours

## Inspection report

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Date of inspection visit: 22 and 23 November 2021(site visit) ; 29 and 30 November 2021 (remote work); 6 December 2021 (provider information return)
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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? | Requires Improvement |
| Are services caring? | Good |
| Are services responsive to people's needs? | Requires Improvement |
| Are services well-led? | Requires Improvement |

# Overall summary

At our inspection in August 2019 we rated the service as requires improvement overall due to shortfalls in good governance. We served a requirement notice under Regulation 17 for the provider to have effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

**This service is rated as requires improvement overall.** (Previous inspection August 2019 – Requires improvement)

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Requires improvement

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at Gloucestershire Out of Hours as part of our inspection programme to follow up on their previous breach of regulation. We undertook a site visit on 22 and 23 November 2021; remote interviews were carried out on 29 and 30 November 2021. We requested further information from the provider after the site visit, and this was received on 6 December 2021. This inspection also fed into a wider CQC piece of work looking at the urgent and emergency integrated care for patients in Gloucestershire. Details of the overarching system findings are included at the bottom of this summary.

At this inspection we found:

- The provider did not consistently ensure there were sufficient numbers of staff available to run the service, to ensure risk was minimised and the service could respond quickly to an increase in demand.
- Risks to patients were not adequately assessed, monitored or managed to maintain patient safety.
- Overall service performance was not always consistently monitored in a way that ensured patient safety.
- Systems and processes to manage risk were applied inconsistently, whilst learning was not always shared effectively and acted upon. There was a lack of clarity on how significant events and risks were identified and managed.
- Improvement was still needed to ensure learning and actions taken from incidents were understood and acted on by all relevant staff.
- There were risks to patients of not receiving effective care or treatment.
- There were shortfalls in systems and processes that did always not enable safe and effective care to be provided.
- Information gathered on service performance was not used effectively to ensure that all patients received appropriate care and treatment in a timely manner to meet their needs.
- Audits of service provision were not fully completed to enable and demonstrate that trends and themes were identified; appropriate actions taken; and systems to monitor performance were effective. Additionally, to ensure learning was effectively shared.
- There were shortfalls in personal development and support for staff. Not all staff had appraisals or supervision sessions, to enable them to develop their skills or reflect on their work.
- There was an organisational strategy, but it had not been implemented sufficiently to ensure that high-quality sustainable and consistent care could be provided.

# Overall summary

- There were shortfalls in communication between senior leaders and staff groups, staff did not consider they had been fully engaged in the running of the service.
- Governance arrangements were not consistent to support the delivery of a safe, effective and well led service in a consistent manner. Limited attention had been paid to achieving and maintaining compliance with the regulations of the Health and Social Care Act 2008.
- Patients were not always able to access care and treatment from the service within an appropriate timescale for their needs.
- Staff involved and treated people with compassion, kindness, dignity and respect.

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.

Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.

Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out their duties.

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

The organisation should continue to work closely with all system partners to tackle the capacity pressures on urgent and emergency care in the health and social care system in Gloucestershire.

**A summary of CQC findings on urgent and emergency care in Gloucestershire**

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. On this occasion we did not inspect any GPs as part of this approach. However, we recognise the pressures faced by general practice during the COVID-19 pandemic and the impact on urgent and emergency care. We have summarised our findings for Gloucestershire below:

Provision of urgent and emergency care in Gloucestershire was supported by health and social care services, stakeholders, commissioners and the local authority. Leaders we spoke with across a range of services told us of their commitment and determination to improve access and care for patients and to reduce pressure on staff. However, Gloucestershire had a significant number of patients unable to leave hospital which meant the hospitals were full and new patients had long delays waiting to be admitted.

The 111 service was generally performing well but performance had been impacted by high call volumes causing longer delays in giving clinical advice than were seen before the pandemic. Health and social care leaders had recently invested in a 24 hour a day, seven day a week Clinical Assessment Service (CAS). This was supported by GPs, advanced nurse practitioners, pharmacists and paramedics to ensure patients were appropriately signposted to the services across Gloucestershire.

# Overall summary

At times, patients experienced long delays in a response from 999 services as well as delays in handover from the ambulance crew at hospital due to a lack of beds available and further, prolonged waits in emergency departments. Patients were also remaining in hospital for longer than they required acute medical care due to delays in their discharge home or to community care. These delays exposed people to the risk of harm especially at times of high demand. The reasons for these delays were complex and involved many different sectors and providers of health and social care.

Health and social care services had responded to the challenges across urgent and emergency care by implementing a range of same day emergency care services. While some were alleviating the pressure on the emergency department, the system had become complicated. Staff and patients were not always able to articulate and understand urgent and emergency care pathways.

The local directory of services used by staff in urgent and emergency care to direct patients to appropriate treatment and support was found to have inaccuracies and out of date information. This resulted in some patients being inappropriately referred to services or additional triage processes being implemented which delayed access to services. For example, the local directory of services had not been updated to ensure children were signposted to an emergency department with a paediatric service and an additional triage process had been implemented for patients accessing the minor illness and injury units to avoid inappropriate referrals. Staff from services across Gloucestershire were working to review how the directory of services was updated and continuing to strengthen how this would be used in the future.

