Primary Care 24 (Merseyside) Limited

Inspection report

4-6 Enterprise Way
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Requires Improvement
Are services responsive to people's needs?	Good
Are services well-led?	Good

Overall summary

We undertook an announced comprehensive inspection at Primary Care 24 (Merseyside) Limited on 22 and 23 August 2023. We carried out this inspection to follow up on:

- A breach of regulation from a previous inspection in May 2022.
- Areas identified where we told the provider they should make improvements.

The full reports for previous inspections can be found by selecting the 'all reports' link for Primary Care 24 (Merseyside) Limited on our website at www.cqc.org.uk

We have rated this practice as Good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Requires Improvement

Are services caring? – not inspected, rating of good carried forward from previous inspection.

Are services responsive? – Good

Are services well-led? – Good

The key questions reviewed during this inspection on 22 and 23 August 2023 included:

- Safe
- Effective
- Responsive
- Well Led

We found that:

- Action had been taken to address the breaches of regulations identified at the last CQC inspection in May 2022.

At this inspection we found:

- The service had clear systems in place to keep people safe and safeguarded from abuse.
- The provider had reviewed the staffing arrangements to ensure that patient needs were met. This included increasing the number of clinicians working at the service and improving oversight of risk and performance, particularly during busy periods.
- The provider had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.
- The service had formalised systems with the NHS 111 service with specific referral protocols for patients referred to the Out of Hours (OOH) service. There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that required them.
- The provider understood the needs of its population and tailored services in response to those needs. To do this the provider engaged with commissioners to secure improvements to services, where these were identified.

Overall summary

- The provider monitored the performance of the time disposition which included monitoring clinical and operational staffing levels against planned levels. This was for telephone consultation, face-to-face appointments, and home visits.
- Patients with the most urgent needs had their care and treatment prioritised.
- The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.
- The provider had introduced several new leadership roles and new staff had been recruited to these.
- Openness, honesty, and transparency was demonstrated when responding to incidents and complaints.
- There were clear responsibilities, roles, and systems of accountability to support good governance and management. This included an effective process to identify, understand, monitor, and address current and future risks including risks to patient safety.
- The service involved patients, the public, staff, and external partners to support high-quality sustainable services.

Whilst we found no breaches of regulations, the provider **should**:

- Continue to monitor and improve service performance against the locally agreed Integrated Urgent Care key performance indicators.
- Further develop and use clinical audits, including two cycle audits as part of the organisations quality improvement processes.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a CQC operational manager, a GP specialist adviser and a CQC pharmacist.

Background to Primary Care 24 (Merseyside) Limited

Primary Care 24 Ltd (Merseyside) Limited is located in the head office at Roy Castle Lung Foundation Building, 4-6 Enterprise Way, Wavertree Technology Park, Liverpool, L13 1FB. The provider is a social care enterprise organisation.

The service is commissioned by Liverpool Place as the lead commissioner for OOH services across Cheshire and Merseyside. In total the organisation provides services to a population of 1.32 million patients in the out of hours period.

The organisation provides the following services for patients who contact NHS 111:

- An OOH service telephone triage, face-to-face appointment, and home visiting service for patients in Halton, Knowsley, Liverpool, Sefton (North and South), St Helens and Warrington. The OOH service operates from 6.30pm to 8am, Mondays to Fridays and 24 hours a day on weekends and bank holidays.
- A clinical assessment service for patients who would benefit from further assessment of their symptoms and clinical advice. This service is available every day, 365 days a year.

In addition, the organisation provides:

- An extended access appointment service with GP's and clinicians for patients in Knowsley and Liverpool. Patients are booked into these appointments via their own GP practice.
- A call answering and GP advice service from other healthcare professionals, on behalf of patients, who require further assessment from a clinician.

