Urgent Care Centre North Staffordshire

Inspection report

Emergency Department - Royal Stoke University Hospital
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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	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Inadequate**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Inadequate**

Overall summary

This service is rated as inadequate overall. The service has not been inspected previously.

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Inadequate

Are services caring? – Good

Are services responsive? – Requires Improvement

Are services well-led? – Inadequate

We carried out an announced comprehensive inspection on 22 and 23 April 2018. Our key findings from this inspection were as follows:

- Processes to manage risks relating to shared learning from significant events and incidents were not being used effectively. Staff had stopped reporting on significant events and incidents, or were reporting through the hospital system.
- Emergency equipment and medicines were not always easily accessible to staff.
- Staff employed did not always have the appropriate skills to treat some of the patients accepted into the service.
- There was a lack of suitable analgesia to treat acute pain.
- Patient Group Directions were seen to be contradictory and did not always include the dosage.
- Clinicians were not working to the exclusion criteria, inappropriate patients were being accepted into the service, resulting in delays to patients in need of urgent treatment.
- Prescriptions were securely stored but their use was not monitored effectively.
- Patients' care needs were not always be assessed and delivered in a timely way and according to need.
- Systems to safeguard vulnerable adults were effective but the numbers referred were very low.
- Systems and processes failed to enable the provider to effectively assess, monitor and improve the quality and safety of the services provided.
- There was an inconsistent approach for identifying risks, issues and implementation of mitigating actions.
- The governance arrangements were not sufficient for permanent and temporary staff recruitment and training.

There were also areas of service where the provider needs to make improvements:

Importantly, the provider must:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The provider should:

- Explore how patient feedback about the service can be improved.
- Develop a clearly defined strategy to deliver the vision for the centre.

For more information on these requirements, please refer to the enforcement action at the end of this report. On the day after the inspection, we took urgent action and the provider implemented an action plan to mitigate the immediate risks to patients.

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

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

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Our inspection team

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

Background to Urgent Care Centre North Staffordshire

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

The service known as UCC North Staffordshire is provided within the Emergency Department at The Royal Stoke University Hospital. SDUC has provided a GP led urgent care centre (redirecting patients to appropriate care) service since August 2017, a service aimed at reducing the pressure on the emergency department by treating those patients who do not require emergency care. This service operates 24 hours a day, 365 days a year, and the local governance is managed at the organisation's headquarters at Staffordshire House, in Stoke-on-Trent. There is a lead nurse and an operations manager based at the hospital. The service receives approximately 3,000 contacts per month.

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

Further details can be found by accessing the provider's website at

Inadequate

Are services safe?

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

- Clinicians were not always working to the exclusion criteria resulting in inappropriate patients being accepted into the service, which resulted in delays to patients in need of emergency treatment.
- Staff employed did not always have the appropriate skills to treat some of the patients accepted into the service.
- Emergency medicines and equipment were not readily accessible to clinical staff.
- There was a lack of suitable analgesia to treat acute pain.
- Patient Group Directions were seen to be contradictory and did not always include the dosage to be used.
- Prescription forms were not monitored by recording individual prescription numbers.
- Adult safeguarding numbers were very low.

Safety systems and processes

The provider had a safeguarding lead and systems to safeguard children and vulnerable adults from abuse. However, the adult safeguarding figures were very low with only two patients having been reported through the Vocare system since August 2017. Some staff told us that they had reported safeguarding concerns through the hospital reporting system but this did not allow the provider to have oversight or take appropriate action when required. Children with safeguarding concerns were normally referred to the children's emergency department.

- A review of the two safeguarding referrals showed that when a concern was raised the service worked with other agencies to support patients and protect them from neglect and abuse. For example, social services were contacted when concerns were raised for the safety of a child when the mother was showing signs of poor mental health.
- Staff had received up-to-date safeguarding and safety training appropriate to their role. Staff we spoke with knew how to identify concerns. Policies were seen to be up to date and relevant, for example; they included the modern day definitions for vulnerable adult safeguarding. The service had made two referrals in March 2018, one for an adult and one for a child. A quarterly safeguarding newsletter included details of the safeguarding leads, shared learning and information on training events.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken on all staff. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- There were effective systems to manage infection prevention and control measures. The site we visited was clean and tidy; regular audits were carried out at the centre. There were systems for safely managing healthcare waste.
- Emergency medicines and equipment were not readily accessible to clinical staff and an oxygen cylinder in one of the streaming rooms was empty. Clinicians we asked were unable to find adult nebuliser masks. Emergency medicines were kept in a locked cupboard within clinical rooms, but the keys were kept in a separate room not always accessible to clinicians (a nebuliser is a drug delivery device used to administer medication in the form of a mist inhaled into the lungs). However staff were able to alert the emergency department of an emergency situation using a buzzer system.