We found urgent and emergency care pathways could be simplified to ensure the public and staff could better understand the services available and ensure people access the appropriate care. Health and social care leaders also welcomed this as an opportunity for improvement. We also identified opportunities to improve patient flow through community services in Gloucestershire. These were well run and could be developed further to increase the community provision of urgent care and prevent inappropriate attendance in the emergency departments.

There was also capacity reported in care homes across Gloucestershire which could also be used to support patients to leave hospital in a timely way. The local authority should be closely involved with all decision-making due to its extensive experience in admission avoidance and community-based pathways.

**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 a CQC inspection manager, a GP specialist adviser, and a team of CQC inspectors who worked remotely and on site.

## Background to Gloucestershire Out of Hours

Gloucestershire Out of Hours is the registered location for services provided by Practice Plus Group 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 county's population live. 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 five 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 five sites:**

**Gloucester Royal Hospital**, Great Western Road, GL1 3NN (6.30pm to 8am weekdays and 24-hour service 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 and 10am to 9pm over weekends and bank holidays).

**Cirencester Community Hospital**, Tetbury Road, GL7 1UY (6.30pm to 11pm weekdays and 8am to 11pm over weekends and bank holidays).

**Stroud Community Hospital**, Trinity Road, GL5 2HY (6.30pm to 11pm weekdays and 8am to 11pm over weekends and bank holidays).

During the inspection we visited the Gloucester and Cheltenham sites.

**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?

**At our inspection in August 2019 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 and were not being monitored by the organisation.
- There was no process in place for regular and ongoing driver assessments.

**At this inspection we rated the service as requires improvement for providing safe services because: whilst some improvements had been observed there remained shortfalls in providing training in sepsis awareness, planning and monitoring staffing levels, and management of significant events.**

**Safety systems and processes**

**The service had systems to keep people safe and safeguarded from abuse.**

- The provider conducted safety risk assessments. It had safety policies, including Control of Substances Hazardous to Health and Health & Safety policies, which were regularly reviewed and communicated to staff. 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 all staff. They outlined clearly 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 team. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. 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.
- 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 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).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. 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.

**Risks to patients**

There were systems to assess, monitor and manage risks to patient safety although improvements were needed to ensure these were effective.

- There were arrangements for planning and monitoring the number and mix of staff needed, but these were not effective and actual numbers of staff working (shift fill) was declining over time. This had led to delays in patients receiving timely care and treatment.

Requires Improvement

# Are services safe?

- Data for the period November 2020 to October 2021 showed that unfilled shifts on the rota for all staff groups ranged between 2.43% and 52.72%. For clinical staff for the same period this ranged from 3.6% to 50.27%, with an upward trend of unfilled shifts evident in the period of June to September 2021. Agency clinician hours used for the same period remained stable between 23.6% and 29.5 % for the period of November 2020 to October 2021. The provider stated that these shortfalls were due to the COVID-19 pandemic and the national shortage of clinicians.
- There were periods when there was only one GP covering the whole of the county and occasions where there were no drivers available. Staff reported times when driver shifts were cancelled at short notice by the service without pay. The service had five bases and not all of the bases were consistently open as planned. Staff said that it was not unusual for only two bases to be open for face to face appointments. They had been told there was a shortage of clinicians to staff all the bases. Information from Datix entries indicated that this had been highlighted to senior leaders. This meant that in some instances patients would be required to travel further in order to receive the care they required.

We requested information from the provider on when bases were closed. For the period of 1 August 2021 to 1 December 2021:

- The bases at Gloucester and Cheltenham were the only ones open for all 123 days.
- The base at Stroud was open for two days out of the 123 days.
- The base at Cirencester was open for nine days out of the 123 days.
- The base at Dilke was open for 18 days out of 123 days.
- The provider said in their presentation to CQC at the start of the inspection, that patients were not expected to travel for more than 30 minutes to access a base, as set out in their contract with the commissioners of the service. Due to the geography and rurality of parts of the county and bases being closed, this travel time was exceeded.
- Data on shifts filled for the period 2 August 2021 to 2 December 2021 showed that fill ranged from 40% to 91%. On the day when shift fill was 91%, only two bases were open.
- On the day when shift fill was 40% three bases were manned.

The provider told us that the decisions around closing some bases for face to face appointments was in discussion with the Clinical Commissioning Group.

None of the respondents to our survey considered there were adequate numbers of staff. In addition to reports of shifts being cancelled by the service with short notice, staff said that on occasion some advanced nurse practitioners were expected to work with other clinicians and then were told at the start of the shift that there were no GPs on shift. This resulted in a shortage of clinicians available to support each other during working hours if needed. Administration staff who responded to our survey commented that they considered clinicians were overworked.

The provider informed us that when there was no GP available on site, a mobile clinician was available to provide support remotely, and there was a medical director on call.

The system in place for dealing with surges in demand and to manage patients who experienced long waits were not effective. Clinicians said that they used to get a copy of the rota, so they could see whether there were any shifts which required covering, but this no longer happened. They also said that requests for extra staff were made with short notice and not as previously experienced at the start of the working week.

The system for incentivising extra shifts was not effective and led to some staff feeling undervalued There were no incentives offered for non-clinical staff to work extra hours at short notice.

Requires Improvement

# Are services safe?

Since September 2021 the provider had introduced a clinical shift commencing in the early hours of Monday mornings to address delays. However, staff reported that by this time the backlogs in calls had been building up since the Saturday afternoon and this early morning shift was not effective in reducing the numbers of call needed significantly.