All services are coordinated from the Wavertree headquarters with face-to-face care being offered at the following locations across the commissioning areas. Some are not open every day but are available should the service be needed, and staffing levels allow:

- Old Swan Neighbourhood Centre
- Sefton Litherland NHS Treatment Centre
- Southport District General Hospital
- Formby Clinic
- Huyton Nutgrove Villa
- St Helens Lowe House, Primary Care Resource Centre
- Warrington Bath Street Health and Wellbeing Centre
- Wavertree
- South Liverpool Treatment Centre, Garston

Extended Access is also coordinated from Wavertree Headquarters, however there is a small number of clinicians that will undertake this work remotely at home. Face-to-face appointments are available from the following sites:

- Garston Walk in Centre, 32 Church Road, Garston, Liverpool L19 2LW. Monday to Friday 6pm to 11pm.
- Townsend Health Centre, 98 Townsend Lane, Anfield, Liverpool, L6 0BB. Monday to Friday 4pm to 10pm, Saturday 9am to 4pm.
- Whiston Primary Care Resource Centre, Old Colliery Road, Whiston, Prescot, L35 3SX. Thursday 10am to 2pm.
- St Chads Clinic, Kirkby, 132 St Chad's Drive, Kirkby, Liverpool, L32 8RE. Monday, Wednesday and Friday 10am to 2pm, Saturday 10am to 3pm.

During the inspection we visited Lowe House Primary Care Resource Centre, 103 Crab Street, St Helens, WA10 2DJ and Wavertree Headquarters.

The service operates against nationally and locally agreed Integrated Urgent Care key performance indicators which are monitored by commissioners monthly.

The provider is registered to provide the following regulated activities:

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

Good

Are services safe?

At the last inspection in May 2022, we rated the practice as requires improvement for providing Safe services because:

- Not all staff had received up-to-date safeguarding training for their role.
- There were periods of staff shortages which were not addressed in a way that ensured peoples safety was always protected. For example, during busy times, particularly weekends and bank holidays, patients awaiting call backs from GP's and clinicians experienced long delays. This was a regular occurrence which the provider flagged as a risk.

At this inspection we found the provider had taken action to address the required improvements and we have rated the service as good for providing safe services.

Safety systems and processes

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

- The provider conducted safety risk assessments. The service had safety policies, including Control of Substances Hazardous to Health and Health & Safety (COSHH) 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. For example, multi-agency meetings were held when safeguarding investigations took place and identified improvements could be made to services. 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. 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).
- At the last inspection, the provider did not ensure that all staff received up-to-date safeguarding training, appropriate to their role. At this inspection we found 100% compliance for all staff for children's and adult level 3 safeguarding training. Since the last inspection the provider had implemented new lead roles for safeguarding, a safeguarding nurse facilitator and a new safeguarding champions role were now in place.
- Evidence provided showed an increase in the number of safeguarding cases reported by staff where concerns had been identified. The provider undertook regular audits of all safeguarding concerns reported by staff. Staff we spoke with 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. On-going audits were in place to monitor infection prevention and control risks. There was sufficient access to personal protective equipment (PPE) for staff, cleaning equipment and hand sanitizer. Infection prevention and control protocols, policies and procedures had been updated throughout the Covid-19 pandemic including the use of PPE to protect staff and patients attending the service. The service had a reporting system in place to capture infection control risks for patients and staff.
- The premises were clinically suitable for the assessment and treatment of patients and the number of locations providing this service, could be expanded during peak periods of activity. Facilities and equipment were safe, and 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.

Good

Are services safe?

- At the last inspection the service had expanded across a wide geographical area. The service also had faced significant challenges recruiting clinical staff, which had a considerable impact on patient experience and safety during busy periods.
- At this inspection, the provider had reviewed the staffing arrangements to ensure that patient needs were met. This included increasing the number of clinicians working at the service, improving oversight of risk and performance to ensure resources were appropriately used, particularly during busy periods. Records showed the rota fill had remained strong across the past year with over 95% of clinical hours covered.
- 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. They 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. Systems were in place to manage people who experienced long waits or who had been inappropriately transferred into the service.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse. A new system had recently been introduced to notify patients that their information had been received and patients would be sent a text message when calls had been made and not answered.
- 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. A target was monitored whereby a patient's GP should be notified and information shared about their condition by 8am the following morning. Performance data shared with us showed that this target was mostly met between April 2022 and March 2023.

Safe and appropriate 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.
- The service carried out regular medicines audits to ensure prescribing was in line with best practice guidelines. For example, a recent audit undertaken into drug seeking behaviour.
- 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.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately.
- Palliative care patients were able to receive prompt access to pain relief and other medication required to control their symptoms.

