Staffordshire House

Quality Report

Staffordshire House
Unit 5, Riverside 2
Campbell Road
Stoke-on-Trent
Staffordshire
ST4 4RJ
Tel: 01782 764515
Website: www.sduc.nhs.uk

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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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Staffordshire Doctors Urgent care out of hours service on 22 March 2017. 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 an effective system in place for recording, reporting significant events. However, the learning outcomes were not always embedded in policy and process.
- Risks to patients were assessed and managed.
- Patients' care needs were assessed and delivered in a timely way according to need. The service met the National Quality Requirements in most areas although there was a pattern of performance being below the required targets at weekends.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Most staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- The out of hours staff provided other services with information following contact with patients as appropriate. For example, the local GP and hospital,
- The service managed patients' care and treatment in a timely way. However, they found it difficult to achieve the target response times at weekends.
- 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. Improvements were made to the quality of care as a result of complaints and concerns.
- 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 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 was a clear leadership structure and staff generally felt supported by the management team. However we found areas of improvement were needed in the clinical leadership and governance.
- The service proactively sought feedback from staff and patients, which it acted on.

Summary of findings

- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider must make improvement are:

- Review the clinical governance and leadership arrangements to ensure that:
- Audits carried out on clinicians' performance are acted on to minimise risks to patients and are carried out in accordance with the policy.
- Clinicians are able to access the summary care records of patients.
- A review is carried out on the protocol for using untrained staff who acted as chaperone outside of the curtain.
- Further improvements are made to ensure effective communication of shared learning from incidents.
- Policies and protocols are implemented but did not always govern activity. For example, the temperature storage parameters for oxygen and medication when in transit.

The areas where the provider should make improvement are:

- Implement a protocol to cover medicines in transit and how they may be affected by temperatures outside of the recommended storage parameters.
- Continue to explore ways to meet the target response times for patients to be seen at weekends.
- Ensure nurses providing care to children are competent and appropriately trained.
- Ensure that computer hardware and systems have the facility to produce patient information leaflets.
- Review the access and availability of diamorphine to ensure that treatment can be provided across all services in a timely manner (diamorphine is a medication used to treat pain; particularly pain caused by cancer).

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.

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Staff spoke of a 'no blame' culture that helped encourage the reporting of incidents.
- There was an effective system in place for recording, reporting and learning from significant events. However, the learning outcomes were not always embedded in policy and process.
- 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 line with the patients' preferred method of communication. They were told about any actions to improve processes to prevent the same thing happening again.
- The out-of-hours service had clearly defined systems and processes in place to keep patients safe and safeguarded from abuse. These included a follow-up to each safeguarding referral made.
- 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.
- Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- Risks to patients and staff were assessed and managed.
- Staff who acted as chaperones were trained and had been checked through the disclosure and barring system (DBS). However we were told of instances when staff without the training acted as a chaperone by standing outside of the curtain.

Are services effective?

Requires improvement

The service is rated as requires improvement for providing effective services.

Summary of findings

- Our findings at the inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.
- The service was meeting National Quality Requirements (performance standards) for GP out of hours services in some areas but there was a trend of performance at weekends being below the contractual targets.
- Staff assessed needs and delivered care in line with current evidence based guidance. However, some staff told us that they were unable to access patient summary care records.
- There was evidence that audit was driving improvement, particularly in regards to the safe prescribing of controlled medication and those medications at risk of potential abuse.
- Most staff had the skills, knowledge and experience to deliver effective care and treatment. Nurses had been trained to administer care to young children but there was no competency checks in place.
- There was evidence of formal feedback, appraisals and personal development plans for all staff. However, one GP who worked on a self-employed basis told us that there had been no formal feedback in the last 12 months.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The service is rated as good for providing caring services.

- Feedback gained from the large majority of patients through our comment cards and that collected by the provider was 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.
- 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.

Summary of findings

- The service worked closely with other organisations and with the local community in planning how services were provided to ensure that they met patients' needs. For example, the provider supported the emergency department at the nearby hospital to help meet winter pressures.
- 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 in a timely way and according to the urgency of medical need. However, they found it difficult to achieve their contractual targets at weekends.
- Information about how to complain was available and easy to understand. 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.

- 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.
- The service had a number of policies and procedures in place, but these did not always govern activity. For example, the appropriate use of chaperones.
- There was a clear leadership structure and staff felt supported by management. The service held regular governance meetings.
- Staff received regular performance reviews but we saw that these had not always been acted on appropriately or in accordance with policy. For example, we found examples of GP failed audits that had not been acted on appropriately when standards were not being met.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. However, we saw that the governance required further strengthening in certain areas. To include ensuring that policies govern activity and that learning outcomes from significant events are implemented.

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
- The service proactively sought feedback from staff and patients, which it acted on.
- There was a focus on continuous learning and improvement within Staffordshire Doctors Urgent Care Limited (SDUC), supported by the senior management within the Vocare Group.

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 through the NHS Friends and Family Test (FTT). The FTT is a tool used for patients to provide feedback on their experience of the service. Data from the provider for February 2017 showed that from 643 responses:

- 96% of patients stated that they were likely or extremely likely to recommend the service to friends or family.

The provider used postal surveys to gain patient feedback on different aspects of the service. The survey asked patients to rate the service provided between poor, fair, good, very good or excellent. Survey responses for Stoke-on-Trent and North Staffordshire in February 2017 showed:

- 72% of respondents stated that their consultation with a clinician was very good or excellent.
- 11% of respondents stated that their consultation with a clinician was poor.
- 67% of respondents stated that the explanation from the health professional was very good or excellent.
- 6% of respondents stated that the explanation from the health professional was poor.

As a result of the postal surveys, the provider produced a 'You said, we did' report that detailed actions taken as a direct response.

The national GP patient survey asks patients about their satisfaction with the out-of-hours service. The survey results were reported on by Clinical Commissioning Group (CCG). Combined patient satisfaction rates for the six Clinical Commissioning Groups (CCGs) were the same or above the National average. Data from the GP national patient survey published in July 2016 found:

- 66% of patients responded positively when asked how quickly care was received (National average 62%).
- 90% of patients had confidence and trust in the person or people they saw or spoke with (National average 90%).
- 72% of patients responded positively when asked about their overall experience of the out of hours service when their GP surgery was closed (National average 70%).

There were 30 reviews on the NHS Choices website for the provider. The comments and reviews were mixed in with comments and reviews for the NHS 111 service. Twelve of the reviews were positive with 11 praising the staff, four praising the quick service received, and three praising the facilities provided. Eighteen of the reviews were negative with five criticising the attitude of staff, four criticising wait times, four criticising wait times for call backs, three criticising diagnosis, one unhappy with their disposition, one unable to get an appointment, and one unhappy with the "waste of time" NHS 111 service.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 143 comment cards gathered from four of the sites, which were mostly positive. The positive comments related to the cleanliness of the environment, the friendliness of staff and the prompt service provided. There were four negative comments from patients in relation to having to wait for their appointment.

Staffordshire House

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 advisor and two CQC inspectors.

Background to Staffordshire House

Staffordshire Doctors Urgent Care Limited (SDUC) is a limited company commissioned to provide the GP out-of-hours (OOH) service to the population of Staffordshire. In North Staffordshire, SDUC also provides the NHS 111 service but the service contracts are not integrated. We inspected and reported on the NHS 111 service separately. The GP out-of-hours service covers a population of approximately 1,100,000 people living in Staffordshire. SDUC is part of the Vocare Group, a provider of urgent care services across the UK that includes GP OOH services, urgent care centres and the NHS 111 service. The population served includes the more deprived urban areas in and around Stoke-on-Trent as well as the more affluent areas in south Staffordshire with pockets of deprivation around Cannock, Tamworth and Burton upon Trent.

SDUC are commissioned to provide a GP led telephone triage service for the whole of Staffordshire. There are four separate contracts with Staffordshire Clinical Commissioning Groups (CCGs); one contract for North Staffordshire and Stoke-on-Trent CCGs, one for Stafford and Surrounds and Cannock Chase CCGs, one for South East Staffordshire and Seisdon Peninsula CCG and one for East Staffordshire CCG that is sub-contracted to SDUC through Virgincare. Each contract is managed separately using different data sets. The contracts are managed by the commissioning CCGs.

SDUC operates seven urgent care centres (UCCs) in Staffordshire under a hub and spoke model. Staffordshire House in Stoke on Trent is the hub. The spoke sites are based at:

- Moorlands Hospital, Leek
- County Hospital, Stafford
- Cannock Chase Hospital
- Samuel Johnson Hospital, Lichfield
- Robert Peel Hospital, Tamworth
- Queen's Hospital, Burton-on-Trent

The administrative headquarters and three of the UCCs are registered as locations with the CQC. The provider was in the process of updating its registration at the time of the inspection.

As part of the inspection, we visited the administration centre at Staffordshire House, and visited four of the UCCs at Stoke-on-Trent, Burton-on-Trent, Cannock and Tamworth. This report covers all seven of the UCCs operated by SDUC to provide the OOH service in Staffordshire. All of the centres have car parking facilities available to patients and are well served by public transport links. The UCC facilities are all shared with the respective hospitals using them in-hours and SDUC using them between 6.30pm to 8.30am. The exception is Stoke-on-Trent where the UCC is within the same building as the administration headquarters.

In November 2016 the service had received a total of 8,896 cases (telephone advice consultations, face-to-face consultations at the UCCS and home visits) and provided a

total of 2,144 consultations. The daily consultations averaged 170 on weekdays and 648 per day at weekends. The total activity in the past 12 months was 109,995 contacts.

The workforce consists of 67 full time equivalent (FTE) staff, five FTE team leaders, two FTE governance staff. The senior management team consists of a Local Clinical Director who reports into the Group Clinical Director and a Regional Director who reports into a Group Operations Director.

The out-of-hours service operates between 6pm and 8.30am on weekdays and 24 hours on weekends and bank holidays. The clinical consultations are provided by a team of 114 GPs working on a sessional basis (15 WTE), sixteen nurses (two WTE), four pharmacists working on a sessional basis. The remaining staff are made up of team leaders, despatchers, receptionists, drivers, governance and management staff. The UCCs are staffed by a GP or ANP and a receptionist/driver as a minimum.

The provider was previously inspected in July 2013 as part of a routine review of compliance. No ratings were given following that inspection as it was performed under the previous methodology. All of the outcomes reviewed as part of the inspection were found to be compliant. However, we suggested two areas for improvement. These were:

- To review the safeguarding procedures to determine if a follow up to referrals and concerns should be implemented.
- Ensure that standard operating procedures (SOPs) were reviewed and updated where necessary in line with the review dates on the documents and remove outdated SOPs.

The SDUC NHS 111 service was inspected in June 2016 and rated as overall Good.

Why we carried out this inspection

We carried out a comprehensive inspection of this service 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 on 22nd March 2017. During our visit we:

- Spoke with a range of staff that included GPs, the regional director, the assistant regional director, the local clinical director, team leaders, despatchers, the lead pharmacy technician and reception staff.
- Observed how patients were provided with care and talked with 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 transport clinicians to undertake consultations in patients' homes.
- Reviewed the arrangements for the safe storage and management of medicines and emergency medical equipment.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Following the inspection we also liaised with the Deputy Organisation Medical Director.

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 an effective system in place for reporting and recording significant events.

- Staff we spoke with told us that incidents could be entered by any staff member onto a shared database known as 'Datix.' The local governance team then received an automatic notification electronically. Staff were asked to inform the team leader of any incidents and the details were entered onto a shift handover sheet. When the recorded incident was identified as a potential serious incident, a serious incident requiring investigation (SIRI) was completed by the clinical governance lead for the region. The completed SIRI report form would then be sent to the Vocare central assurance team. Classification would be confirmed centrally and if deemed a significant incident, it would be investigated and findings sent to the commissioners. Lessons learnt would be shared at the bi-weekly local team governance meetings and a monthly regional governance meeting held with the executive team. Learning was shared individually when appropriate, newsletters were used to communicate to all staff although the format of these was under review to ensure that they had been read and understood. Learning was sent out to all staff. A set of version controlled briefing notes were in the process of being developed to aid understanding of learning outcomes from significant events. 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.
- The total number of incidents in the last 12 months was 418 (0.38% of contacts) and the total number of serious incidents was 15 (0.01% of contacts). Feedback from the CCGs was positive in that they felt the provider had a strong culture of reporting incidents.
- The service was seen to have carried out a thorough analysis of the significant events and resultant action carried out. For example, an incident recorded in February 2017 highlighted a delay in the verification of death. This had resulted from a GP not being available. In response, the provider trained nurses in death verification, implemented a practitioner verification of death policy and agreed with the commissioners that these nurse practitioners could verify a death. We saw evidence that learning from incidents was disseminated to staff electronically and was a standard agenda item at monthly governance meetings held.
- We found that the learning outcomes were not always seen to have been embedded in policy and process. For example, the procedure for dealing with abnormal laboratory results had resulted in a new policy being implemented. However, some GPs we spoke with told us there were continuing issues with access to test results from the laboratory and they were unaware of any guidance. Also, the policy for oxygen storage in the vehicles used to transport clinicians on home visits stated that the temperature should be maintained between 18 and 23 degrees. However staff told us that they used the guidelines from the supplier that had greater tolerance but this was not detailed nor was there any instruction on what to do should temperatures fall outside these parameters.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant incidents were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the service. For example:

- Medicines and Healthcare products Regulatory Agency (MHRA) and Central Alerting System (CAS) alerts were managed centrally by the Head of Assurance for Vocare, and locally by the Clinical Support Managers who then shared via email with clinicians. These were recorded on a log sheet that included the individual accountable and a record of when actioned.
- Patient alerts were notified to staff by email. These included notifications of missing children. We saw evidence that a follow up call was made with Social Services and notes were added to the patient's record.

Overview of safety systems and processes

Requires improvement

Are services safe?

The service had clearly defined 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 training underway to appoint a lead member of staff for safeguarding to level four. Staff demonstrated they understood their responsibilities and had received training on safeguarding children and vulnerable adults relevant to their role. GPs and nurses were trained to child safeguarding level three. There was a safeguarding strategy and policy in place but no appointed safeguarding lead for Staffordshire. The national lead was covering in the interim. Online safeguarding training was available for all staff and classroom based learning was provided for clinicians. We saw the contact details for the local safeguarding team were displayed in all clinical rooms, in the cars for GPs out on home visits, in the reception area and on the operational floor for staff to access. Referrals were followed up with social services and outcomes chased, recorded on the referral spreadsheet and shared with the CCG.
- The service maintained appropriate standards of cleanliness and hygiene. We observed the out-of-hours premises to be clean and tidy. There was an appointed infection control lead and an infection control protocol in place. All staff had received up to date training. Infection control audits were undertaken monthly and we saw evidence that action was taken to address any improvements identified as a result.
- There was a system in place to ensure equipment was maintained to an appropriate standard and in line with manufacturers' guidance e.g. annual servicing of fridges including calibration where relevant. GP bags were checked at the beginning of each shift.
- We reviewed five 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, indemnity cover and the required checks obtained through the Disclosure and Barring Service.
- In addition to an initial driver training competency test, regular assessments were carried out on the drivers. Driving instructors accompanied any driver where an issue had been identified. Drivers were allowed a maximum of six points on their driving licence, which were checked annually. We saw that breakdown cover arrangements were in place and were told that any accident involving a vehicle was recorded.

There was one exception found where the processes to keep patients and staff safe required improvement:

- A notice in the waiting room and in the clinical rooms advised patients that chaperones were available if required. However, staff told us that some receptionists who acted as chaperones had not received formal training and stood outside of the curtain when acting as a chaperone.

Medicines Management

- The arrangements for managing medicines at the service, including emergency medicines and vaccines, kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). The service carried out regular medicines audits, with the support of the local CCG medicines management team, to ensure prescribing was in accordance with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- Patient Group Directions (PGDs) used had been ratified in accordance with the Medicines and Healthcare products Regulatory Agency guidance.
- The provider held a Home Office licence to permit the possession of controlled drugs within the service and held stocks of controlled drugs. (medicines that require extra checks and special storage because of their potential misuse). Standard operating procedures were 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. There were also appropriate arrangements in place for the destruction of controlled drugs.
- Processes were in place for checking medicines, including those held at the service and also medicines bags carried in the out-of-hours vehicles.

- Arrangements were in place to ensure medicines and medical gas cylinders carried in the out of hours vehicles were stored appropriately. These were included in the vehicle checklist completed at the start of each shift. However, there was no severe weather contingency plan that covered the storage of medication.
- The provider had a centralised stock of diamorphine (a powerful opioid used for pain relief) held in the Stoke-on-Trent headquarters. We saw that usage was low and although there was no evidence that patients had not received the treatment when needed, the potential distance to transport the medication could result in delayed treatment.

Monitoring risks to patients

Risks to patients were assessed and managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in areas accessible to all staff that identified the local health and safety representative. The health and safety lead was supported by an external consultant who carried out the fire risk assessment, completed health and safety policy updates and provided training and support for the lead. The service had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. Clinical equipment that required calibration was calibrated according to the manufacturer's guidance. The service had a variety 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 fuel, tyres, lights, oil and checks on the clinical waste holder kept in each vehicle. Records of MOT and servicing requirements were kept at the local dealerships. All vehicles in the fleet were less than two years old and staff told us that cars were serviced every 20,000 miles and a third party visual tyre check was carried out every 10 weeks. We checked the vehicles and found them to be clean and free from clutter. Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a 'rotamaster' system in place for all the different staffing groups to ensure enough staff were on duty. For example, GPs and ANPS. The central rota team used this system alongside an electronic forecasting tool. The inspection team saw evidence that the rota system was effective in ensuring that there were enough staff on duty to meet expected demand, with the exception of Saturday evenings. Staffing shortages were particularly being felt in the North Staffordshire and Stoke area. The service had originally been commissioned on a GP only basis, but commissioners had revised the contractual staffing arrangement allowing ANPs to be used to support the service. On-going recruitment was underway but staffing the service at weekends had proven difficult. Data from September 2016 to February 2017 showed that 76% of the contractual breaches (when target response times were not met) occurred at weekends. In response, plans to address staffing shortages included expanding the workforce by moving away from a GP led service to a multidisciplinary approach. Utilising local capacity e.g. using the Vocare national triage service, using GPs who lived outside of the area to do telephone triage from home at times of pressure, and increasing capacity at base by lifting the telephone triage out of the base.

Arrangements to deal with emergencies and major incidents

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

- There was an effective system to alert staff to any emergency. Emergency panic buttons were available in clinical rooms to alert staff within the buildings. Staff had personal panic alarms at centres not equipped with panic buttons.
- The provider had standard operating procedures in place advising staff how to respond in an emergency situation. We reviewed the standard operating procedure for how to manage the situation of a collapsed patient. The procedure detailed the assessments that should be carried out and the treatment to be given including medication and the

dosing details for the different age groups. A pictorial algorithm (self-contained sequence of actions) gave a clear step by step guide to what process to follow in a given situation.

- All staff received annual basic life support training, including use of an automated external defibrillator, a portable device used to treat sudden cardiac arrest.
- The service had a defibrillator available on the premises at each site and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The provider had a severe weather contingency plan in place that included steps to activate a fleet of four-wheeled drive vehicles. However, the plan did not cover the impact of hot or cold temperatures on medication when in transit.
- The service had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included a disaster recovery and continuity planning checklist to direct staff through the appropriate actions in the event of an incident. The checklist adopted an approach that provided clear accountability as well as a tailored plan to follow dependent on the severity of the service interruption.

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. For example, we saw that audits had been carried out on the prescribing of antibiotics and on the treatment of urinary tract infections (UTIs).

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). The NQRs are used to show the service is safe, clinically effective and responsive. Providers are required to report monthly to the Clinical Commissioning Group (CCG) on their performance against standards. This includes audits, response times to phone calls, whether telephone and face-to-face assessments took place within the required timescales, seeking patient feedback and actions taken to improve quality. However, CCGs did not require the provider to report on all of the NQRs and had introduced other key performance indicators (KPI) to monitor the service.

We looked at NQR Four in detail. This requirement related to providers to perform monthly case audits focussed on quality of triage calls, telephone consultations and face-to-face consultations (at the urgent care centre or home visits). The provider had a clinical audit policy to regularly audit a random sample of patient contacts and take appropriate action on the results of those audits. New clinicians had five random calls reviewed within the first three months (three telephone advice and two home visits). After three months, existing clinicians had four random calls reviewed per annum (two telephone advice and two home visits). Call reviewers were required to assess up to eight calls and two calibration calls per month. Regular reports of these audits are to be made available to the contracting CCG. However, call audits identified issues relating to competence of GPs, particularly relating to record keeping. The provider had not always followed up on these findings or provided appropriate training, support or feedback.

We looked at a sample of the KPIs for February 2017 for Stafford and Surrounds CCG. The overall compliance was 90% which was the target set by the commissioners. The data showed that the provider was responding well to non-urgent cases. For example:

- 94% of non-urgent cases received a face to face consultation at an urgent care centre or in the patient's place of residence within two hours. The target was 95%.

However, the data showed that urgent cases were not always meeting the contractual targets. For example:

- 74% of urgent cases received a face to face consultation at an urgent care centre or in the patient's place of residence within one hour. The target was 95%.
- 91% of non-urgent cases received a face to face consultation at an urgent care centre or in the patient's place of residence within six hours. The target was 95%.
- 100% of appropriate calls were passed to 999 within three minutes.

The provider told us that performance in the last quarter had been impacted by resources being used to support the local accident and emergency department. Staff told us and rotas evidenced that the provider had encountered difficulties sourcing GPs for Saturday evening shifts.

There was evidence of quality improvement for prescribing. There had been clinical audits completed in the last year on antibiotic prescribing, controlled drug prescribing and large volume prescribing of medications of potential abuse (those that would have a street value on the black market). The prescribing of medications of potential abuse was monitored weekly and collated quarterly and the provider told us that the pattern of prescribing these medications had shown a gradual decline.

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. We reviewed the induction material provided for GPs and found this to be comprehensive. It included an introduction to urgent care, triage principles, home visit criteria, palliative care issues and reporting of incidents.

- The service could demonstrate how they ensured role-specific training and updating for relevant staff. For example, nurses were supported with their revalidation requirements. An individual nurse training log was kept and we saw that training included wound care, end of life care advanced life support and independent and supplementary prescribing courses.

Advanced Nurse Practitioners (ANP) who undertook this role were signed off as competent and had received appropriate training in clinical assessment. The provider planned to use video link to offer support to ANPs from GPs.

- 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. Staff employed had received an appraisal within the last 12 months.
  However self-employed GPs had not always received any formal feedback by the provider in the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support, infection prevention and control and information governance. Staff had access to and made use of e-learning training modules and in-house training.
- Staff involved in handling medicines received training appropriate to their role.

We did find examples where the skills imparted were not seen as sufficient to commence providing care:

- The provider had introduced a course for nurses in paediatric care. Following completion of a three day course, nurses were required to produce a portfolio to evidence their shadowing before signed off as competent. The provider told us that although some nurses had completed the training, they had not commenced the treatment of young children. The provider told us that they would not allow these nurses to provide care to children without the supervision of a GP until they had been signed off as competent.
- Staff told us that employees had acted as chaperones, but had not completed role-specific training. We were told that in these individuals had been asked to act as a chaperone by standing outside of the curtain.

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.

- This included access to required 'special notes' which detailed information provided by the person's GP. This helped the out of hours staff in understanding a person's need.
- The service shared relevant information with other services in a timely way, for example when referring patients to other services.
- The provider worked collaboratively with the NHS 111 provider in their area which was also part of the Vocare Group.
- 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.
- We saw that updates were received daily for patients receiving palliative care. These were added to the electronic system each day to allow access for the local palliative care coordination team.
- There was a dedicated phone line in place to be used by external health professionals in the area. The provider told us that it was not used appropriately. For example, by paramedics requesting a fast-track referral. However, the use of the line was being reviewed due to the level of inappropriate usage.
- The provider had plans to implement a single system for information management and technology.

The clinicians did not always have access to patients' summary care records. The staff we spoke with told us that this was the case at UCCs where the computer system and

Requires improvement

Are services effective?

(for example, treatment is effective)

equipment not being owned by Staffordshire Doctors Urgent Care Limited (SDUC). The provider investigated this following the inspection and confirmed that the problem had been rectified.

The service worked with other service providers to meet patients' needs and manage patients with complex needs. It sent out-of-hours notes to the registered GP services electronically by 8am the next morning. This was monitored on a monthly basis and data from the provider showed that they had achieved 100% transfer of notes in the last 12 months.

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 in these rooms could not be overheard.
- Staff had undertaken information governance training that covered patient confidentiality.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Clear signposting was in place to direct people to where to find the urgent care centres.
- Staff had received training in customer services and equality and diversity and this was part of the annual training updates required by all staff.
- The waiting area at the Burton on Trent urgent care centre (UCC) was out of view of the reception desk. The provider was aware and told us that they planned to address the issue having recently moved to the current site.

A total of 139 of 143 patient Care Quality Commission comment cards we received were positive about the service experienced. The positive comments included compliments on the friendliness of staff and the prompt service provided. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required. For example, one patient described how the receptionist had provided them with hot drinks while waiting to be seen.

Results from the provider's own survey (for patients in North Staffordshire and Stoke-on-Trent) carried out in February 2017 showed:

- 90% of respondents stated that their consultation with a clinician was very good or excellent.

The national GP patient survey asks patients about their satisfaction with the out-of-hours service. The survey results were reported on by the Clinical Commissioning Group (CCG). Combined patient satisfaction rates for the six Clinical Commissioning Groups (CCGs) were in-line or above the National average. