Oxford Health NHS Foundation Trust - HQ

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?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at of the Out of Hours services at Oxford Health NHS Foundation Trust – HQ between 7 and 9 November 2016. Overall the service is rated as requires improvement.

Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety and a system in place for recording, reporting and learning from significant events.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- The provider offered a wide range of training opportunities and maintained records of training completed by staff. However, 11 staff had not completed training in basic life support and not all receptionist/drivers had received chaperone training.
- There was a system in place that enabled staff to access patient records, for example the local GP and hospital, with information following contact with patients as was appropriate.
- The service proactively sought feedback from staff and patients, which it acted on.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. There is an active review of complaints, how they are managed and responded to and improvements are made as a result. People who use services are involved in the review.
- The service worked proactively with other organisations and providers to develop services that supported alternatives to hospital admission where appropriate and improved the patient experience.
- The provider 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.
- The provider was aware of and complied with the requirements of the duty of candour.

Summary of findings

- There was a comprehensive system in place to keep patients safeguarded from harm. This included an additional prompt at the end of the consultation record to remind GPs and advanced practitioners to consider if the consultation required referral or consideration as a safeguarding event. There was a clear leadership structure. Communication channels were open and staff felt supported by management.
- Patients' care needs were assessed and delivered following a two stage assessment process which prioritised need. The service was meeting some of the National Quality Requirements and had plans in place to address the areas where they were not.
- At the time of inspection there were not enough clinical staff in post to ensure the provider met national quality requirements (performance standards). In 2015 the provider had met these standards consistently. However, this performance could not be maintained in 2016 due to shortages of GPs and practitioners. A recruitment programme was underway and there was evidence that this was proving successful with new staff appointed to start in December 2016 and January 2017.
- The provider had systems in place to identify, assess and manage risk but the systems were operated inconsistently. Some risks associated with managing prescriptions and cleanliness of treatment facilities had not been identified during monitoring of the service.
- The provider had identified the risk associated with staff shortages and had taken steps to recruit new staff and manage sickness levels. However, the actions taken had been time consuming and staff recruitment was still being pursued at the time of inspection.
- The provider had not obtained evidence of some recruitment checks and mandatory training in a timely manner.

The areas where the provider must make improvement are:

- The provider must ensure governance processes and systems are consistently applied in a timely manner to assess, monitor and improve the quality and safety of the services provided.

The areas where the provider should make improvement are:

- Ensuring calibration and checking of blood glucose meters is carried out in accordance with the manufacturer's specification at all times.
- Ensure the controlled drugs receipt log at Oxford City base is signed when controlled drugs are received into stock.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The service is rated as requires improvement for providing safe services as there are areas where improvements should be made. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example;

- The provider did not hold records to demonstrate the completion of DBS checks for 24 sessional GPs and six out of 124 GPs had not produced evidence of their training in safeguarding children and had not received assurance that 24 sessional GP had completed DBS checks and that six out of 124 GPs were not appropriately trained to safeguarding children level three.
- Systems to monitor the cleanliness of the premises had not identified inappropriate cleaning standards at two of the out of hours bases.
- A revised process for checking out of hours vehicles and their contents had been introduced in the month before inspection. Medicines and equipment were checked and we saw evidence of this.
- Systems to manage medicines were not always operated consistently. The provider did not have a system to track blank prescriptions at five of the six out of hours bases.
- The provider had been experiencing recruitment difficulties throughout 2016. They introduced additional assessment and pre consultation screening tools to ensure patients were kept safe. Clinical prioritisation of urgency was effective.
- There was an effective system in place for recording, reporting and learning from significant events and lessons were shared to make sure action was taken to improve safety in the service.
- When things went wrong patients were informed in keeping with the Duty of Candour. They were given an explanation based on facts, an apology if appropriate and, wherever possible, a summary of learning from the event in the preferred method of communication by the patient. They were told about any actions to improve processes to prevent the same thing happening again.
- The out-of-hours service had clearly defined and embedded system and processes in place to keep patients safe and safeguarded from abuse.

Summary of findings

- When patients could not be contacted at the time of their home visit or if they did not attend for their appointment, there were processes in place to follow up patients who were potentially vulnerable.
- There were systems in place to support staff undertaking home visits.

Are services effective?

Requires improvement

The service is rated as requires improvement for providing effective services as there are areas where improvements should be made.

- Staff assessed needs and delivered care in line with current evidence based guidance.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all employed staff.
- Clinicians provided urgent care to walk-in patients based on current evidence based guidance.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- Data showed the service was not meeting the National Quality Requirements (performance standards) for GP out of hours services. In the six months leading up to inspection the provider had achieved 82% (5,738 out of 7,000) face to face consultations at an out of hours base within two hours of assessment for those patients classified as urgent. This fell short of the 95% target. However, the provider advised that this arose from staff shortages and demonstrated that this was being addressed.
- The clinical audit programme demonstrated quality improvement. However, the service had planned expansion of the clinical audit programme in 2017.

Are services caring?

Good

The service is rated as good for providing caring services.

- Feedback from the large majority of patients through our comment cards and collected by the provider was very positive.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Summary of findings

- Patients were kept informed with regard to their care and treatment throughout their visit to the out-of-hours service.

Are services responsive to people's needs?

Good

The service is rated as good for providing responsive services.

- Service staff reviewed the needs of its local population and engaged with its commissioners to secure improvements to services where these were identified. For example, when the in hours GP services in the Banbury area came under pressure out of hours staff were able to assist during normal working hours.
- The service had good facilities and was well equipped to treat patients and meet their needs.
- The service had systems in place to ensure patients received care and treatment according to the urgency of need.
- Information about how to complain was available and easy to understand and evidence showed the service responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Requires improvement

The service is rated as requires improvement for being well-led as there are areas where improvements should be made.

- There was an overarching governance framework which supported the delivery of the strategy and good quality care. However this was inconsistent in monitoring arrangements to improve quality, identify, assess and manage risk.
- The service had methods for communicating with its staff. Staff were able to identify communications relating to safe and effective delivery of services. However, some staff were not clear on the provider's preferred route by which to obtain this information.

We saw some examples of good practice including:

- The provider proactively sought feedback from staff and patients, which it acted on.
- The service had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The service had a number of policies and procedures to govern activity and held regular governance meetings.

Summary of findings

- The provider was aware of and complied with the requirements of the duty of candour. The provider encouraged a culture of openness and honesty. The service had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- There was a strong focus on continuous learning and improvement at all levels.
- The provider held open and honest discussions with commissioners and other health organisations and supported delivery of services when pressures arose during normal working hours.

Summary of findings

What people who use the service say

We looked at various sources of feedback received from patients about the out-of hours service they received. Patient feedback was obtained by the provider on an ongoing basis and included in their contract monitoring reports. Data from the provider for the period of April 2016 and September 2016, which included 158 patient responses, showed:

- 92% of patients said they were involved in decisions about their care (4%, seven patients responded that they were not well enough to be involved in decision making at the time they received care and treatment)
- 92% of patients said they were likely or very likely to recommend the service to others.
- 96% of patients had confidence and trust in the doctor or nurse they saw during their visit
- 96% said they were treated with dignity and respect

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 69 comment cards which were all positive about the standard of care received. Patients who completed the comment cards referred to being given good explanations of their care and treatment and friendly and compassionate staff. Three patients were complimentary of the care they received but added comments that they had waited a long time to be seen.

We spoke with 12 patients during the inspection. All 12 patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

Oxford Health NHS Foundation Trust - HQ

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included two GP specialist advisers, three further CQC inspectors, a member of the CQC medicines team and a service manager specialist adviser.

Background to Oxford Health NHS Foundation Trust - HQ

The out of hours service in Oxfordshire is provided by Oxford Health NHS Foundation Trust. The service covers the entirety of Oxfordshire and the registered patients from three GP practices in a small part of south Northamptonshire. A total population served is approximately 660,000. In the last year the service received approximately 110,000 contacts from patients. Initial assessment when a patient calls for advice and treatment is undertaken by the NHS 111 service operated by South Central Ambulance service. Once the assessment has been completed the NHS 111 team can book patients directly into the out of hours service. This could involve direct booking for a visit to one of the six out of hours bases or for a further review by the out of hours GPs. The second stage assessment can result in either a home visit, request to attend the out of hours centres or immediate telephone advice.

Services are provided from six locations across the county on every day of the year. They are:

- Oxford City Out of Hours base – East Oxford Health Centre, Manzil Way, Oxford, OX4 1XD. This is a dedicated out of hours facility located in a large health centre. It is open from 6.30pm to 8am (overnight) Monday to Saturday and from 8am on a Saturday through to 8am Monday morning. This centre is also open on bank holidays from 8am to 8am the next day.
- Witney Out of Hours base – Witney Community Hospital, Welch Way, Witney, OX28 6JJ. It is open from 6.30pm to 8am (overnight) Monday to Saturday and from 8am on a Saturday through to 8am Monday morning. This centre is also open on bank holidays from 8am to 8am the next day. The out of hours provision is co-located with a minor injuries unit that is also managed by the Trust and accepts walk in patients either directly or via the minor injuries unit.
- Abingdon Out of Hours base - Abingdon Community Hospital, Marcham Road, Abingdon OX14 1AG. At Abingdon the out of hours provision is co-located with a minor injuries unit that is also managed by the Trust and accepts walk in patients either directly or via the minor injuries unit. It is open from 6.30pm to 8am (overnight) Monday to Saturday and from 8am on a Saturday through to 8am Monday morning. This centre is also open on bank holidays from 8am to 8am the next day
- Henley out of hours base - Townlands Memorial Hospital, York Road, Henley, RG9 2EB. This service is co-located with a minor injuries unit which is also managed by the Trust. Nursing and paramedic staff are able to work between both services. The out of hours

service is open from 6.30pm to 11pm every weekday and from 8am to 11pm at weekends and on bank holidays. When the base is closed overnight services are provided from either the Abingdon or Oxford City bases.

- Bicester out of hours base - Bicester Community Hospital, Piggy Lane, Bicester, OX26 6HT. This site is located alongside a first aid unit also managed by the Trust. The out of hours service is open from 6.30pm to 11pm every weekday and from 8am to 11pm at weekends and on bank holidays. The overnight service for the north of the county is then provided from the Banbury base.
- Banbury out of hours base - Horton General Hospital, Hightown road, Banbury, OX16 9AL. The out of hours service shares this facility with the outpatients department of the Horton General Hospital. It is open from 6.30pm to 8am (overnight) Monday to Saturday and from 8am on a Saturday through to 8am Monday morning. This centre is open on bank holidays from 8am to 8am the next day. The out of hours service is close to the hospital emergency department and accepts patients from this department who require primary care treatment.

All six sites receive, assess and treat patients via the triage and assessment service operated by NHS111 and walk in patients.

We inspected all six sites during the inspection and also visited the Trust headquarters to review policies and procedures relevant to the service and meet with the service managers. The provider recognises that a peak in demand occurs on a Saturday each week and operates two additional services at:

- Washington house surgery, Brackley, Northamptonshire, NN13 6EQ
- Chipping Norton Health Centre, Russell Way, Chipping Norton, Oxon, OX7 5FA

Both of these services are open between 9am and 12pm every Saturday morning. We did not visit these sites as part of the inspection.