Track record on safety

Good

Are services safe?

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- 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 local A&E departments, ambulance services, NHS 111 service and other urgent care services.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- Improvements were made to the reporting of significant events and serious incidents following the last inspection. Weekly patient safety meetings had taken place for some time and feedback forms were now used to update staff about the investigations and outcomes they had reported. These included actions taken to prevent a reoccurrence. Several examples were shown to us to demonstrate how the service made improvements when things had gone wrong.
- Staff understood their duty to raise concerns and report incidents and near misses. Minutes of meetings showed the lessons learnt and improvements made. For example, accessing a patient's main medical record for their contact details when they were uncontactable on the details provided.
- 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.
- The provider took part in end-to-end reviews with other organisations. Learning was used to make improvements to the service. For example, in March 2023 the provider undertook a review of the operating model to ensure it matched the needs of the population they served. The outcomes of the review demonstrated the need for change with a proposed solution, including improving access to face to face appointments.

Requires Improvement

Are services effective?

At the last inspection in May 2022, 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 as indicated by the services ability to comply with the National Quality Requirements (NQR) for out-of-hours providers.
- In terms of the patient journey there were missed opportunities for working with other services such as hospital Trust's and NHS 111 to co-ordinate services more effectively.

At this inspection we found that the service used locally agreed Integrated Urgent Care key performance indicators. The service had improved a number of indicators relating to responding to patient need. However, some still required further improvement to be demonstrated over time. We have rated the service as requires improvement for providing effective services.

Effective needs assessment, care, and treatment

The provider had systems to keep clinicians up to date with current evidence-based practice. We saw 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. For example, the provider proactively assessed the quality of clinicians work via audits of case notes against agreed standards from the Royal College of General Practitioners.
- Telephone assessments were carried out using a defined operating model. Staff were aware of the operating model which included the use of a structured assessment tool before the transfer of calls from the call handler to the clinician.
- Patients' needs were fully assessed. This included their clinical, mental health and physical wellbeing. Patients with the most urgent needs had their care and treatment prioritised. The service had recently introduced a 'streaming' system to facilitate prioritisation according to clinical need, where more serious cases could be assessed more quickly if needed.
- Care and treatment were delivered in a coordinated way, which considered the needs of those whose circumstances may make them vulnerable. For example, older patients, patients with a learning disability or having palliative care needs, those with poor mental health, infants under 6 months old and patients without transport.
- Local commissioners undertook quarterly evaluations of the prescribing of clinical staff. This included individual non-medical prescribing data being reviewed against declared competencies. The reviews particularly focussed on antibiotics, non-formulary, hospital only drugs, and use of controlled drugs. If any issues were identified these were fed back to the chief pharmacist for further investigation and action.
- Arrangements were in place to support patients with particular needs. For example, palliative care patients who might need to contact the service frequently. This information was recorded in a Special Patient Note (SPN) and care plans were in place for patients to ensure the appropriate support was provided. 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 a clear explanation was given to the patient or person calling on their behalf.
- Technology and equipment were used to improve treatment and to support patients' independence. The provider ensured staff were using the latest version of triage software and the service had recently started working with a technology company to improve the functionality in the call centre. This included processes to telephone patients based on their clinical need and priority and managing calls that were not answered.
- Staff assessed and managed patients' pain where appropriate.

Requires Improvement

Are services effective?

Monitoring care and treatment

The provider monitors the service by using locally agreed Integrated Urgent Care (IUC) key performance indicators (KPIs). Providers report monthly to local commissioners on their performance against the KPIs 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 April 2022 to March 2023 and the results showed some improvements to performance were needed. For example:

- The percentage of urgent calls who had received a telephone clinical assessment within 20 minutes ranged from 64% to 82%.
- The percentage of urgent calls who had received a telephone clinical assessment within 60 minutes ranged from 16% to 52%.
- The percentage of urgent calls who had received a telephone clinical assessment within two hours ranged from 11% to 54%.
- The percentage of urgent calls who had received a telephone clinical assessment within 4 hours ranged from 14% to 60%.
- The percentage of urgent calls who had received a telephone clinical assessment within 6 hours ranged from 34% to 63%.
- The percentage of urgent calls who had received a telephone clinical assessment within 12 hours ranged from 29% to 81%.
- The percentage of urgent calls who had received a telephone clinical assessment within 24 hours ranged from 52% to 87%.

