Gloucester Out of Hours

Quality Report

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

Ratings

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

Key findings

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Letter from the Chief Inspector of General Practice

This service is rated as Requires Improvement overall. This service has not been previously inspected

The key questions are rated as:

Are services safe? – Good

Are services effective? – Requires Improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? –Requires Improvement

We carried out an announced comprehensive inspection at Gloucester Out of Hours on 3, 4 and 5 September 2018 as part of our inspection programme and regulatory functions under Section 60 of the Health and Social Care Act 2008.

At this inspection we found:

- The service had systems to manage risk so that safety incidents were less likely to happen. For example, there were systems to fill any gaps in the rota to ensure appropriate clinical cover at all sites. When safety incidents did happen, the service learned from them and made efforts to improve their processes.
- The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- The service was not consistently meeting performance targets; however, a detailed and measurable recovery plan was in place to address these areas.
- Staff involved and treated people with compassion, kindness, dignity and respect. Feedback from patients for all aspects of care was positive.
- Patients could access care and treatment from the service within an appropriate timescale for their needs.
- The service had good facilities and was well equipped to treat patients and meet their needs. The vehicles used for home visits were clean and well equipped.
- There had been significant recent management changes which had impacted upon the operating of effective governance processes. For example, staff training and appraisals.
- Leaders were not visible and not all staff felt supported, respected and valued.

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

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.

Summary of findings

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

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Gloucester Out of Hours

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Gloucester Out of Hours

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

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

The service is commissioned by Gloucestershire Clinical Commissioning Group and covers a population of approximately 640,000 people across the county of Gloucestershire. Patients access the out-of-hours service via the NHS 111 telephone service. The NHS111 service for the area is provided by a different provider. Patients may be seen by a clinician at one of the six primary care centres, receive a telephone consultation or a home visit, depending on their needs The vast majority of patients access the service via NHS 111, however, there were agreements with different services for walk in patients to access the service, including a system to accept walk in patients from other services, such as A&E and the minor injuries units.

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

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

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

The provider is registered to provide the following regulated activities:

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

At the time of the inspection there was not a registered manager in post.

Good

Are services safe?

Our findings

We 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. It had safety policies, including Control of Substances Hazardous to Health and Health & Safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction and refresher training. The provider had systems to safeguard children and vulnerable adults from abuse. Policies were 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. We saw that staff had reported appropriately to both adult and children's safeguarding teams. Patients at risk were highlighted on the clinical system to alert staff, and following any intervention the service updated the relevant 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. Information was collated by an administrator responsible for the administration of recruitment. There were gaps in these records. For example, one file did not include evidence of full employment history, one file did not contain evidence of conduct in previous employment. One file of a member of clinical staff did not contain evidence of immunisation status recommended for staff who were likely to come into contact with bodily fluids. All six recruitment files we looked at contained proof of identity. 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). All six files we looked at had a contract agreement in place, although none had been signed by the employees. All clinical files contained evidence of professional registration and qualifications checks which were also monitored by the computer rota system. When the dates of these registrations were due to expire a warning notice flashed on the rota screen in order to prevent staff being booked onto shifts.
- The organisation proactively used agency staff to fill staffing gaps. Staff told us the agencies varied. We looked at three agency staff files which showed assurances of pre- employment checks were requested but not always received. We found two files contained evidence of all employment checks and training. However, one file just contained only evidence of training and another contained a CV, proof of identity and training, but no further employment checks.
- All staff had access to up-to-date safeguarding and safety guidance appropriate to their role. Staff we spoke with knew how to identify and report concerns. Not all staff who acted as chaperones had been trained for the role but could describe their responsibilities for the role. All staff who were likely to act as chaperone had received a DBS check.
- There was an effective system to manage infection prevention and control. The organisation had a member of staff responsible for the oversight of infection control. Policies had been reviewed and were available to staff.
- The provider used facilities and premises managed by other providers and had equipment stored at these sites. We saw that their equipment was safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste. Additional infection control audits were conducted by Care UK staff on a three-monthly rolling programme. We saw the standard of cleanliness and waste management at Gloucester hospital were cluttered, not secure and easily cleanable.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective system in place for dealing with surges in demand.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. 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. For example, reception staff had posters to display or electronic display boards showing the wait times expected.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse. This was also included on the audits completed by the organisation.
- When there were changes to services or staff the service assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