The service is managed by a team of officers from the NHS Trust and there are two GPs that are part of the leadership team. There are a total of 136 GPs working within the service of whom 132 are not directly employed and undertake a sessional commitment. In addition to the GPs there are the equivalent of approximately 27 whole time advanced practitioners (either advanced nurse practitioners or emergency care practitioners) and approximately 23 whole time equivalent driver/ receptionists.

The Trust had undergone an inspection in September 2015. At that time the Out of Hours services were not inspected. This is the first inspection of this part of the service managed by the Trust.

Why we carried out this inspection

We inspected the services delivered from the six out of hours bases managed by Oxford Health NHS Foundation Trust as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service, between Monday 7 and Wednesday 9 November 2016, under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew. We carried out an announced visit between Monday 7 and Wednesday 9 November 2016. We visited the service headquarters and inspected the six bases that provide seven day a week out of hours services. During our visits we:

- Spoke with a range of staff, this included nine GPs, two clinical team leaders, four emergency practitioners, two health care assistants and eight driver/receptionists.
- Met with members of the Trust Executive team and the senior clinical and operational leads for the out of hours service.
- Also spoke with 12 patients.

Detailed findings

- Observed how patients were provided with care and spoke with patients their carers and/or family members
- Inspected the out of hours premises, looked at cleanliness and the arrangements in place to manage the risks associated with healthcare related infections.
- Looked at the vehicles used to take clinicians to consultations in patients' homes, and we reviewed the arrangements for the safe storage and management of medicines and emergency medical equipment.
- Reviewed 69 comment cards where patients and members of the public shared their views and experiences of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Please note that when referring to information throughout this report, for example any reference to the National Quality Requirements data, this relates to the most recent information available to the CQC at that time.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. The provider operated a three tier recording system for such events. This was based on the risk associated with the incident ranging from low level concerns to high risk significant incidents.

- Staff, including contractor GPs, told us they would inform the service manager, or lead GPs, of any incidents and there was a recording form available on the service's computer system. The incident recording form supported the recording of notifiable incidents under 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).We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received support, an explanation based on facts, an apology where appropriate and were told about any actions to improve processes to prevent the same thing happening again. For example, when the provider identified an I.T. issue had prevented the out of hours notes being forwarded to the patient's registered GP by 8am the next morning they instituted a full investigation and logged the incident as a significant event. Arrangements were made to put additional resources in place to recover the data and ensure it was sent to the patients registered GP.
- The service carried out a thorough analysis of the significant events. We found that there were a variety of communication systems used to share learning from them. These included bi-monthly learning events. The records of the learning event discussions were made available to all staff, including locums and contractor GPs and we saw significant events were covered in detail. Three of the staff we spoke with referred to receipt of learning either by e-mail or via Adastra (Adastra is an IT system for patient records used by out of hours providers). This demonstrated that not all staff recognised the Trust's preferred method of communication. However, all staff we spoke with were able to recognise significant events and the learning arising from them. The provider demonstrated that e-mails were sent to all staff including GPs that undertook a sessional commitment. This showed that learning was disseminated consistently and to all staff whether employed or self-employed.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the service. The provider had a system in place to deal with national safety alerts. These were reviewed by a senior team of staff within the Trust. They were disseminated to relevant managers within the service to take appropriate action. Alerts regarding medicine interactions were communicated to all GPs that worked in the service and other prescribers via the provider's IT system. GPs we spoke with identified recent alerts and were aware of the action arising from them.

Overview of safety systems and processes

The service had clearly defined and embedded systems, processes and services in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. Staff demonstrated they understood their responsibilities and there were records confirming that most had received training on safeguarding children and vulnerable adults relevant to their role. The provider held records confirming that most GPs were trained to level three in child safeguarding. However, we noted that the provider had not obtained confirmation of the child protection training level attained by six of the sessional GPs working within the service. We reviewed records that identified these GPs had been contacted on various occasions before the inspection to confirm their safeguarding training level.
- The provider had added an additional check to ensure clinical staff considered if a consultation with a child or vulnerable adult required a safeguarding referral. Before the record of a consultation was closed clinical staff were required to enter a decision whether the consultation required a safeguarding referral or not.

Requires improvement

Are services safe?

- A notice in the waiting rooms at each out of hours base advised patients that chaperones were available if required. Drivers and reception staff we spoke with had not received training as a chaperone but had received a Disclosure and Barring Service (DBS) check. (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). These staff could be called upon to carry out chaperone duties both at the out of hours bases and whilst on a home visit.
- The service maintained appropriate standards of cleanliness and hygiene at four of the six bases we inspected. The disposable curtains in treatment rooms at the Oxford City base should have been changed at the end of September 2016 but had not been replaced. At Bicester base we found dust on the safety rails of two couches in the treatment rooms. Infection control audits we saw had identified these issues but monitoring of cleaning standards had not identified the failure to achieve appropriate standards. We found the other four bases were clean and tidy and appropriate cleaning standards were maintained. There was an infection control lead for each base and an infection control protocol in place. Annual infection control audits were undertaken and we saw evidence that action, at four of the bases, was taken to address any improvements identified as a result.
- There was a system in place to ensure most equipment was maintained to an appropriate standard and in line with manufacturers' guidance e.g. annual servicing of fridges including calibration where relevant. However, during the inspection we found that blood glucose meters were not being calibrated. (A blood glucose meter is a medical device for determining the approximate concentration of glucose in the blood). We discussed this with the provider. By the end of the inspection we found that calibration of these devices had been introduced.
- We reviewed twelve personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body, appropriate indemnity and the appropriate checks through the Disclosure and Barring Service. However, we noted that some of the GPs who had worked on a sessional basis for over three years had not supplied evidence of their DBS checks. The provider had contacted these GPs and offered to fund a new DBS check for them. We saw records of the contact made and a timetable for obtaining the outstanding DBS clearances. When locum staff were required to cover shifts the provider used accredited suppliers of locum staff. We saw evidence that appropriate checks were undertaken for locum staff before they were deployed into the service.
- There were systems to check whether sessional GPs met requirements such as having current professional indemnity and registration with the General Medical Council. The provider had checked that all GPs working as Trust employees and sessionally were on the national performers' list (the Performers' list provides a degree of reassurance that GPs are suitably qualified).There was also a check to ensure GPs had appropriate English language skills.