Information was shared with CQC to show the provider has implemented an action plan to reduce delays and to improve patient safety. Some of the actions included, in a new patient flow system, introducing streaming pathways, the introduction of a new paediatric pathway pilot and working with systems partners in an integrated way to ensure that patients who require more urgent assessment within the community were streamed to the relevant service.

The provider undertook a comparison of the performance for the average time to first contact in June and July 2022 and the same months in 2023. Information presented showed that improvements were made for the average time it took to make first contact with patients. Over the last 12 months the data showed improved response times for 4 of the 8 indicators which demonstrated patients were contacted within the assigned clinical priority.

The provider was meeting the following national performance indicators:

- The percentage of patients who required an urgent response and were consulted within two hours at an appointment centre ranged from 88% to 99%, and performance was stable.
- The percentage of patients who did not require an urgent response and were consulted within six hours at an appointment centre, ranged between 97% and 99% and performance was stable.
- Case details sent to the patients GP by 8am next working day ranged from 98% to 100%.

The provider was aware of areas where performance improvement was required, and we saw evidence that attempts were being made to implement improvements to service performance.

- The provider had made improvements to the service to enhance the patient experience. For example, staff could send text messages to patients with details of appointment times and when telephone calls were not answered.

Requires Improvement

Are services effective?

- Shift leaders monitored the service activity and could staff accordingly to meet demand during the busy times. Data presented showed there has been a recognised reduction in the number of incidents being reported around excessive delays and breaches.
- Some cases sent through to the service were not appropriate and the provider was working with NHS 111 to resolve this.
- The service made improvements through the use of completed audits and reviews. There was clear evidence of action to resolve concerns and improve quality. We were shown an audit cycle plan which outlined quality improvement reviews based on indicators including incident and complaint themes and the implementation of quality improvement initiatives. The report highlighted audits that were undertaken for antibiotic prescribing for patients with sore throats, antibiotic prescribing for acute otitis media in line with NICE guidelines and safeguarding audits relating to issues reported.
- The provider told us they had plans to raise the profile of the audit and effectiveness department, and this would improve the uptake for 2 cycle audits which were not taking place at the time of inspection. A clinician had been recruited to lead on clinical audit and effectiveness. A new audit proposal form had been developed and shared with clinicians throughout the organisation to propose future audits.
- The service was actively involved in quality improvement activity, and we saw numerous examples of this. For example, audits of clinician consultations with patients took place on a regular basis. Learning from these reviews, amongst other matters, were shared with all staff via a monthly staff newsletter.
- External assurance reviews took place by other agencies and action plans were monitored to make improvements.

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 newly appointed staff. This covered such topics as the services systems, processes and health and safety matters.
- The provider ensured that all staff 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 mandatory training were maintained. Staff were encouraged and given opportunities to develop and all staff we spoke with were positive about the support they received.
- All staff were provided with ongoing support. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision, and support for revalidation. The provider could demonstrate how they ensured the competence of staff employed in advanced roles by auditing their clinical decision making, including for non-medical prescribers.
- There were a number of ways that clinical staff received supervision and support. This included operating a clinical guardian policy where individual clinicians case and performance data were reviewed. The provider had a process to support clinical staff who were experiencing difficulties. Safeguarding peer supervision sessions were regularly held, and staff champion roles had been recently developed to review cases and share experiences. After a difficult safeguarding event, 'debriefing sessions' took place with staff. All staff told us about a staff newsletter where learning and information was shared with staff.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together 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.

Requires Improvement

Are services effective?

- The service had formalised systems with the NHS 111 service with specific protocols for patients referred to the service. 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. For example, staff communicated promptly with the patient's registered GP practice, so the GP was aware of the need for further action. There were established pathways for staff to follow to ensure callers were referred to other services for support as required.
- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that required them. Staff were empowered to make direct referrals and/or appointments for patients with other services.
- There were arrangements in place for there to be an overlap between shifts to enable coordinators to pass on relevant information. The provider closely monitored this. 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.
- At the last inspection it was identified that additional clinical hours were needed to work through the backlog of cases that occurred over the weekend. At this inspection, we found the provider had taken steps to improve this and additional in-hours clinical time was not required.
- 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.
- Issues with the Directory of Services were resolved in a timely manner. For example, meetings took place with NHS 111 to review cases that perhaps should not have been referred to the OOH service.