Risks to patients

Adequate systems to assess, monitor and manage risks to patient safety were not always in place. On the day after the inspection, we took urgent action and the provider implemented an action plan to mitigate the immediate risks to patients.

- Clinicians were not always working to the agreed exclusion criteria and we saw examples of when very ill patients, who should have been directed straight into the emergency department, were accepted into the service. For example, a patient with a heart rate of 33 was not referred to the emergency department immediately. The exclusion criteria consisted of a list of conditions and symptoms that should not be treated in the service, but referred to the emergency department. A second example we saw was of a patient who arrived by ambulance with serious abnormal observations being accepted into the service.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups. Staff told us

that filling rotas at weekends was heavily reliant on agency staff. Agency staff were not always given an induction or familiarisation process before starting their first shift.

We found positive examples of where risks to patients were managed appropriately:

- Training records showed that face to face basic life support training (BLS) had been planned or completed by all staff. Vocare had changed their recruitment policy to request that when GPs did not produce evidence of completion of BLS training, they must book on a course within one month of starting or they would not be employed.
- Clinical staff we spoke with knew how to identify and manage patients with severe infections, for example sepsis.
- The provider had appropriate safety arrangements, including Control of Substances Hazardous to Health (COSHH) and health & safety within the workplace policies, which were regularly reviewed and communicated to staff.
- Staff received safety information from the provider as part of their induction and refresher training. We found comprehensive risk assessments, for example for fire and lone working.

Information to deliver safe care and treatment

Exclusion criteria was provided to inform clinicians which patients should not be accepted into the service. This had recently been displayed on the walls in clinical rooms. However, we found examples of when the exclusion criteria was not being applied and this resulted in inappropriate patients being accepted into the service for treatment. Some of the clinical staff we spoke with were unaware of the exclusion criteria.

We saw that the service had contacted hospital staff to set up meetings for sharing information, in particular to review incidents and inappropriate patients who had been accepted into the service. A weekly meeting was held, however we were told that this meeting was not regularly attended by sufficient staff to facilitate meaningful reviews.

Safe and appropriate use of medicines

There were processes were in place for checking medicines although these were not always found to be effective:

- Blank prescription forms and pads were securely stored but there was no system in place to monitor their use. A system was implemented following the inspection.
- Patient Group Directions (PGDs) used had been ratified in accordance with the Medicines and Healthcare products Regulatory Agency guidance. However we found examples when these directions were contradictory. For example; the PGD for Amoxicillin (an antibiotic used for the treatment of a number of bacterial infections) stated that the medicine should not be given to children under 12 months of age, but then included the quantity of medicine to administer to a child between one and eleven months.
- PGDs did not always include details of the appropriate dosage.

Track record on safety

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

- The provider had written health and safety policies and a health and safety committee was made of Vocare staff from across the group; staff 'ambassadors' had written up terms of reference for this group written by the management team. There were risk assessments in relation to safety issues. An independent health and safety risk assessment had been carried out and a 'health and wellbeing' schedule was in place, managed within the human resources department.
- A fire risk assessment had been carried out in January 2018. Staff had completed fire safety training, team leaders and managers were trained as fire marshals. Annual service plans were in place to maintain the fire extinguishers and the fire alarm. The fire alarm and emergency lighting were tested weekly and fire evacuation drills carried out every six months. These included a review of any areas of improvement identified.
- Joint reviews of incidents were carried out with partner organisations and communicated to the quality team that represented the Staffordshire Clinical Commissioning Groups (CCGs). However, incidents reported to the hospital governance team had not been shared by the hospital staff.

Lessons learned and improvements made

Inadequate

Are services safe?