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

Appropriate and safe use of medicines

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

- The systems and arrangements for managing medicines, including medical gases, emergency medicines and equipment, and controlled drugs and vaccines, minimised risks. The service kept prescription stationery securely and monitored its use. Arrangements were also in place to ensure medicines and medical gas cylinders carried in vehicles were stored appropriately. Furthermore, we saw the service had reviewed the provision and supply of medical gases in vehicles. As a result, the service had increased the amount of oxygen stored in vehicles as some areas within Gloucestershire were consider highly rural and were a distance from a hospital.
- The service carried out regular medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing.
- 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.
- The organisation employed Advanced nurse practitioners (ANP) who could prescribe medicines for clinical conditions within their expertise. They received mentorship and support from the lead nurse and GPs for this extended role.
- Patient Group Directions were used by nurse practitioners and emergency care practitioners who were not able to prescribe. However, these had not been signed to show they had been adopted by the organisation to allow staff to administer medicines in line with legislation.
- Palliative care patients were able to receive prompt access to pain relief and other medication required to control their symptoms.

Track record on safety

The service had a good safety record.

- There were 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, for example NHS111 and the clinical commissioning group.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.

Good

Are services safe?

- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service. There was a monthly clinical meeting where incidents were discussed and learnings shared with staff who were able to attend. GPs told us that they were informed of incidents and changes to ways of working via newsletters and emails. A quarterly journal was also shared, detailing learning points from regional and national incidents which had occurred in the wider organisation. However, when we looked at the documented incidents which covered all staff groups, we saw that there was an inconsistency in the sharing of learnings. In the three incidents we looked at, learning points had been shared in only one of these, which was not in line with the providers processes.
- 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, we saw that the service had worked closely with NHS111 to improve the service offered to patients with suspected sepsis.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

We 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. Examples of this were monthly clinical meetings and a newsletter sent to all staff. We saw that the August 2018 edition included best practice for best interest decision making and duty of candour as well as sharing learning points from recent incidents. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

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

Monitoring care and treatment

The service had a comprehensive programme of quality improvement activity and routinely received the effectiveness and appropriateness of the care provided. For example, quality improvement work and an audit was carried out to ensure patients experiencing stroke symptoms were assessed in accordance with recognised national guidance. A consultant neurologist provided an educational update and guidance was issued to all OOH clinicians. The audit identified that documentation of the nationally recognised scoring system could be improved and this was highlighted to clinicians.

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

We reviewed national quality standards from October 2017 to August 2018 and found that the service had not consistently met the standards required. Data over this period showed:

- The percentage of urgent calls triaged within 20 minutes of arrival ranged from 87% in December 2017 to 63% in June 2018, against a target of 95%.
- The percentage of urgent and routine calls triaged within 60 minutes of arrival: Percentage achievements ranged from 95% in April 2018 to 81% in August 2018 against a target of 95%.

Requires improvement

Are services effective?

(for example, treatment is effective)

- The percentage of routine calls triaged within two hours of arrival: Percentage achievements ranged from 96% in April 2018 to 86% in August 2018 against a target of 95%.
- The percentage of urgent patients consulted within two hours ranged from 95% in April 2018 to 71% in June 2018 against a target of 95%.
- The percentage routines consulted within six hours ranged from 95% in April 2018 to 97% in June 2018 against a target of 95%.
- The percentage of urgent patients visited within two hours ranged from 100% in October 2017 to 73% in April 2018 against a target of 95%.

We saw that the service consistently met the target of 95% in some areas:

- The percentage of emergencies visited within 1 hour was consistently 100%
- The percentage of routines consulted within 6 hours and the percentage of calls triaged within 6 hours (routine).

The provider was aware of the areas that standards were not being met and we saw evidence that a recovery plan was in place with the Clinical Commissioning Group which included performance against targets. We saw that monitoring of the service was being carried out three hourly during operational hours. It had been recognised that challenges in recruitment and retention were directly impacting achievements in this area. A recruitment programme had been implemented which was beginning to demonstrate that additional GPs were being recruited to the service.