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 need extra support. For example, patient special notes were set up to identify and review the needs of vulnerable patients. This information was added to the organisation's patient record system, and this was then shared with other NHS services.
- Where appropriate, staff gave people advice so they could self-care. This formed part of the clinical assessments undertaken by staff and procedures were in place to support this.
- Risk factors, when identified, were highlighted to patients and their normal care providers so additional support could be given. For example, if a new or emerging condition was found and needed to be shared with the patient's GP urgently, this would be called through to the practice at 8am the following morning. The service had alternative telephone numbers to contact GP practices on so this could be achieved.
- 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 responsive to people's needs?

At the last inspection in May 2022, we rated the practice 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.

At this inspection we found the provider had taken action to address the required improvements and we have 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. To do this the provider engaged with commissioners to secure improvements to services, where these were identified. There were monthly contract monitoring board (CMB) meetings in place with local commissioners to monitor activity, productivity, key performance indicators (KPI) compliance, incident management and quality standards. The meetings were attended by the Integrated Care Board (ICB) Place leads from the six local authority areas across Merseyside.
- The provider improved services where possible in response to unmet needs. For example, in April 2023, the provider conducted an OOH service review and made recommendations to local commissioners to optimise service delivery, within what was considered available resources.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service. For example, the systems had alerts (patient special notes) in place for patients who were on an end-of-life pathway. Pathways were also in place for responding to babies, children, and young people.
- In line with national and system wide objectives, the provider had introduced a paediatric pathways pilot in partnership with the Beyond Children & Young People's programme. The provider had led on the pilot using paediatric specialist nurses in the OOH service period to manage calls for children referred into the service. This was part of the streaming process to direct the patient to the right clinician at the right time.
- The service worked with partnership NHS trusts to support an acute respiratory service. GPs and advanced nurse practitioners (ANP) worked at the hub sites during winter pressure months to attend to patients presenting with acute respiratory conditions.
- The facilities and premises were appropriate for the services delivered. The service made reasonable adjustments when people found it hard to access the service. For example, patients who were unable to drive for a face-to-face appointment would have a home visit for assessment and treatment.
- Care and treatment were delivered in a coordinated way, which considered the needs of those whose circumstances may make them vulnerable. For example, older patients, patients with a learning disability or having palliative care needs, those with poor mental health, infants under 6 months old and patients without transport.

Timely access to the service

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

- The service operated from 6.30pm to 8am, Mondays to Fridays 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.

Good

Are services responsive to people's needs?

- Patients could access the OOH service via NHS 111. The service did not see walk-in patients and a 'Walk-in' policy was in place. This 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.
- Primary Care 24 Ltd accepted dispositions from NHS 111 with response times ranging from 20 minutes to 24 hours.
- The provider monitored the performance of the time disposition which included monitoring clinical and operational staffing levels against planned. This was for telephone consultation, face-to-face appointments and home visits. When the service had long waiting times and they were not able to achieve the time disposition, escalation processes were in place to inform senior managers and key external stakeholders that the service was under pressure. We were informed that at these times operational teams undertook 'comfort calls' to patients to inform the patient of the delay, and to assess if there has been any change to symptoms and provide safety netting advice.
- Data presented showed there had been improvements to the times taken to make the first attempt to contact a patient by a clinician, from July 2022 to July 2023. The data showed that 4 of the 8 indicators on average were contacted within the assigned clinical priority.
- Patients with the most urgent needs or those considered to be vulnerable, had their care and treatment prioritised. Patients were generally seen on a first come first served basis, however, recently the provider had introduced a new streaming process to facilitate prioritisation according to clinical need where more serious cases or young children could be assessed sooner.
- Reception staff at bases were aware of the need to alert clinical staff if a patient had an urgent need whilst waiting to be seen, for example, if a patient presented with symptoms of sepsis. The receptionists informed patients about anticipated waiting times.