- The provider had processes for reviewing and investigating when things went wrong. The Staffordshire Doctors Urgent Care (SDUC) governance team led on the process of recording, reporting and learning from incidents. Staff had access to an electronic system (Datix, an electronic system that allows learning from incidents to be shared). SDUC had adopted this as their system of choice for recording all incidents.
- There was an 'adverse event' policy that included an action plan that provided a flow chart detailing what to do having identified an incident. This included reference to the duty of candour principles.
- There was a process in place for sharing any learning with staff following an incident or complaint to improve the service. Staff newsletters were circulated monthly and a central website allowed learning to be shared within the Vocare Group. The clinical directors discussed incidents at monthly meetings. However, agency staff were not always aware of the access to a central website. Staff we spoke with understood their duty to raise concerns and report incidents and near misses. However, clinicians told us that they had stopped reporting incidents as they had lost confidence in the system. This was in part due to the lack of feedback received. Staff told us that in some cases incidents had been raised through the hospital reporting process. However, incidents reported through the hospital reporting system had not been shared with the provider by hospital staff.
- The provider analysed incidents on a monthly basis and this included a review of the level of harm caused. In total, there had been two safeguarding incidents reported since August 2017.
- There was a document that tracked each incident including any action taken and noted when the incident was closed.
- We reviewed a 'serious incident' (SI) report for a clinician who had worked outside of their scope of practice. The investigation was thorough and detailed; however there was no evidence that the learning outcome; to improve the clinical induction process; had been implemented.

Inadequate

Are services effective?

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

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

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice. However, some agency staff we spoke with were not aware how to access the guidelines, clinical pathways and protocols because they did not know how to access to the shared electronic folders.

- Not all clinical staff had awareness of the access to guidelines from the National Institute for Health and Care Excellence (NICE) for information to help ensure that people's needs were met. However the provider monitored that these guidelines were followed; for example, through clinical consultation reviews.
- There was a lack of suitable analgesia to treat acute pain. The protocol for analgesia contradicted the clinical and operational model. The protocol stated that the only urgent medicines that could be given were ibuprofen and paracetamol but the clinical and operational model stated that the service may include the provision of stronger analgesia. The provider took action immediately after the inspection to ensure suitable analgesia was available.
- Care and treatment was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. For example, the patient record system had special notes for those patients requiring specific care.
- There was a system in place to identify frequent callers and patients with particular needs, for example, patients with mental health problems were triaged to assess their mental capacity.

Monitoring care and treatment

We looked at the key performance indicators (KPIs), which provide a clear and consistent way of assessing performance as they help inform our decisions about the quality of care. There was a data set of 11 KPIs used to monitor performance of the service. Performance data reviewed for the past six months showed that the service was achieving the contractual targets consistently in eight of the KPIs. For example, data for March 2018 showed:

- 48% of the patients seen were diverted away from the emergency department. This showed that the service was significantly exceeding the target of 30%.
- 0.2% of patients left without being seen. The contractual target was less than 3%.
- 100% of all patients streamed had a post event message regarding each episode of care sent to the patient's registered GP by 8am the following day. The contractual target was 100%.

The streaming figures (clinical assessment used to navigate patients to the most appropriate department) were not meeting contractual targets:

- In December 2017, 63% of patients had been streamed within 15 minutes of their arrival. The contractual target was 95%.
- In December 2017, 89% of patients had been streamed within 60 minutes of their arrival. The contractual target was 99%.

The most recent data for March 2018 showed that improvements had been made:

- In March 2018, 91% of patients had been streamed within 15 minutes of their arrival. The contractual target was 95%.
- In March 2018, 98% of patients had been streamed within 60 minutes of their arrival. The contractual target was 99%.

However, we were told by clinicians that in some cases, patients were being streamed for a further assessment in order to achieve the targets. The service was not achieving the indicator for returning patients back to the emergency department when emergency treatment was required:

Inadequate

Are services effective?

- In March 2018, 78% of patients who required a transfer back to the emergency department were transferred with 60 minutes. The contractual target was 99%.

Effective staffing

Staff did not always have the skills, knowledge and experience to treat some of the patients accepted into the service.

- The provider had an induction programme for all newly appointed staff. However, some clinicians we spoke with had not completed an induction or familiarisation process prior to their first shift. Staff who streamed patients did not always have the knowledge and experience to treat some very poorly patients accepted into the service.
- The provider had an effective system for monitoring training requirements by individual staff members. Electronic records were kept for each staff member and contained up to date records of training completed and dates when refresher training was due. Training needs had been identified for each role. SDUC had amended its recruitment policy to improve the number of GPs who provided evidence of completed training. However, this system did not always extend to agency staff employed.
- The provider had a clear process to provide staff with ongoing support; this included appraisal. There was a clear approach for supporting and managing staff when their performance was poor or variable. However, these processes were not always seen to have been used.
- The provider could not demonstrate how it ensured the competence of staff employed in advanced roles by audit of their clinical decision making.
- Staff were made aware of external training opportunities provided free by the local hospital and distance learning courses provided by a local college. Staff were given the information to enrol and the opportunity to complete training if they left SDUC's employment.