These factors had led to delays in patients receiving call-backs for an assessment of their condition. Information from the provider showed that for the period April 2021 to September 2021 the target of 95% or above of calls to patients on weekdays for urgent call-backs within 20 minutes was not met. Data showed that achievement ranged between 67.23% and 88.13% during the week, with an emerging trend of deterioration in meeting the targets. Data for the same period for urgent call-backs to patients on weekends and bank holidays ranged between 18.99% and 89.95%.

Information received from the provider showed that some patients waited over 24 hours for a call-back. Examples of this occurring were also provided by staff during our inspection.

- There was an 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. However, records showed that 12 out of 79 non clinical staff had not received training in identifying sepsis.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.

**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 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 referrals in line with protocols and up to date evidence-based guidance.

**Appropriate and safe use of medicines**

There were shortfalls in systems and arrangements for managing medicines, including prescription stationery and controlled drugs.

- The service had ineffective systems to ensure prescription stationery was kept securely and monitored appropriately. There were six examples detailed in the service's Datix related to handling of prescriptions and medicine management. In particular, an incident occurred in July 2021 regarding missing prescriptions, this incident was not reported until August 2021. Comments on lessons learnt included that it was 'easy for staff to lose count of paper prescriptions when too many were in use at one time'. There was no reference as to whether the two missing prescriptions were located. Actions for the incident included reducing the amount of blank prescription pads in place. The provider was unable to provide evidence that this had been completed.
- In November 2021 there were two Datix incidents reported which related to security of prescriptions and identification of discrepancies related to missing prescriptions. Prescriptions had also been left in a printer when the consulting room was unlocked, which did not demonstrate that the process for only one prescription being issued at a time by reception had been followed.
- Arrangements were in place to ensure medicines and medical gas cylinders carried in vehicles were stored appropriately. We found evidence of one occasion when these arrangements were not fully effective. An incident

occurred where a clinician failed to sign a quantity of morphine correctly back into base. The morphine had been found in a prescription safe, rather than the controlled drugs storage The clinician was spoken with and all relevant staff who handled controlled medicines were reminded of the correct procedure. We were told that a clinician may have taken a risk with medicine security to try and save time when seeing patients in base.

- 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.
- The service carried out regular medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing. We requested information on medicine prescribing audits and found that no information was provided on how this information was used to improve performance and what actions were being taken to ensure that medicines were being prescribed appropriately and when needed. For example, when medicines usually used in palliative or end of life care were being prescribed, there were comments on the cost of the medicine, the quantity and whether it was the responsibility of the out of hours service (OOH) to prescribe. There was no information on whether the service had considered the patient's condition and the care and treatment they required, which might have included prescribing these types of medicine, to ensure symptoms such as pain and sickness were effectively controlled.
- Processes were in place for checking medicines and staff kept accurate records of medicines.

**Track record on safety**

The service had a good safety record.

- There were risk assessments in relation to safety issues.
- There was a process in place for regular and ongoing driver assessments.
- Each base had been risk assessed; documentation showed that there were no concerns identified from these assessments. Processes were in place to monitor risks at bases.
- There were some operational issues outside of the provider's control which required other partners or stakeholders support to fix or remedy. For example, access to one of the out of hours bases at night and the need for patients and staff to walk through poorly lit areas. The provider was in discussion with the premises managers to improve safe access for patients and staff.
- Another issue related to emergency pull cords in one of the hospitals used as a base not being active during the out of hours period. The provider had spoken with the hospital to get this addressed after a serious incident, but it was not addressed, and another incident occurred where emergency assistance was needed, and the emergency cord system had not been reset. The provider said that this issue had now been resolved.
- 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.
- There was a system for receiving and acting on safety alerts.
- Joint reviews of incidents were carried out with partner organisations, including the local A&E department, other parts of the Practice Plus Group (PPG) organisation and the NHS 111 service.

**Lessons learned and improvements made**

The service was not able to demonstrate fully how it learnt from and made improvements when things went wrong.

There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses.

Requires Improvement

# Are services safe?

The systems for reviewing and investigating when things went wrong needed improvements to ensure patient safety at all times. The service was unable to fully show how lessons learned were shared effectively with all relevant members of staff and how actions taken improved safety in the service.

The provider had only one significant event recorded during the past 12 months. This related to a request by the ambulance service for the out of hours (OOH) service to review contact with a patient who later died after having a cardiac arrest.

The provider's policy on significant events stated a serious incident was one which will either require life-saving or major surgical/medical intervention, will shorten life expectancy or will result in prolonged pain or psychological harm. If needed an investigation would be started to determine whether an incident had met the threshold to be categorised correctly. There was also the expectation that providers and commissioner should engage in open and honest discussions to agree an appropriate and proportionate response.

The provider maintained a log of incidents, known as Datix. Datix records showed that between August 2021 and 1 December 2021 there had been 78 incidents which included:

We saw an example of where the provider identified that a failure in clinical assessment had contributed to the death, but following an incident review conference call the providers did not feel it met the threshold of being classed as a serious incident. This was in contrast to information received in the serious incident policy about what is considered to be a serious incident.

We saw another similar example in the management of someone who had been given advice to call if their condition worsened but subsequently ended up being admitted to hospital with a life-threatening condition.