Information was shared with CQC showing the service performance for the period April 2022-March 2023. The results showed;

- The service met face-to-face consultation at appointment centre to commence within: Emergency/one hour the service achieved 100% (apart from February 2023 which achieved 50% compliance).
- Face-to-face consultation at appointment centre to commence within: Urgent/two hours – the service achieved a range between 88% and 98%.
- Face-to-face consultation at appointment centre to commence within: Less urgent/six hours – the service achieved a range between 97% and 99%.
- Face-to-face consultation at home to commence within: Emergency/one hour – the service achieved a range between 50% and 100%.
- Face-to-face consultation at home to commence within: Urgent/two hours hour – the service achieved a range between 67% and 81%.
- Face-to-face consultation at home to commence within: Less urgent/six hours – the service achieved a range between 74% and 94%.

Where the service was not meeting the target, the provider was aware of these areas, and we saw evidence that action plans were in place to improve this. Data presented showed that the highest numbers of incidents reported by staff related to patient delays, and the service had implemented an action plan to respond to this. For example, there had been investment in a patient flow management system to prioritise patients awaiting call back as the demand on the service increased and to keep patients updated whilst being managed within the service.

Good

Are services responsive to people's needs?

Ongoing reviews of incidents relating to delays in contacting patients indicated that patient experience would be improved by better communication between services. As such, the provider arranged a multi-provider integrated learning forum with NHS111, local community, hospital, and ambulance services. The aim of this was to share ideas, understand services and their specific pressures, and improve patient flow between services when significant demand was being experienced to maintain patient safety and improve patient experience.

Waiting times, delays and cancellations were monitored closely. 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. For example, during periods of high escalation and demands of the service, an Advanced Care Practitioners (ACPs) will review cases and identify any patients who, based on their clinical parameters might need to be assessed sooner than the expected time during the delay. The ACP reviewed cases as they were received to try to identify concerning referrals.

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

Referrals and transfers to other services were undertaken in a timely way. For example, the service worked to improve integrated working across the system by working with the Urgent Community Response (UCR) service. The aim was to ensure that patients who required more urgent assessment within the community, were streamed to the relevant service and were not subject to an avoidable delay.

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.

- There were 36 total complaints received between 1 April 2022 to 31 March 2023. This was a reduction compared with the previous year.
- The complaint policy and procedures were in line with recognised guidance. The service learned lessons from individual concerns and complaints and from analysis of trends. A weekly 'Safety First' meeting reviewed all complaints received into the service the previous week. The meeting consisted of multi-disciplinary teams who reviewed incidents, identified any immediate key lessons learned and discussions took place to inform future improvement work when required. The meeting also allowed for triangulation of data with incidents and thematic analysis was developed based on the discussion.
- We reviewed a sample of complaints and found that they were satisfactorily handled in a timely way and responses were made to complainants from the Chief Executive.
- Issues were investigated across relevant providers, and staff were able to feedback to other parts of the patient pathway where relevant.
- Learning from complaints was part of the service patient engagement and involvement strategy. Several new initiatives had been put into place to learn from patient complaints. For example, a patient experience group was set up recently to invite patients and families who have complained to the service to meet with staff to tell of their experiences.

Good

Are services well-led?

At the last inspection in May 2022, we rated the practice as requires improvement for providing good leadership because:

- Staff satisfaction about working at the service was mixed. Staff did not always feel actively engaged with or empowered by the leadership team.
- Where risks were identified relating to the insufficient numbers of clinical staff, the provider had not introduced measures to reduce or remove the risks within a timescale that reflected the level of risk and impact on people using the service. The systems in place for dealing with surges in demand and to respond to patients who experienced long waits were not effective.
- Improvements were needed to ensure there was a culture of high-quality sustainable care.

At this inspection we found the provider had taken action to address the required improvements and we have rated the service as good for being well led.

Leadership capacity and capability

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

- Permanently appointed Executive Directors had been recruited since the last inspection. The provider had introduced and recruited to several new leadership roles. There was a designated head and deputy for the management of urgent care services.
- We found leaders had the experience, capacity, and skills to deliver the service strategy and address risks to it. Across the inspection we spoke with managers and leaders who were knowledgeable about issues and priorities relating to the quality and the future of services. They understood the challenges and were addressing them.
- Staff told us that improvements had been made in terms of how visible and approachable the new management team were. We heard they worked closely with staff across the service, and frontline staff we spoke with told us the managers were supportive and compassionate. Senior management were accessible throughout the operational period, with an effective on-call system that staff were able to use. Escalation plans could be brought into effect during the operational period to contact a senior manager and front-line staff knew how to trigger escalation.