Coordinating care and treatment

There was no clear structure in place for staff to work with colleagues from the hospital team. This was evident in the lack of sharing of safety incidents and the failure to share concerns over safeguarding. All patients streamed had a post event message regarding each episode of care sent to the patient's registered GP by 8am the following day. Team leaders contacted GP practices when concerns and risk factors such as high blood pressure were identified.

Helping patients to live healthier lives

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

Consent to care and treatment

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

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

Good

Are services caring?

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

Kindness, respect and compassion

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

A total of 18 Care Quality Commission comment cards were received. The comments were generally negative about the service received. Five of the comment cards were positive; three patients complimented the caring and compassionate staff.

Involvement in decisions about care and treatment

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

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

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.

Requires improvement

Are services responsive to people's needs?

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

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

Responding to and meeting people's needs

The service reviewed the needs of its local population and engaged with its commissioners to secure improvements to services where these were identified.

- There were accessible facilities, baby-changing facilities, a hearing loop and translation services available (to be provided within 15 minutes of the initial contact).
- The service was able to access the mental health crisis team or single point access for rapid response community matrons. There were direct referral pathways in place for patients experiencing poor mental health who attended the urgent care centre.
- The facilities and premises were appropriate for the services delivered.

However, the service was not responding effectively to the needs of people in vulnerable circumstances. For example, health care professionals caring for vulnerable people were not always raising safeguarding concerns for vulnerable adults. In March 2018, the service reported approximately 70 patients had attended with suicidal tendencies. However only two safeguarding referrals had been made since August 2017. Clinicians told us that patients were not always kept under observation when presenting with suicidal tendencies. A situation was reported to us when a patient had walked out of the waiting area having told staff that they planned to commit suicide.

Timely access to the service

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

Patients could access the service via NHS 111 (NHS 111 is a telephone-based service where callers are assessed, given advice and directed to a local service that most appropriately meets their needs). The service also saw 'walk in' patients and patients who arrived at the hospital by ambulance.

Patients did not always have timely access to clinical diagnosis and treatment. Data obtained from the service regarding timescales for streaming patients and referring them back to the emergency department were consistently not meeting the contractual targets.

Listening and learning from concerns and complaints

Information about how to make a complaint or raise concerns was accessible and easy to understand. The complaint policy and procedures were in line with recognised guidance. The governance team managed the complaints process and spoke to all complainants upon receipt of a complaint. We looked at the complaint system provided to us at the inspection that included a copy of complaints that dated back to when the service commenced in August 2017.

- A total of 32 complaints were received, this represented approximately 0.2% of total contacts.
- The provider analysed the complaints and identified the main cause for complaint was delays in receiving care and treatment (including waiting times). This accounted for approximately half of all complaints received.
- The response time to complaints was timely, the longest response time had been 37 days and 11 of the 32 complaints had been responded to within one day.
- The provider had implemented a two tier approach to managing complaints. This consisted of formal complaints that were taken through the formal process and informal complaints that could be closed without the need for a formal investigation.
- Monthly themes and trends around complaints such as delays and cancellations in care and access to treatment were reported to the clinical commissioning group.
- The service shared learning by dedicating one in four of the weekly governance meetings to discuss lessons learnt and share good practice. These meetings were open to all staff who worked within the service. Issues that stemmed from complaints were discussed at the monthly quality and safety meeting and included on staff newsletters.

Inadequate

Are services well-led?

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

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

Leadership capacity and capability

Leaders did not demonstrate the skills and the capacity to run the service and were not always able to demonstrate awareness or oversight of the issues and how they ensured safe care and treatment was being provided by all staff.

- The clinical leadership management structure showed clear lines of accountability. However leaders were said to be not accessible by some members of the clinical team, most notably at weekends.
- An operations manager had been appointed in the weeks leading up to the inspection.

Vision and strategy

- Vocare had a corporate vision and defined it's role to be 'the urgent healthcare provider and partner of choice for the NHS which will allow them to provide better clinically led, evidenced based, innovative and sustainable services for patients'. This was accessible on the provider's website.
- The senior management team had formalised a localised strategy to develop an integrated urgent care model, especially with the NHS111 service. Staff worked across both services and urgent care practitioners were being multi-trained; e.g. paramedics were trained as urgent care practitioners, able to work in all areas of the urgent care system.
- However, a clearly defined strategy to achieve the vision was not in place and some staff we spoke with were not always aware of the vision, values and strategy and their role in achieving them.