Medicines Management

- The storage of medicines at bases and in mobile vehicles was secure. We found the medicines management processes (ordering, supply and prescribing) made sure that patients received medicines when needed. Processes were in place for checking medicines, including those held within the premises and medicines bags for the out of hours vehicles. The provider carried out medicines audits, with the support of the Trust's pharmacy team, to ensure prescribing was in accordance with best practice guidelines for safe prescribing.
- While blank prescriptions forms and pads were stored securely, the stock management process at five bases (Henley, Witney, Banbury, Bicester and Oxford Central) was not sufficient to identify which prescriptions had been issued to each prescriber. We discussed this with the provider. They raised a significant event report based on our findings and tasked a senior manager to institute a stock control system to ensure the issue of prescriptions could be tracked at each of the bases.
- During the inspection, we identified that manual records of the fridge temperature dated before October 2016 did not provide assurance that medicines had been stored within the correct temperature range. The provider had identified that the fridge temperature recording system required improvement and had installed data loggers in the medicines fridges in October 2016. (Data loggers constantly record the

temperature to give a more accurate record). Staff accessed this data from computer files. The provider had made arrangements to ensure medicines requiring refrigeration were maintained in a fit for use condition.

- Patient group directions (PGDs) were used by nurses and paramedics to supply or administer medicines without a prescription. PGDs in use had been ratified in accordance with legislation.
- The service held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had standard operating procedures in place that set out how controlled drugs were managed in accordance with the law and NHS England regulations. These included auditing and monitoring arrangements, and mechanisms for reporting and investigating discrepancies. The provider held a Home Office licence to permit the possession of controlled drugs within the service. There were also appropriate arrangements in place for the destruction of controlled drugs. However, we noted that the CD order book received section had not been signed since April 2016. This did not follow the trust protocol or best practice. Our check of the controlled drugs held showed that individual register entries had been signed and corresponded with stock held, receipts of replacement drugs and issue of these medicines. The register had, in all cases, been appropriately completed when controlled drugs had been administered.
- Arrangements were in place to ensure medicines and medical gas cylinders carried in the out of hours vehicles were stored appropriately. The provider ensured that medical equipment and medicines were not left in vehicles during the hours when the service was not operating. These items were removed from the vehicles and stored securely within the six bases from which the serviced operated.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- We found there were procedures in place for monitoring and managing risks to patient and staff safety. We saw the health and safety policy. The service had copies of the up to date fire risk assessments for each of the premises where the out of hours bases were sited. There was evidence that regular fire drills were undertaken. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The provider also held copies of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a bacterium which can contaminate water systems in buildings).
- There were systems in place to ensure the safety of the out of hours vehicles. Checks were undertaken at the beginning of each shift. These checks included; ensuring all medicines required for home visits were available, checking that oxygen cylinders held at least 30 minutes of oxygen, that all equipment required for home visits was on board and ensuring that safes were in place to hold controlled drugs and prescriptions. The drivers also undertook a visual check of the vehicle to ensure it was roadworthy and free from damage to tyres and wheels. Records were kept of MOT and servicing requirements. We checked the vehicles and found that they were kept in a clean and tidy state. All equipment and medicines were held securely in the boot of the vehicle and that regular checks of the vehicles had been undertaken.
- We checked the medicines and equipment used in the vehicles at all six bases. When we first checked the vehicle at Henley base we found it did not hold water for injections. If a patient had required an injection the GP or paramedic practitioner would not have been able to administer it. The provider dealt with this promptly and ensured the water for injections was replenished in the vehicle. A revised protocol for checking the vehicles had been introduced in the month before inspection. The vehicles we checked at the other bases were all appropriately stocked. There were spare vehicles available for use in the event of another being out of service. For example, two vehicles were kept at the Oxford City base.

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. However, these arrangements had not proven effective in 2016. The provider had experienced shortages of clinical staff since the start of 2016. There was evidence that recruitment drives had taken place and that staff had been appointed to come into post from December 2016 through to March 2017. The recruitment of the new staff would enable the provider to fill their rota. The inspection team saw evidence that there were some occasions during the previous 9 months where the rota had not been filled. However, the provider's contingency plan

and cover arrangements enabled them to either bring in locum staff to cover vacancies or cross cover between the six bases where gaps on the rota were identified thus mitigating any risks.

- The provider opened two further premises on a Saturday morning to ensure patients were seen at times of peak demand. This improved safe delivery of the service by provision of more staff to see patients in a timely manner at a location closer to the patient's homes.
- The role of health care assistants had been reviewed and enhanced. These staff undertook initial assessments of patients to ensure it was safe for the patient to wait for their care and treatment. They were able to undertake initial observations for patients such as blood pressure checks and other tests. Information was therefore available to the clinical staff to prioritise those patients in greater need of early advice and treatment.

Arrangements to deal with emergencies and major incidents

The service had appropriate arrangements in place to respond to emergencies and major incidents.