Some of the examples had been received by the service in the form of a complaint. Such as: A complaint alleging there was a missed diagnosis of a life limiting condition, which was diagnosed by another service. The disease was found to have spread and the patient was put on end of life care. The recorded action by the provider was sharing learning of the incident with the clinicians involved.

Requires Improvement

# Are services effective?

**At the previous inspection we rated the provider as good.**

**At this inspection we rated the service as requires improvement for providing effective services because there had been a decline in delivering effective care and treatment for patients.**

**Effective needs assessment, care and treatment**

The provider had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians usually 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 people's needs were met. The provider monitored that these guidelines were followed.
- Patients' needs were assessed. This included their clinical needs and their mental and physical wellbeing. However, we found shortfalls in assessments of patients' needs. Such as, one patient who was immunocompromised and was seen by an ambulance crew who requested a home visit by another clinician, being re-triaged as self-care advice. Another patient who was experiencing abdominal pain, a raised pulse rate and cold sweats was triaged as a routine call back. This potentially could have led to a delay in appropriate care and treatment.
- Care and treatment was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. Such as, special notes for end of life care and safeguarding information.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to respond to repeat patients and information was included in their records to enable coordinated care.
- 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**

Gloucestershire OOH used the National Quality Requirements (NQR) for OOH 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.

We reviewed data for the period November 2020 to September 2021:

- The percentage of urgent calls triaged within 20 minutes ranged from 81% to 95% against a target of 95%. There had been consistency of performance during this period.
- The percentage of urgent and routine calls triaged within 60 minutes ranged from 42% to 97% against a target of 95%, with a deterioration in performance from May to September 2021.
- The percentage of routine calls triaged within two hours ranged from 56% to 98% against a target of 95%, with a deterioration in performance from May to September 2021.
- The percentage of patients who required an urgent response and consulted within two hours ranged from 95% to 77%, against a target of 95%. There had been a drop in performance from April to September 2021 with an average achievement of 82.5%.
- The percentage of patients who did not require an urgent response and consulted within six hours, ranged between 95% and 99% and performance was stable.

Requires Improvement

# Are services effective?

- Calls volumes during November 2020 to September 2021 ranged from the lowest with 4689 in February 2021 to the highest with 7374 in May 2021. Calls volumes on average were 5998 per month.

Where the service was not meeting the target, the provider had put actions in place to improve performance in this area. This included closing bases and redeploying staff to other sites and getting clinicians to work remotely. However, this resulted in increased journey times for patients and poor management of call queues which resulted in a backlog of calls waiting to be actioned. For example, on Saturday 6 November 2021 there were 68 patients waiting for an assessment by the clinical assessment service (CAS service) and 62 patients waiting for a face to face appointment at 8am in the morning. On Sunday 7 November 2021 at the same time there were 60 patients in the CAS queue and 69 patients waiting for a face to face appointment. Staff reported that this situation was not unusual and in their experience occurred on a regular basis.

- The service had a programme of quality improvement activity and reviewed the effectiveness and appropriateness of the care provided. These audits included call handling, prescriptions and quality of notes taken during calls.
- The service made improvements through the use of completed audits. However, the provider was unable to fully demonstrate how service provision was changed as a result of these audits. For example, an audit of clinicians' notes did not have actions recorded to improve performance. Shortfalls identified in clinical record audits included limited patient history, no safety netting advice given, and allergies being asked about.
- Medicine management audits did not have details of any actions taken when concerns were identified, such as when a medicine was prescribed for use in a syringe driver (a piece of equipment that is often used in palliative care patients for pain control); it was identified as a medicine that had potential for misuse and one that potentially should not be prescribed in the OOH setting. Other medicine used for the treatment of patients living with dementia had notes which queried why it was being prescribed in the OOH setting, even though it was a repeat prescription request.
- There was no information on the circumstances of these patients contained in the audit to provide context to the prescribing decisions to determine whether they were necessary and appropriate. The provider was unable to demonstrate how the information from medicine audits was used to change or improve prescribing when needed.

**Effective staffing**

- Frontline operational staff which included receptionists and coordinators were overseen by an operations manager who had line management responsibility for a total of 47 members of staff. They were expected to carry out annual appraisals for employed staff; oversee the rotas; carry out one-to-one supervision meetings and undertake audits as part of their duties. Plans were in place to recruit another OOH manager to take over the call centre management. 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 newly appointed staff. This covered such topics as infection control, health and safety and safeguarding.
- There was a programme of training which the provider considered was necessary for all staff, including bank and agency staff. Although, training opportunities were limited to staff directly employed by the service.
- Staff who responded to our survey and who we met on the site visit said that due to the fact they were not directly employed they were unable to access the provider's learning system. They added that as sessional staff who worked in a variety of settings, it was not always easy to access training to maintain their competence. The provider's training policy stated that all staff, including locum staff were to have completed the required training and if needed were able to access the provider's learning modules.
- After the inspection the provider informed us that there were processes in place for bank staff to access the learning system, however we did not see evidence to fully confirm that this had been sent to all staff.
- Managers reported that staff had one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation.

Requires Improvement

# Are services effective?

- There was an appraisal system in place and employed staff who responded to our survey said they had had an annual appraisal. However, staff said that on occasion they had been given short notice of their appraisal and did not have time to prepare. They added written feedback or objectives to meet as a result of the process were not provided.
- The provider was unable to demonstrate fully how the arrangements for supporting and managing staff when their performance was poor or variable were put in place. There was some evidence of shared learning in newsletters and emails, but it was not specific to the OOH service. Details on what actions were needed as a result of audits of staff performance were not consistently recorded.

**Coordinating care and treatment**

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

- We saw records that showed 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 practice, so 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.
- 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 OOH service. An electronic record of all consultations was sent to patients' own GPs.
- The service ensured 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 required them.
- There were arrangements in place for there to be an overlap between shifts to enable coordinators to pass on relevant information.
- We asked the provider to provide us with details of calls they handed back to the in hours GP practices as there had been concerns around this. The provider reported that there were only three occasions dating from May 2021 when calls were handed back:
- On 11th October the clinicians working stayed as long as they could but were unable to complete all call backs to patients, so thesewere handed back to the in hours GP practices.
- At 6am on the morning of 1 November there were 81 patients waiting for call backs with five clinicians working and 69 were handed back. The number of shifts filled was 86% at this time.
- On 7th November 2021 at 6am there were 51 patients waiting for call-backs with five clinicians working, an extra clinician had been employed overnight but there was also a member of staff who had to go off sick, this resulted in 38 calls being handed back. Shifts filled was 82% at this time.
- The provider stated that there had been no calls handed back since 8 November 2021.

**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 those who may need translation services.

Requires Improvement

# Are services effective?

- Where appropriate, staff gave people advice so they could self-care. Systems were available to facilitate this.
- Risk factors, where identified, were highlighted to patients and their normal care providers so additional support could be given.
- 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.
- 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 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.
- The provider's trend report for 1 November 2020 to 24 October 2021 for patient feedback received showed that most patients who responded to a short survey post consultation, considered they were treated with respect. Patients also considered they were listened to during their consultation. Comments included staff were compassionate and empathic to patient needs.

**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 speak English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them. Information leaflets were available in easy read formats, to help patients be involved in decisions about their care.
- 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 respected confidentiality at all times.
- 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.

Requires Improvement

# Are services responsive to people's needs?

**At the previous inspection we rated the provider as good for providing responsive services.**

**At this inspection we rated the service as requires improvement for providing responsive services because patients were not always able to access care and treatment from the service within an appropriate timescale for their needs..**

**Responding to and meeting people's needs**

There were shortfalls in organising and delivering services to meet patients' needs.

The provider understood the needs of its population and tailored services in response to those needs. The service provided out of hours support to four 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. Changes had been made to the way patients accessed out of hours treatment centres due to the COVID-19 pandemic. Patients were asked to wait in their cars and the receptionist would then see them in the car to check their details, before inviting them in to see a clinician for their appointment.

**Timely access to the service**

Patients were not always able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients were usually able to access care and treatment at a time to suit them. The service as a whole operated from 6.30pm to 8pm Mondays to Friday and 24 hours a day on weekends and bank holidays. There were different opening hours for some of the bases and these were displayed on the provider's website.
- However, over the past four months, there were only two treatments centres open consistently through this time and these may not be the most local to a patient. This meant that travel times for some patients would take longer than the 30 minutes specified in the contract the provider had with the clinical commission group.
- Patients could access the out of hours service via NHS 111. 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. All 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. Patients did not consistently have timely access to initial assessment, test results, diagnosis and treatment.

We saw the most recent local and national key performance indicator results for the service for the period November 2020 to September 2021 which showed the provider was meeting the following indicators:

Requires Improvement

# Are services responsive to people's needs?

- The percentage of patients with urgent care needs visited within one hour was 100% for this time period. With one exception reported in May 2021, where the percentage was recorded as 0%.

For the same period the provider was not meeting the following indicators:

- The percentage of patients with urgent care needs visited within two hours ranged from 71% to 95% against a target of 95%. Performance during the period April to September 2021 was consistently below 95%.
- The percentage of patients with routine care needs visited within six hours, ranged from 82% to 96% against a target of 95%. Performance during the period April to September 2021 was consistently below 95%.

Where the service was not meeting the target, the provider was aware of these areas but there were limited attempts made to improve performance. The provider stated that it was due to staffing shortages that bases were not open and the impact of the COVID-19 pandemic. However, staff told us that there were delays in filling rotas and shifts were cancelled at short notice by the provider. Incentives to attract staff to work were offered sometimes as late as midday on the day that an evening shift needed to be filled. We also had reports that queues built up on the weekends and by the time extra staff were sourced there was no way to effectively clear the backlog created.

We noted from rotas that staff started work in the early hours of Monday mornings to assist with triaging the call queue, but patients did not always answer the telephone, had sought help from another service, or decided to wait until their own GP practice was open.

There were systems in place to manage waiting times and delays, but these were not effective. A clinical navigator monitored the call queue to identify patients with the most urgent needs and when necessary reprioritised their care and treatment. However, staff shortages and a lack of treatment centres which were open impacted on the service's ability to reduce waiting times effectively.

There were incidents where patients had been adversely affected by a delay, such as a young child who was unwell and was triaged as a routine call by the NHS 111 service; the call back was undertaken after 14 hours. This was only identified by a clinician who was looking at the routine call list for any concerning cases. Another delay occurred when a patient presented with symptoms of a stroke to the NHS 111 service and was allocated a call back instead of an emergency ambulance. These events were not captured as significant events or more widely investigated to determine whether improvements could be made in monitoring the call queue and discussions could be had with the NHS 111 service about any potential shortfalls in their systems.

Where people were waiting a long time for an assessment or treatment there were arrangements in place to manage the waiting list and to support people while they waited. The service undertook 'comfort calls' to inform patients of delays and these were documented on their records. We saw the quality of information held varied, even though there was guidance on what should be recorded. The provider's policy stated that an apology should be given to the patient and an explanation of what would happen if their condition had not worsened. If a patient's condition worsened, then patients should be contacted by a clinician as soon as possible to assess the patient. When calls to patients were not answered call handlers should then instigated service's protocol of uncontactable patient and make further attempts to contact them.

We looked at data on comfort calls made between August 2021 to the end of November 2021. Some entries stated that comfort calls were attempted, but no answer and others had more detailed information such as whether the patient's conditions had worsened. The provider was unable to demonstrate that their policy when calls were not answered was implemented.

Requires Improvement

# Are services responsive to people's needs?

Staff also reported that when carrying out comfort calls, due to the time delay patients would often agree for their call to be handed back to their own GP practice. Such as when patients who needed to be triaged were called at 6am and the waiting time was no longer than the two hours before the in-hours GP opened.

After the inspection the provider implemented a system of auditing comfort calls to review the quality and consistency of these calls.

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. 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**

Information about how to make a complaint or raise concerns was available.

- The complaint policy and procedures were in line with recognised guidance. A total of 35 complaints were received in the last year. We reviewed a sample of these fully and looked at the provider's complaints log which had a summary of all complaints. Improvements were needed to ensure that the provider could demonstrate fully how a complaint had been handled with reasons as to why the complaint was upheld or not.
- There were some complaints related to poor outcomes for patients such as when a patient was unwell. They were told by the NHS 111 service when they rang them initially to seek help from their GP when they were next open over 24 hours later. The patient's condition deteriorated so they phoned the NHS 111 service again and were given a disposition (outcome) for a GP to contact them within an hour. This call-back was not made within the designated timeframe and the patient was given a face to face appointment for that evening. The patient attended for the appointment but had to wait a further four hours after the appointment time before being seen. At this stage the patient was extremely ill and had developed sepsis which required a hospital stay of five days. This was not classed as a significant event by the service and actions taken included providing feedback to staff and to share learning, but there were no specific details on what learning was needed and how it would be delivered.
- The service was unable to demonstrate fully how lessons learned from individual concerns and complaints, and also from analysis of trends, were used to drive improvements where needed. There was a designated member of staff who was responsible for managing complaints and Datix incident reports. This member of staff had a regional role and was responsible for two other registered services within the provider (Practice Plus Group). Information regarding any actions taken in response to complaints received by Gloucestershire OOH service was not easily identifiable in documents supplied to us as part of this inspection. The provider was therefore unable to demonstrate fully how it assured themselves that incidents and concerns were handled appropriately. Themes and trends were included in the complaint log and covered areas such as staff attitude during calls; not being seen face to face; poor communication on home visits; and delays in call backs of up to 24 hours; and misdiagnosis.
- The provider did not maintain a separate complaints log and had collated the information manually specifically for the purpose of our inspection. Regular meetings were held where complaints were discussed, but these were not fully minuted to demonstrate what was discussed and what actions would be taken to address concerns.

Requires Improvement

# Are services well-led?

**At our inspection in August 2019 we rated the service as requires improvement for leadership, because:**

- A 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

**We rated the service as requires improvement for leadership. This was because the issues found at the previous inspection remained.**

**Leadership capacity and capability**

**Leaders could not fully demonstrate that they had the capacity and skills to deliver high quality sustainable care**

The provider reported the management structure was now more stable, although we found some staff were interim and had responsibility for large areas of work. For example, the out of hours operations manager who covered three counties and line managed 70 staff. Staff on the frontline reported a disconnect between senior leaders and themselves. Examples provided to us included a lack of action by leaders on suggestions made by staff such as those related to skill mix and improving performance.

Feedback from staff about the leadership team was mixed with some reporting positive interactions with their managers and others less favourable.

Some staff said there was limited autonomy at a local level and decisions were made at regional or national level.

Improvements were needed to deliver the service strategy and address risks to it. We found there was a reactive approach to risk and limited use of themes and trends identified from performance information, incidents and complaints to drive improvements.

Feedback included that leaders were not always visible at a local level and meetings tended to be region based and difficult for staff to attend. Senior leaders said they visited bases, but this was not achieved in a planned way to enable effective engagement with staff. There were elements of positive team working at local levels but not across all organisational levels.

We also received reports from staff of feeling bullied and favouritism by managers. Some described the managerial style as controlling. However, we also received positive comments including leaders were approachable and helpful, and staff were confident that any concerns would be discussed openly and addressed. Eight of the 21 members of staff who answered our survey were positive about managers.

**Vision and strategy**

Staff were aware of the vision and values of the services but did not consider that it was evident in practice and felt that this needed to be embedded. Respondents to our survey and staff we spoke with considered that effective governance systems were needed to link the values and vision to the work carried out.

Requires Improvement

# Are services well-led?

Some staff who worked remotely or on a bank or agency basis did not feel engaged in the delivery of the provider's vision and values.

The service provision was not routinely planned to meet the needs of patients, for example closure of bases meant patients had to travel further for face to face appointments.

The strategy for the service was not specific to Gloucestershire Out of Hours provision but was part of the overarching business model of the provider organisation as a whole.

**Culture**

**Improvements were needed to ensure there was a culture of high-quality sustainable care.**

The majority of respondents to our survey were aware of what whistleblowing was and where to find the policy. The majority also expressed they did not feel confident in speaking up or using the whistleblowing procedure. Comments on why they would not use the process included that the organisation would find a way to terminate their employment if they spoke out. The designated Freedom to Speak Up Guardian was based at a national level and there was no local person staff could speak with.

Senior leaders considered the culture was more open and transparent now and learning from a whistleblowing investigation earlier in the year had increased communication with staff. As part of the outcome of the investigation the provider considered that the whistle-blowers did not understand how an OOH service worked.

They also said that staff wellbeing was paramount and gave an example of supporting staff who were subject to abusive behaviours from patients.

Staff who responded to our survey had mixed views on communication between senior leaders, managers and staff. There were comments that they considered senior leaders to be focussed on finances and profit, rather than providing care and treatment to meet patients' needs. These comments included closure of bases and poor management of staffing rotas. Other comments included not being involved in decision making and not receiving explanations as to why certain aspects of their role needed to be done. Staff also reported a lack of response to emails and their concern they were perceived by senior leaders and managers as 'moaners'. This had led to poor morale amongst some staff. These views were also reflected in our conversations with staff at the time of the site visits.

For example, comments from our staff survey included a 'positive spin' being placed on what was happening on the front line and a disparity between terms and conditions, and rewards for working hard. Such as when non-clinical staff were sent home with no pay when their shifts were cancelled at short notice, due a clinician not being available.

Positive views received about the culture included clinical staff being focussed on patient need and getting care and treatment right to meet patient need. Positive team working at a local level and staff remaining calm when under pressure and workload increased. Some staff considered that they were able to develop and progress within the organisation. Staff considered they were supported by their immediate team members and local managers.

**Governance arrangements**

Governance arrangements did not support the delivery of a safe, effective and well led service in a consistent manner. Systems did not easily enable a view of service performance at a local level. The provider was not able to fully

Requires Improvement

# Are services well-led?

demonstrate what was happening at a local level. Information on service performance and governance of the out of hours service was not easy to gather as there was joint working with other parts of the provider's group of organisations. Information required at the local level could be extracted but this was a time-consuming process. For example, we were told the complaints log we saw for evidence was created specifically for the purpose of our inspection.

There were systems and processes for governance of the service provided which included training provision, performance and audits of clinical work, but these were not fully effective to ensure that a safe service was provided.

Systems and processes for ensuring all staff have received an appraisal had shortfalls in demonstrating these were used for improving and maintaining staff performance. Staff who worked on a bank or agency basis were not provided with consistent feedback on their work. Comments from our survey included that an appraisal had not been undertaken, and staff thought this was because they were self-employed. Other comments from employed staff said that they had received appraisals via telephone calls and the documentation to support the telephone conversation was not reflected accurately. Staff did not routinely receive the outcome of their appraisal and the structure was poor, as no objectives were documented, and short notice was given of the appraisal.

Comments we received included; more clinical staff were needed; documentation and communication needed to be effective; and there needed to be a consistent approach to concerns raised with feedback provided and appropriate actions taken.

**Managing risks, issues and performance**

Systems and processes to manage risk were applied inconsistently and learning was not always shared effectively and acted upon. There was a lack of clarity on how significant events and risk were identified and managed, to show how risks to patients was minimised.

There were regular meetings to discuss demand and capacity in relation to workforce planning, but insufficient action had been taken to improve rota fill and provide a service which met patient needs in an effective way. Performance over time showed there were delays in providing call-backs to patients and ensuring that call queues were effectively managed. Rota fill was reactively managed, with limited forward planning to ensure there were sufficient staff available to open as many bases as possible. The provider said that bases were not used due to staff shortages and the clinical commissioning group who contracted the service were aware of this. However, we found times when bases were closed, when rota fill was at 91%.

The provider told us that usually there were up to six cars available for home visits at weekends and they aimed to have at least three operational, but there were times when only one car was available, and the clinician had to drive themselves.

Reports were compiled on areas such as complaints, significant events, patient feedback and training and presented to the board. Systems for managing significant events were internal and we identified concerns from complaints which were potentially significant events, when considered in line with the guidance the service used but were not managed as such.

The provider was unable to demonstrate fully how information from medicine audits and clinical audits was used to drive improvements. There was a lack of detail on whether actions to share learning had been completed. The monitoring of actions taken did not fully reduce the risk of a similar incident occurring again, such as prescriptions going missing. Another event which occurred and was handled internally related to prescribing by a clinician. The provider said that the

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# Are services well-led?

concern had been taken to the internal responsible officers who decided that a referral to the relevant professional body was not required. After the inspection the provider wrote to us and gave an explanation that the national employer liaison officer had regular contact with the relevant professional body, who had advised that a referral was not needed, and previous referrals the organisation had made were appropriate.

The process to identify, understand, monitor and address current and future risks including risks to patient safety required improvement to ensure they were effective.

We identified key trends in performance management, which included delays in patients receiving care and treatment. Staff reported to us anonymously that they had experienced times when 200 to 300 patients were awaiting call backs and when patients were telephoned back in the early hours of the morning cases were closed as there was no answer, or they learnt the patient had already gone to another service for treatment.

The triage pool at the service was designed so that cases could be received from other areas, such as London and the neighbouring county of Warwickshire. Clinicians said that they would be triaging these calls whilst there were long wait times for patients in Gloucestershire.

We received mixed views from staff regarding implementing changes, some said there were delays in implementing changes, other staff had a more positive response. Examples given included; increasing staff numbers to undertake comfort calls; and improving personal safety on home visits; but there had been delays in replacing IT equipment.

The provider had plans in place and had trained staff for major incidents.

**Appropriate and accurate information**

Information collated on performance was not used to drive improvement in performance. Staff said they had noticed on every weekend over the summer months there was a high number of call-backs which were delayed. Comfort calling had been introduced, but proactive actions to manage the queues had not been put into place. Staff said the queues were allowed to build up and requests for extra staff were not put out until Sunday afternoons, rather than employing extra staff on Saturdays to minimise delays as far as possible.

Comfort calling documentation was not consistent and details such as further actions needed, for example another call from a clinician was not detailed. There was guidance on what should be recorded, but staff were not effectively monitored to ensure it occurred. We requested information on comfort call audits and were provided with a list comfort calls carried out. There had been no analysis to showed whether there were any themes or trends, and what actions had been taken if there was a lack of detailed information.

Performance data we reviewed showed that overall achievement in meeting the required targets for call handling and providing care and treatment had declined since May 2021. Clinicians reported they had been asked to sign off calls to be passed back to in hours GP practices and there was no structured approach when the number of calls awaiting action were high. The provider was unable to demonstrate fully how they intended to improve performance.

There were 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**

Requires Improvement

# Are services well-led?

The service did not fully involve patients, the public, staff and external partners to support high-quality sustainable services.

Regular meetings to share information and learning were planned and carried out. However, staff who responded to our survey said there were issues with the times these were arranged for. For example, meetings were held during mornings and afternoons when staff were not working. Also, there were issues with local meetings being replaced with regional staff engagements. Concerns were also raised about emails being the main way of communicating. Newsletters were also produced but were not specific to the OOH service.

Staff said they were able to offer ideas to improve service provision based on their experience of working in other OOH services, but sometimes no response was received on whether it would be implemented. Other staff reported being listened to and action taken in response to their ideas.

The service had regular meetings with the clinical commission group about service performance.

**Continuous improvement and innovation**

The provider said there was a focus on continuous learning and improvement at all levels within the service. However, when we requested examples of this in relation to the running of the OOH services, we were provided with information on another service the provider was responsible for.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
|---|---|
| Transport services, triage and medical advice provided remotely<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014<br><br>**How the regulation was not being met:**<br><br>The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided.<br><br>**In particular:**<br><br>• There was a lack of clarity on when a complaint or incident should also be treated as a significant incident.<br>• Themes and trends from significant events were not effectively shared with staff, there were limited arrangements to cascade learning. There were limited monitoring systems to ensure that learning required had been understood and acted upon.<br>• The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.<br><br>Systems for continuous learning and improvement did not operate effectively, this included but is not limited to:<br><br>• Information from clinicians' performance and audits of service users' records was not used effectively to improve service performance and ensure care and treatment was provided in a safe way.<br>• Information from medicine audits was not used effectively to improve performance. |

This section is primarily information for the provider

# Requirement notices

The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to evaluate and improve their practice in respect of the processing of the information obtained throughout the governance process.

**In particular, but not limited to:**

- Themes and trends identified in performance data were not used effectively to drive improvements.
- There was a lack of focus in performance at a local level and the provider was unable to demonstrate fully how the service operated at a local level.
- The system in place for dealing with surges in demand and to respond to patients who experienced long waits were not effective.
- The service had ineffective systems to ensure prescription stationery was kept securely and monitored appropriately.
- Arrangements to ensure controlled were handled appropriately required improvement.

There was additional evidence of poor governance.

**In particular:**

Senior leaders were unable to demonstrate a thorough understanding of the responsibilities under the health and Social Care Act 2008.

Improvements were needed to ensure that performance was monitored and improved at a local level. This includes visibility of leaders and opportunities for staff to feedback effectively.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

| Regulated activity | Regulation |
| --- | --- |
| Transport services, triage and medical advice provided remotely<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>**How the regulation was not being met**<br><br>The registered person had failed to ensure that sufficient numbers of suitably qualified, competent, skilled and |

This section is primarily information for the provider

# Requirement notices

experienced persons were deployed in order to meet the requirements of fundamental standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

**In particular:**

The provider had allowed bases to be non-operational for long periods of time, even though staffing levels had not fundamentally changed over time.

The provider was not proactive in addressing staff shortages at times when a declining trend in performance was evident. Actions to improve staffing levels to provide a safe service were reactive and poorly implemented.

The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.

**In particular:**

Training considered mandatory by the service was not consistently monitored to ensure that it was completed as detailed in their policy. This included sepsis awareness training and ensuring all staff who worked for the service had access to and completed the required training.

This was in breach of Regulation 18 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.