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 realistic strategy and supporting business plans to achieve priorities.
- The service developed its vision, values, and strategy jointly with staff, and external partners. Staff were aware of and understood the vision, values and strategy and their role in achieving them. Away days were planned for various departments to review this. The provider ensured that staff who worked away from the main base felt engaged in the delivery of the service vision and values.
- 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.
- The provider monitored progress against delivery of the strategy.

Culture

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

- Staff felt respected, supported, and valued. They were proud to work for the service and they believed the service focused on the needs of patients.

Good

Are services well-led?

- Openness, honesty, and transparency were demonstrated when responding to incidents and complaints. Staff told us this had improved since the last inspection. They were now encouraged to report incidents and feedback forms were completed and shared with staff. The provider was aware of, and had systems to ensure compliance with the requirements of the duty of candour. This included policies, staff training and reviews of incidents and complaints.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They were aware of the service whistle blowing policy and knew the service had a Freedom to Speak Up Guardian. Staff told us the culture was free from bullying and they would not hesitate to raise concerns, they felt confident that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. Some of the staff we spoke with reported that they were being developed in roles they had not been recruited into, as part of a structured plan in place for their individual development.
- All staff had access to an annual appraisal and 97% of staff had completed this since the last inspection. Staff were supported to meet the requirements of professional revalidation where necessary. Clinical staff, including nurses, were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff. Staff were supported when they were involved in a traumatic incident, complaints, or investigations.
- 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, and they described positive relationships between staff and managers.

Governance arrangements

There were clear responsibilities, roles, and systems of accountability to support good governance and management.

- Structures, processes, and systems to support good governance and management were clearly set out, understood and effective.
- Leaders had established policies, procedures, and activities to ensure safety and assured themselves that they were operating as intended.
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- A revised leadership structure was in place and had been updated since the last inspection. All areas had a clinical lead providing clinical leadership and support to staff.
- Staff we spoke with were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.

Managing risks, issues, and performance

There were clear and effective processes for managing risks, issues, and performance.

- There was an effective process to identify, understand, monitor, and address current and future risks including risks to patient safety. 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.
- There were monthly contract monitoring meetings taking place with local commissioners to monitor activity, productivity, KPI compliance, performance, incident management and quality standards.
- The provider had processes to manage current and future performance of the service. In March 2023, a review of the OOH service operating model was undertaken to understand the current delivery demand against the contract requirements set out in 2020.
- Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions.

Good

Are services well-led?

- Leaders had oversight of patient safety alerts, incidents, and complaints.
- Leaders had a good understanding of service performance against the locally agreed key performance indicators. Performance data, risk information, productivity information and response times were reviewed at team, divisional and Board level. This information was also shared with local commissioners and partnership organisations to monitor progress to improve patient experience.
- 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 the 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. Performance information was combined with the views of patients.
- 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. 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

The service involved patients, the public, staff, and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard, and acted on to shape services. For example, a patient feedback survey was undertaken from patients and their families/ carers who had used the service paediatric pathway. The service received 48 responses and this information was used to identify what worked best and what could be improved upon.
- Staff were able to describe the systems in place to give feedback. The frequency of meetings across all staff groups had improved. Generally, staff told us communications with the senior management team had improved and they felt involved and listened to when their views were sought. We saw evidence of the most recent staff survey and how the findings were fed back to staff. We also saw staff engagement in responding to these findings.
- Staff members and patients shared their experience of working at or using the service the beginning of board meetings.
- A number of reports and reviews were shared with CQC to demonstrate 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.

- There was a focus on continuous learning and improvement at all levels within the service and a number of these were highlighted during our inspection. For example, improvements in telephone technology, the text messaging service, the paediatric pathways pilot and the partnership working at acute respiratory hubs.

Good

Are services well-led?

- Staff knew about improvement methods and had the skills to use them.
- 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.
- There was a strong culture of innovation evidenced by the number of pilot schemes the provider was involved in. There were systems to support improvement and innovative work.