- There was an effective system to alert staff to any emergency.
- The provider had a programme of training for staff to receive basic life support training, including use of an automated external defibrillator. We noted that 11 of the driver /reception staff out of 60 (the majority of non-clinical staff were employed to undertake both driver and reception roles) had not received their training at the time of inspection. However, the training records we saw showed this was planned for all staff by the end of December 2016.
- The service had access to defibrillators at each of the out of hours bases and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were available at each base and all staff knew of their location. All the medicines we checked were in date and stored securely. When we arrived to inspect the Banbury base we found that some of the stock of emergency medicines held was shared with the hospital emergency department. The provider also held some emergency medicines for the out of hours service. Staff had to remember where the various medicines were held and this could have led to a delay in finding the medicine they needed for the patient. We received confirmation within a day of completing the inspection that emergency medicines had been rationalised into one stock.
- The service had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. The continuity plan enabled the provider to switch provision of services between their six bases. Services could therefore be maintained if one of the bases was unable to be accessed.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The service assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best service guidelines.

- The service had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The service monitored that these guidelines were followed.
- The health care assistants who undertook baseline observations when patients arrived at the service had information relating to normal values and vital signs, which enabled them to easily escalate concerns to clinicians.

Management, monitoring and improving outcomes for people

From 1 January 2005, all providers of out-of-hours services have been 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 the clinical commissioning group on their performance against 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. The initial assessment and booking into the service was undertaken by the NHS 111 service, the provider was not therefore required to report on response times to telephone calls.

The provider had been experiencing clinical staff shortages throughout 2016. This had resulted in the provider not attaining some of the quality requirements. Despite significant effort to recruit additional staff there had been difficulties sourcing appropriate staff in a timely manner. The provider had alerted their commissioners to the difficulties and had maintained an open and honest dialogue with the commissioners whilst recruitment was underway. We found evidence that the provider had:

- Clearly identified the staffing requirements needed to meet the NQR's and provide safe and effective services.
- Reviewed the use of the service to identify peaks and troughs in demand to plan the numbers of staff required for each shift operated.
- Reviewed the types of care and treatment required by patients to match the skills of staff to the treatments required. This enabled the provider to change the skill mix of staff employed in the future to more closely match demand and assist in recruitment.
- Instituted additional safety checks and assessments to ensure patients were kept safe whilst recruitment was ongoing.
- Maintained close contact with their commissioners on progress made in recruiting the required number of staff. We reviewed a report that showed the progress made in the three months August to October 2016. This showed that 79% of the OOH sessions required were filled in August rising to 90% in October. The provider also supplied information that identified further staff coming into post in November and December 2016.

Proactively managed higher than average levels of sickness absence amongst employed clinical staff.

The provider's performance against national quality requirements (NQRs) included:

- NQR 4, audit a random sample of patient contacts and act on the results of the audit: A random sample of at least 1% of patient contacts per GP was completed every year. The provider set a standard of a score of 17 out of a maximum of 22 as a target. This standard exceeded the national recommendation of a minimum score of 14. When the audit identified GPs falling below this standard the provider demonstrated that action was taken to support the GP to improve their performance. For example by offering coaching, mentoring and further training. Data showed that 78% of GPs were attaining the consultation standards set by the service.
- NQR 10 Face to face assessment (emergency), commence definitive assessment for this group of patients within three minutes of arrival at a centre: The provider had met the standard for starting definitive clinical assessment for patients with emergency needs within three minutes of the patient arriving at the out of hours base. Data from January to October 2016 showed that there were no patients who fell into the emergency category. NQR 10 Face to face assessment (urgent), commence definitive clinical assessment within 20

minutes of arrival at an OOH centre: The provider had not been meeting this standard since January 2016. Data showed that since April 2016 out of 288 patients defined as in need of urgent assessment 198 (74%) had been assessed within 20 minutes when the target was 95%. However, a safety system had been introduced whereby the service had employed specially trained Emergency Nursing assistants to undertake immediate assessments of patients walking into bases to ensure that they were safe and that their priority is reflected accurately.

- This ensured those in most urgent need of assessment were seen first. The provider showed us evidence that the number of reported incidents remained low due to the prioritising system the provider had in place. We noted that undertaking the clinical prioritisation resulted in slower assessment but incorporated appropriate prioritisation of need to ensure patient safety.

- NQR 10 Face to face assessment (non-urgent), commence definitive clinical assessment within 60 minutes of arrival at an OOH centre: Since April 2016 there had been 3,451 contacts with patients with non-urgent needs. Of these 2991 (87%) had received their clinical assessment within the 60 minute target. This fell short of the 95% target to undertake the clinical assessment. A similar system of prioritisation of need was in place for this group of patients and patients were advised to alert the provider to any change in their condition or symptoms whilst they awaited their assessment.

- NQR 11 match the skills of clinicians available with peaks of demand in the service. The provider also opened two additional OOH centres on Saturday mornings. We noted that this coincided with a period of high demand for out of hours services. These were staffed with suitably qualified GPs and practitioners. The provider demonstrated that adjustments in staff rosters were underway to increase staffing levels at peak times and reduce the staff cover during times of lowest demand. We also saw that additional highly qualified advanced practitioners had been recruited to commence duties in January 2017. A recruitment programme had been underway to recruit additional suitably skilled and experienced staff. Data from the provider showed that 4062 (84%) of the target 4813 shifts had been filled since January 2016.

The provider had maintained close scrutiny of reported incidents and events. There had been four serious (red) incidents in the last year and 11 second level incidents which the provider graded as 'orange'. This was similar to the levels of incident reporting from the previous year when the provider was closer to full staffing and had been achieving all of the national quality requirements.

- NQR 12 (Face to face consultations) The NHS 111 service had direct access to book patients, whom they have assessed through NHS Pathways, into the bases. This was achieved via a link into the provider's computer system. NHS 111 provided information including the patient's demographics, the clinical assessment and priority. This ensured that information was correct and reduced the need for the patient to repeat their history. Other patients could be booked in by out of hours clinicians when they talked to the patient on the telephone.