Effective staffing

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

- The provider had an induction programme for all newly appointed staff. This covered such topics as safeguarding, emergency procedures, infection control and management of medicines.
- The lead nurse ensured that all Advanced nurse practitioners and Emergency care practitioners worked within their scope of practice and had access to clinical support when required.
- The provider understood the learning needs of staff and provided protected time and training to meet them. However, training had been identified by the provider as an area which required action. A training matrix was maintained which showed that some refresher training was out of date for staff working for the organisation as a second employment who had not provided evidence of mandatory training updates. For example, we looked at the training matrix which showed that 94% of the self-employed practitioners had provided evidence that they had received level three safeguarding training and 29% of the contracted staff had received level three training. Plans were in place to provide this training.
- The ongoing support of staff was mixed. Clinical staff had received one-to-one meetings, appraisals, and mentoring. This included agency staff. However, non-clinical staff had not received appraisals and the same level of support, which the provider was aware of.
- There was a clear approach for supporting and managing staff when their performance was poor or variable. For example, the auditor within the organisation completed call back audits on 1% of all calls. These had been used for identification of training needs and poor performance. We were given examples to demonstrate appropriate action had been taken.

Coordinating care and treatment

Staff worked 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.
- 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 the End of Life Implementation and Educational Group and translation services. Staff communicated promptly with patient's registered GP's so that the GP was aware of the need for further action. Staff also referred patients back to their own GP to ensure continuity of care, where necessary. If a patient required urgent follow up by their GP, in addition to the electronic notification sent to GP practices by the start of the following day, the service would telephone the GP surgery to ensure this was actioned. The service worked with patients to develop personal care plans that were shared with relevant agencies.

Requires improvement

Are services effective?

(for example, treatment is effective)

- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- The service had formalised systems with the NHS 111 service with specific referral protocols for patients referred to the service. An electronic record of all consultations was sent to patients' own GPs.
- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that require them. Staff were empowered to make direct referrals and/or appointments for patients with other services.

Helping patients to live healthier lives

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

- The service identified patients who may be in need of extra support.
- Where appropriate, staff gave people advice so they could self-care. Systems were available to facilitate this.
- Risk factors, where identified, were highlighted to patients and their normal care providers so additional support could be given.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

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

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

Good

Are services caring?

Our findings

We rated the service as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to patients.
- The service gave patients timely support and information. There were arrangements and systems in place to support staff to respond to people with specific health care needs such as end of life care and those who had mental health needs. For example, the service worked collaboratively with the End of Life Implementation and Education Group.
- Comfort calls were carried out by receptionists and drivers to check patients' conditions and to inform them how long it would be before they would receive a home visit or telephone consultation.
- Of the 37 patient Care Quality Commission comment cards we received 27 were positive about the service experienced. Three of the ten negative comments related to delays in treatment and insufficient GP cover. This was is in line with the results of the NHS Friends and Family Test and other feedback received by the service.
- The service engaged with patients and regularly reviewed patient feedback. Results showed that for the month of June 2018 94% of respondents were extremely likely or likely to recommend the service to friends and family and 88% felt listened to during their consultation with the nurse or doctor.

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, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them. Information leaflets were available in easy read formats, to help patients be involved in decisions about their care.
- Patients told us through comment cards, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the service as good for providing responsive services.

Responding to and meeting people's needs

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

- The provider understood the needs of its population and tailored services in response to those needs.
- The provider engaged with commissioners to secure improvements to services where these were identified.
- 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, staff had access to 'special notes', additional notes about the patients' health, social situation, past medical history and medicines. Care pathways were appropriate for patients with specific needs, for example those at the end of their life, babies, children and young people.
- The facilities and premises were appropriate for the services delivered.
- The service made reasonable adjustments when people found it hard to access the service.
- The service was responsive to the needs of people in vulnerable circumstances.

Timely access to the service

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

- Patients were able to access care and treatment at a time to suit them. The service operated seven days a week from 6.30pm to 8am
- Patients could access the out of hours service via NHS 111. The service did not see walk-in patients and a 'Walk-in' policy was in place which clearly outlined what approach should be taken when patients arrived without having first made an appointment, for example patients were told to call NHS 111 or referred onwards if they needed urgent care. All staff were aware of the policy and understood their role with regards to it, including ensuring that patient safety was a priority. We saw a local operating policy relating to this at the sites where the service operated from.
- Patients were allocated an appointment, although the service had a system in place to facilitate prioritisation according to clinical need where more serious cases or young children could be prioritised as they arrived. The reception staff had a list of emergency criteria they used to alert the clinical staff if a patient had an urgent need. The criteria included guidance on sepsis and the symptoms that would prompt an urgent response. The receptionists informed patients about anticipated waiting times.
- There were areas where the provider was outside of the target range for an indicator, however where the service was not meeting the target, there was an awareness of this and we saw evidence that attempts were being made to address them and were detailed within the recovery plan.
- There were systems in place to manage waiting times and delays. For example, patients could be contacted and their appointment transferred to a site where there was better capacity. Where people were waiting a long time for an assessment or treatment the center's reception staff we spoke with demonstrated how they would inform patients of waiting times.
- The service engaged with people who are in vulnerable circumstances and took actions to remove barriers when people found it hard to access or use services.
- Patients with the most urgent needs had their care and treatment prioritised.
- Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.
- Referrals and transfers to other services were undertaken in a timely way.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. There were 66 complaints received in the last year. We reviewed three complaints and found that they were satisfactorily handled in a timely way.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Issues were investigated across relevant providers, and staff were able to feedback to other parts of the patient pathway where relevant. A complaint was made regarding delayed call back to a patient. Following investigation, the provider acknowledged that their processes had not been followed. Staff were communicated with regarding the need to adhere to the comfort call policy which was sent to all staff as a reminder of best practice.
- The service learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. However, we saw that learning points were not consistently shared with staff. Of the three we looked at learning points had been shared from only one complaint, which was not in line with the processes put in place by the provider.

Are services well-led?

Requires improvement

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

We rated the service as requires improvement for leadership.

Leadership capacity and capability

Leaders had the skills to deliver high-quality, sustainable care. However there had been significant changes to the leadership team in the recent months and this had impacted on the embedding of governance processes. The recent gaps in leadership have placed a reliance on staff drawing on previous and inherited experience, rather than the systems that were currently operating.

- Leaders had the experience and skills to deliver the service strategy and address risks to it. However, several members of the senior local leadership team had only recently come into post, one a week ago and one five weeks ago and had not had time to embed improved systems and processes. Additionally, several managers had responsibilities for other Care UK out of hours services within the region.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. A senior manager told us that on joining the Gloucester OOH team there had been limited documented handover and that the last three months had necessitated being reactive to arising situations. However, this was changing and plans to move the service forward were now being implemented.
- Leaders at all levels were not visible. Non-clinical staff told us that there had been so many changes in management that they were not always sure who their manager was or who they could go to if they needed support. However, a new manager of non-clinical staff had been in post for one week and had contacted and visited some of the sites to introduce themselves, which staff confirmed. We also saw that the manager of the nursing team worked closely with staff and others to make sure compassionate and inclusive leadership was prioritised.
- Senior management was accessible throughout the operational period, with an effective on-call system that staff were able to use.
- The provider had processes to develop leadership capacity and skills, including planning for the future leadership of the service.

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 and had taken into consideration patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The provider planned the service to meet the needs of the local population.
- The provider monitored progress against delivery of the strategy.
- The provider had not ensured that all staff who worked away from the main base felt engaged in the delivery of the provider's vision and values. Some staff at the sites told us that due to lack of communication and engagement from management it was difficult to feel part of the overall organisation

Culture

- Not all staff we spoke with felt respected, supported and valued. During the inspection we visited five of the six sites. At four of the sites staff were positive about the service and the support received from operational staff, however one site told us that they did not feel supported and valued.
- The service focused on the needs of patients. The leadership team were aware of shortfalls in the delivery of the service and were working to resolve them.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values. For example, regular call and notes audits were undertaken and if an individual fell below expected standards, performance management processes were implemented.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. We saw from the incidents and complaints

Are services well-led?

Requires improvement

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

we looked at that in all instances those affected were contacted and kept informed of outcomes. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.

- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. However, we were told that they did not have confidence that these would be addressed. For example, staff had been reporting that there were insufficient, missing or lost fuel cards but nothing had been actioned. We saw in the communication book that there had been a number of concerns raised about this, between April and August 2018. We spoke with a member of staff who confirmed that the fuel cards had still not been replaced, which meant that there was always a risk of running out of fuel as high mileage was covered during shifts.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. However non-clinical staff had not received an appraisal in the last year. We were told that this was due to management changes and that the new manager had plans in place to undertake all appraisals within the next two months. The nursing team had received an appraisal and staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including regular agency staff, were considered valued members of the team. They were given protected time for professional time for professional development and evaluation of their clinical work. For example, two emergency care practitioners were being supported to complete the non-medical prescribing course.
- The service promoted equality and diversity.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management. However, these were not always implemented effectively.

- Structures, processes and systems to support good governance and management were set out but were not consistently applied. For example, there were processes in place for the checking of equipment at the sites, however there was no evidence that these had been done and there was no check list to ensure missing items could be identified. We did see though, that medicine checks were documented and carried out regularly and supported good governance.
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care. For example, Gloucester Care services, NHS111 and local GP practices.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control. However, the organisation had not ensured staff had undertaken all training or received appraisals in line with their policies.
- There were policies, procedures and activities in place to ensure safety, but the leaders had not assured themselves that they were operating as intended. For example, learning from incidents and complaints were not always shared with staff.

Managing risks, issues and performance

There were processes for managing risks, issues and performance but these were not all encompassing.

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. The leaders recognised that the greatest current risk to the service was the challenge in ensuring adequate staff cover. There had been a recruitment drive to meet this challenge. There was a winter pressures plan in place.
- The provider had processes to manage current and future performance of the service. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of MHRA alerts, incidents, and complaints. Leaders also had a good understanding of service performance against the national and local key performance indicators. The leaders were aware that the service was not meeting the required quality standards. Performance was regularly discussed at senior management and board level. Performance was shared with the local clinical commissioning group (CCG) as part of contract monitoring arrangements and a recovery plan was in place and actions were being taken.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of

Are services well-led?

Requires improvement

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

action to resolve concerns and improve quality. For example, training needs were identified and implemented where call and/or note audits identified a need.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where 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 but at the time of the inspection these plans had either not been embedded, or implemented so recently that sustained positive impact could not be measured.
- 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.
- At the time of the inspection there was no CQC Registered Manager in post, in line with requirements.
- 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 and heard but some staff told us they were not acted on, to help shape services and culture. We spoke with and received feedback from 40 employees across all staff groups during the inspection. Most of the clinicians responded positively to the improvements that were being implemented and felt the feedback they gave was responded to. However, feedback from non-clinical staff was not all positive. We were told that meetings to discuss issues were often cancelled or held at the head office at times that staff who worked at the sites could not attend and minutes of meetings were not distributed. Staff did have the opportunity to dial into these meetings. We looked at the attendees for one meeting and saw that only four members of staff had attended and none were from PCC's that were not local. This had been fed back to management but there had been no response.
- Staff were able to describe to us the systems in place to give feedback. Staff told us that the organisation had gone through a lot of change in the last year in regard of management changes, working patterns and job structure and this had left them feeling unsettled and unsupported. Non-clinical staff told us that accountability had changed and this had resulted in uncertainty. One member of staff told us that communication upwards or downwards from the management was very limited.
- A reward scheme for staff was in operation. For example, the service held a monthly 'Healthcare Hero Award' for staff and the organisation held a National Care UK awards ceremony to recognise staff achievements and accomplishments.
- The service engaged with patients and regularly reviewed patient feedback. Results showed that for the month of June 2018, 94% of respondents were extremely likely or likely to recommend the service to friends and family and 88% felt listened to during their consultation with the nurse or doctor.
- The service was transparent, collaborative and open with stakeholders about performance. For example, the service engaged with the Primary Care UK quality and assurance reviews.

Continuous improvement and innovation

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

- There was a focus on learning and improvement within the service. For example, the management team had initiated a recruitment programme to encourage GP registrars to join the service with incentives that promoted sustainability and improved rota fill. We were told 10 GP registrars were ready to join the service.
- Staff knew about improvement methods and had the skills to use them.

Are services well-led?

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- 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 review individual and team objectives, processes and performance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The provider did not do all that was reasonably practicable to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. They had not ensured: • Records relating to people employed documented information in line with requirements. • Patient Group Directions were correctly adopted. • Consistent sharing of learnings from all incidents and complaints. • Oversight that all appropriate equipment checks were being carried out. • Staff feedback was responded to and acted upon. • That a CQC registered manager was in post. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The provider had not ensured: • Suitable numbers of appropriately qualified staff were deployed to ensure that peoples care and treatment needs were met and therefore meet the national quality requirements standards of care. • All staff had received appropriate training, and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

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Requirement notices

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