Culture

The provider had strengthened the leadership and governance arrangements at the regional SDUC headquarters. However the management team did not have clinical oversight of the service.

- Staff did not always feel respected, supported and valued, most notably agency staff who worked weekend shifts.
- They told us they were able to raise concerns but had stopped reporting as they had lost confidence in the system.
- The provider was aware of and had systems in place around compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- There were organisational policies for providing employed staff with the development they needed, for example; support with revalidation.
- Shared learning events with workshops were planned to encourage a learning culture.

Governance arrangements

Structures, processes and systems to support good governance and management were not clearly set out or effective. Some staff we spoke with told us that the information available to staff to make decisions was confusing and inconsistent. For example, there was no effective system to determine which patients should be accepted into the service.

- There was a clear staffing structure at the regional head office, staff were aware of their own roles and responsibilities. However this governance structure had not been extended to incorporate the service provided at the hospital.
- The provider had a good understanding of their performance against local key performance indicators. These were discussed at senior management and board level. Performance was shared with staff and the local clinical commissioning group as part of contract monitoring arrangements.

Managing risks, issues and performance

The governance systems and processes to identify and manage risks and issues were not effective and not all risks had been identified. We found examples of where patients were at potential risks due to delayed treatment, but this

Inadequate

Are services well-led?

information had not been captured and acted on. When risks had been identified, the provider had effective systems and processes to assess, monitor and improve the quality and safety of the services.

The service had failed to achieve compliance with the local indicators that monitored the streaming of patients in a timely manner. Staff told us that some patients were transferred to a triage queue to meet contractual targets.

Leaders had an understanding of service performance against the national and local key performance indicators. Performance was regularly discussed with the local clinical commissioning group as part of contract monitoring arrangements. However, the poor performance in delivering timely care when treatment was deemed as urgent resulted in risks to patients. There were plans in place with Staffordshire Clinical Commissioning Groups (CCGs) to improve the service.

Appropriate and accurate information

The service reported on appropriate and accurate information. However the data did not always provide an effective monitor on performance.

- The service used a set of local indicators to monitor performance and the delivery of quality care which they reported on monthly.
- The service submitted data or notifications to external organisations such as Clinical Commissioning groups (CCGs) as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.
- Patients had been transferred from a streaming (redirecting patients to appropriate care) queue to a triage (the process of determining the priority of patients' treatments based on the severity of their condition) queue. It was not clear why this had been done and there was evidence that this system resulted in risk to patients due to delayed treatment.

Engagement with patients, the public, staff and external partners

- Systems were in place for staff to give feedback and be involved in service development.
- We saw there was a locally produced monthly newsletter and a monthly clinicians' newsletter.
- Staffordshire Doctors Urgent Care (SDUC) engaged with other urgent care services such as the ambulance service.
- Engagement with staff was insufficient at weekends. Some of the clinical staff we spoke with had not met any of the management team and were unsure of who to contact for support.
- The provider was seen to be recruiting service users to form a patient forum.
- SDUC had developed links with the local Healthwatch team in Stoke-on-Trent to provide patient feedback on the service.

Continuous improvement and innovation

SDUC planned to improve the flow of information through a project named 'black pear'. This involved a piece of software to perform system inter-operability allowing different clinical systems to be accessible from the OOH service. The project aimed to link in with GP practices and the community healthcare team.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these. We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation
Treatment of disease, disorder or injury Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service usersClinicians were not working to the exclusion criteria, inappropriate patients were being accepted into the service, resulting in delays to patients in need of urgent treatment. Staff employed did not always have the appropriate skills to treat some of the patients accepted into the service.Emergency medicines and equipment were not readily accessible to clinical staff.There was a lack of suitable analgesia to treat acute pain.Patient Group Directions were seen to be contradictory and did not always include the dosage.Prescription forms were not monitored by recording role numbers.Adult safeguarding numbers were very low.

Regulated activity	Regulation
Treatment of disease, disorder or injury Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance 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 2014Systems and processes failed to enable the provider to effectively assess, monitor and improve the quality and safety of the services provided.There was an inconsistent approach for identifying risks, issues and implementation of mitigating actions.Systems for the management of emergency medicines and equipment were not effective.Staff had stopped reporting on significant events and incidents.The governance arrangements were not sufficient for permanent and temporary staff recruitment and training.