Achievement against the standards was mixed:

- Patients classified as in need of urgent consultation following definitive clinical assessment to be seen within two hours at an OOH centre: In the six months leading up to inspection the provider had achieved 82% (5,738 out of 7,000) face to face consultations at an out of hours base within two hours of assessment for those patients classified as urgent. This fell short of the 95% target.
- Patients classified as in need of less urgent consultation following definitive clinical assessment to be seen within six hours at an OOH centre: In the six months prior to inspection these face to face consultations had been commenced within six hours for 12,631(97%) out of 12,991 patients classified as routine. The target was 95%.

Patients classified as urgent requiring a face to face consultation at their place of residence to be seen within two hours following definitive clinical assessment: In the six months prior to inspection 2,202 (94%) of 2,349 patients had been seen within two hours in their place of residence. The target was 95%.

Patients classified as less urgent requiring a face to face consultation at their place of residence to be seen within

Requires improvement

Are services effective?

(for example, treatment is effective)

six hours following definitive clinical assessment: Face to face consultations with patients assessed as less urgent in their place of residence was achieved for 2,303 (98%) out of 2,340 patients within six hours. The target was 95%.

There was evidence of quality improvement including clinical audit. The provider had identified that expansion and enhancement of their audit programme would assist in further improvement in patient outcomes. We noted that the job descriptions for advanced practitioners appointed to join the service in December included leading on clinical audits.

- There had been four clinical audits undertaken in the last two years. We saw that three of these were completed audits where the improvements made were implemented and monitored.
- The service participated in local audits, national benchmarking, accreditation and peer review.
- Findings were used by the service to improve services. The provider had undertaken two cycles of an audit focussed on the clinical guidance for taking all relevant observations when a child with a fever was seen in the out of hours service. The first audit identified that the full guidance had been followed in 50% of the random sample of consultations chosen. The provider sent an update of the clinical guidance to GPs and advanced practitioners that reinforced the best practice evidence and the need to clearly document that all observations undertaken were entered in the consultation record. The second audit showed an improvement in a similar sized random sample to 65%. The audit report we reviewed identified that further communication of the clinical guidelines was to be undertaken. The audit was chosen as relevant to the service because children with a fever were often seen within the service.
- Information about patients' outcomes was used to make improvements such as implementing a change in skill mix to appoint more senior practitioners to match the range of conditions patients were presenting with.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The service had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. New staff were also supported to work alongside other staff and their performance was regularly reviewed during their induction period.
- The service could demonstrate how they ensured role-specific training and updating for relevant staff. For example, training for telephone consultations included theory and practical training, Advanced Nurse Practitioners (ANP) who undertook this role were signed off as competent and had received appropriate training in clinical assessment. Health care assistants were also required to undertake the new Care Certificate introduced nationally to equip them with the skills and knowledge for their role, there wasevidence that HCAs had undertaken specific training for each aspect of their role and had been assessed as competent. Training records we saw confirmed this.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of service development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, and clinical supervision. All employed staff who had been in post for over a year had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness and information governance. We noted that all staff were required to complete life support training. However, 11 staff were to complete this training in December 2016. Staff had access to and made use of the extensive NHS Trust in-house training programmes. Training sessions were held every two months when specific topics were covered. For example, a recent training session included advice to GPs and practitioners on diagnosis of Lyme disease. (Lyme disease is an infectious disease originating from a tic bite). This topic was chosen after a recent case of the disease in the Oxfordshire area.
- Staff involved in handling medicines received training appropriate to their role. The provider had a policy in place that ensured controlled drugs were only handled by appropriately trained and competent staff.

Requires improvement

Are services effective?

(for example, treatment is effective)

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the service's patient record system and their intranet system.

- The provider used an electronic patient record system called Adastra. Information provided from local GP practices was entered onto the system. These records could be accessed and updated by out of hours clinicians, reception staff, emergency department staff in Oxfordshire, district nurses, palliative care nurses and other health professionals with the consent of the individual concerned. The system was also used to document, record and manage the care patients received.
- When a patient had contact with the out of hours service information from the Adastra system was transferred by an automated programme from the provider to their GP by 8am the next morning. We noted that the provider closely monitored that these communications were successful. NQR data showed that from April to September 2016 46,096 communications had reached the patient's registered GP by 8am out of a total number of contacts of 46,311 (99.5% success rate against a target of 95%).
- Staff we spoke with found the systems for recording information easy to use and had received training. Clinical staff undertaking home visits also had access to IT equipment so relevant information could be shared with them while working remotely. This equipment did not always pick up a signal in remote areas thus preventing staff from completing record entries whilst on a visit. Staff had to return to base to complete the records which took time they could have used to treat other patients. The provider had been aware of this problem and was able to demonstrate that updated equipment had been ordered. This equipment was not due for delivery until early 2017.
- Information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the provider's main policy repository and guidelines held on the Adastra system.
- The service shared relevant information with other services in a timely way, for example when referring patients to other services.
- The provider worked closely with the NHS 111 provider in their area, for example the NHS 111 service undertook initial assessment of all patients seeking to access the out of hours service. There were monthly performance review meetings held that involved officers from the NHS 111 service.
- The provider worked collaboratively with other services. Patients who could be more appropriately seen by their registered GP or an emergency department were referred. If patients needed specialist care, the out-of-hours service, could refer to specialties within the hospital. Staff also described a positive relationship with the mental health and district nursing team if they needed support during the out-of-hours period.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear clinical staff assessed the patient's capacity and, recorded the outcome of the assessment.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- 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. At five of the bases conversations in consulting and treatment rooms could not be overheard. However, at the Banbury base we noted that conversations could be heard from the waiting area. The provider had plans in place to relocate in 2017 to a more suitable building on the Banbury site.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

We noted that 96% of the 69 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the provider offered an excellent service that responded quickly to patients needs and staff were helpful, caring and treated them with dignity and respect. The three comment cards that were not wholly positive contained comments about waiting a long time to be seen.

Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the provider's survey carried out by an independent survey organisation between March and September 2016 showed that of the 158 patients surveyed:

- 92% of patients said they were likely or very likely to recommend the service to others.
- 96% of patients had confidence and trust in the doctor or nurse they saw during their visit
- 96% said they were treated with dignity and respect

Care planning and involvement in decisions about care and treatment

The out of hours service dealt, generally, with single episodes of care, and the patient involvement differed from providers such as GP services which addressed the longer term wellbeing of patients. Patients we spoke with said that they were involved in decision making about the care and treatment they received when relevant. This was supported by the patients' views from the comment cards. They said they were 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.

Staff we spoke with had a good understanding of consent and of the need to involve patients in decision making.

Results from the independent survey carried out for the provider between March and September 2016 showed:

- 92% of 158 patients said they were involved in decisions about their care (seven patients responded that they were not well enough to be involved in decision making at the time they received care and treatment)

The service provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation 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.
- Information leaflets were available at all the bases. However, the provider was limited in what could be displayed at three of the bases due to sharing facilities with other health services.
- Facilities for people that used hearing aids were available at three of the bases.
- GPs and practitioners were able to provide patients with condition specific literature by printing these from the computer system.

Patient and carer support to cope emotionally with care and treatment

All GPs had access to the services bereavement policy via the provider's intranet. The policy included information for urgent death certificates due to religious grounds, coroner contact telephone numbers alongside Oxfordshire bereavement support services and charities.

Policy and processes prioritised palliative care calls to ensure these patients received timely care and treatment. Clinical staff could give a direct telephone number to the carers of palliative care patients. Those carers no longer had to go through the NHS 111 service so saving valuable time, stress and the repetition of the details of their very distressing circumstances. Information relating to the

Good

Are services caring?

needs of patients receiving palliative care was shared promptly between the patients' registered GP and the service. These were provided via care plans transferred to the provider's database.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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. The provider had worked with commissioners to see more patients in the north of the County during a time when GP services in this area were under pressure with closures of some GP practices.

- Home visits were available for patients whose clinical needs resulted in difficulty attending the service.
- There were accessible facilities at all of the six bases. However, a hearing loop was only available at four of the bases. The provider had access to a translation service for those patients who had difficulty communicating in English. This service could be accessed within 15 minutes of the request being made.
- The provider supported other services at times of increased pressure.

Access to the service

The service opening times varied dependent upon the base location within the county. The service opening hours were:

- Oxford City Out of Hours base – East Oxford Health Centre open from 6.30pm to 8am (overnight) Monday to Saturday and from 8am on a Saturday through to 8am Monday morning. This centre is also opened on bank holidays from 8am to 8am the next day.
- Witney Out of Hours base – Witney Community Hospital opened from 6.30pm to 8am (overnight) Monday to Saturday and from 8am on a Saturday through to 8am Monday morning. This centre also opened on bank holidays from 8am to 8am the next day.
- Abingdon Out of Hours base - Abingdon Community Hospital opened from 6.30pm to 8am (overnight) Monday to Saturday and from 8am on a Saturday through to 8am Monday morning. This centre is also opened on bank holidays from 8am to 8am the next day
- Henley out of hours base - Townlands Memorial Hospital opened from 6.30pm to 11pm every weekday and from 8am to 11pm at weekends and on bank holidays. When the base is closed overnight services were provided from either the Abingdon or Oxford City bases.
- Bicester out of hours base - Bicester Community Hospital opened from 6.30pm to 11pm every weekday and from 8am to 11pm at weekends and on bank holidays. The overnight service for the north of the county was then provided from the Banbury base.
- Banbury out of hours base - Horton General Hospital opened from 6.30pm to 8am (overnight) Monday to Saturday and from 8am on a Saturday through to 8am Monday morning. This centre is open on bank holidays from 8am to 8am the next day.

Patients could access the service via the NHS 111 service. The out of hours service also accepted 'walk in' patients at all six bases. If a patient walked in they completed a medical questionnaire with the reception staff that enabled an initial assessment of urgency to be undertaken. If the patient's condition required immediate advice a GP, paramedic or advanced nurse practitioner was alerted to enable them to make a clinical judgement of urgency. The provider had assessed the risk of allowing direct access for patients walking in. Their conclusion was that turning a patient away presented a greater risk than allowing the patient to attend for a walk in service. Enabling such access reduced the risk of a patient deciding not to seek advice and treatment.

Patients were also able to access the out of hours service at Chipping Norton Health Centre and Washington house surgery, Brackley between 9am and 12pm every Saturday. These services ran in addition to the main six bases.

The independent patient survey conducted between April and September 2016 showed that 94% of 158 patients surveyed said the location of the out of hours base was either fairly or very convenient for them to attend.

When we inspected all six of the out of hours bases we found that signposting to the service at three (Henley, Bicester and Banbury) was not clear and that the out of hours base was not obvious to patients and their relatives. Managers told us that because they rented space at each of these sites from other services they were restricted by their landlords in placing signs and directions at these locations.

There were arrangements in place for people at the end of their life so they could contact the service directly.

Feedback received from patients from the CQC comment cards indicated that in most cases patients were seen in a timely way.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The service had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

The GPs, or practitioners, at each base telephoned the patient or their relative/carer to obtain additional information about the patient's condition or concerns. This enabled a clinical assessment of urgency to be completed. The patient or relative/carer was then given a timescale for the visit. They were also advised to call the service back should their condition change or deteriorate whilst waiting for their visit.

Listening and learning from concerns and complaints

The provider had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with the NHS England guidance and their contractual obligations.
- There was a designated team within the Trust responsible for co-ordinating the handling of all complaints in the service.
- We saw that information was available to help patients understand the complaints system consisting of notices and leaflets at each of the out of hours bases.

We looked at six complaints received in the last 12 months in detail and found these were dealt with in a timely and comprehensive manner. Each complaint resulted in a thorough investigation and the complainant received a comprehensive response. Lessons were learnt from individual concerns and complaints and also from analysis of trends. Action was taken as a result to improve the quality of care. This information was disseminated to all staff. This included directly employed clinicians and the GPs that undertook sessional work with the provider. For example, following a misdiagnosis the patients relatives received a full report of the incident and an apology.The provider involved the patients relatives in learning how to avoid a similar incident in the future. Research was undertaken into the condition and revised guidance was issued to clinical staff to heighten their awareness of the condition and how to identify it. Additional protocols were issued and learning was shared via a learning event, cascade using the IT system and briefings that both employed and self-employed clinicians attended.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

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

- The service had a mission statement and staff knew and understood the values.
- The service had a strategy and a supporting business plan that reflected the vision and values and were regularly monitored.
- The business plan was shared with the local commissioners and was amended when changes in commissioning requirements were made or planned. The provider was working with commissioners and other agencies in the county on a review of services.

Governance arrangements

The service had an overarching governance framework that supported the delivery of the strategy. This outlined the structures and procedures in place. However, governance of the service had failed to address some of the issues the service faced in a timely manner and had not identified all areas of risk.

- Whilst the provider had a good understanding of their performance against National Quality Requirements their response to staffing shortages had been time consuming and had resulted in them failing to attain the requirements since the start of 2016. We noted that a recruitment plan had been put in place and that appointment of new staff had improved in the three months prior to inspection. Data showed progress in filling vacancies and shifts to bring the service back to a level where quality requirements could be achieved. The performance against the requirements was discussed at senior management and board level. Performance was shared with staff and the local clinical commissioning group as part of contract monitoring arrangements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions but these had failed to identify risks found during inspection. For example, prescriptions were not being tracked at five of the six out of hours bases, actions required from control of infection audits had not been completed at the Bicester and Oxford City bases.
- The provider had not received assurance that all sessional GP had completed DBS checks and that all were appropriately trained to safeguarding children level three. Some of these confirmations of checks and training had been awaited for a year. Of the 60 driver/ receptionists 11 had not received relevant training in life support or chaperone duties at the time of inspection.
- The CD order book received section had not been signed since April 2016. This did not follow the trust protocol or best practice. Our check of the controlled drugs held showed that the register entries corresponded with stock held, receipts of replacement drugs and issue of these medicines.
- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Service specific policies were implemented and were available to all staff.
- Audit was used to monitor quality and to make improvements. We saw plans to enhance the range of audits undertaken and make audit more relevant to the out of hours service. Requirement to undertake audit had been built in to the job descriptions of new paramedic practitioners and advanced nurse practitioners who were coming into post in December 2016 and January 2017.

Leadership and culture

During the three day inspection the provider demonstrated they prioritised safe, high quality and compassionate care. Staff told us that managers and senior leaders were approachable and took the time to listen to all members of staff. There was evidence of the provider completing staff satisfaction surveys and the results of these showed high levels of staff commitment within the service.

The provider was aware of and had systems in place to ensure 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). The provider encouraged a culture of openness and honesty. The service had systems in place to ensure that when things went wrong with care and treatment:

- Affected people received an explanation based on facts and an apology where appropriate, in compliance with the NHS England guidance on handling complaints.
- The service kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

Are services well-led?

Requires improvement

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

- There were arrangements in place to ensure the staff were kept informed and up-to-date. These included a staff newsletter specific to the service, bi-monthly education and learning events, a team information cascade system and briefings from managers. The provider had identified the need to improve support and communication and had appointed clinical team leaders who covered two of the out of hours bases each.
- Staff told us there was an open culture within the service and they had the opportunity to raise any issues and felt confident and supported in doing so. The provider operated an on call senior manager rota. This enabled urgent problems to be escalated to senior management promptly whilst the service was in operation and staff were on site.
- Staff said they felt respected, valued and supported, particularly by the providers. Staff had the opportunity to contribute to the development of the service.

Seeking and acting on feedback from patients, the public and staff

The service encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. For example, the provider conducted their own patient satisfaction surveys on an ongoing basis. The last survey conducted between March and September 2016 showed that of the 158 patients surveyed:

- 92% of patients said they were likely or very likely to recommend the service to others.
- 96% of patients and confidence and trust in the doctor or nurse they saw during their visit
- 96% said they were treated with dignity and respect

- The service had gathered feedback from staff through an annual staff survey, staff meetings and educational events, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt engaged to improve how the service was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the service. The service team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, the provider was actively involved in creation of the Oxfordshire shared care record.

There were a wide range of learning opportunities available to staff throughout the NHS Trust. We saw that training and learning opportunities were promoted.

Evening seminars were held on a bi monthly basis covering a wide range of topics relevant to the service. These were well attended for example one event in early 2016 was attended by 70 staff.

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
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:** **Good governance** The registered person 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 and others who may be at risk which arise from the carrying on of the regulated activity(s); Systems and processes in place were not operated consistently to ensure compliance with the regulation. For example: • Monitoring systems had not identified inappropriate cleaning standards at Bicester and Oxford City bases. • Completion of DBS checks had not been verified for all self-employed GPs and validation of training in child safeguarding had not been achieved in a timely manner. • The security of prescriptions was not maintained appropriately at five out of hours bases. • Response to identified risks such as failure to attain national quality standards and employ sufficient numbers of clinical staff had not been completed effectively to ensure national quality standards were achieved in a timely manner. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.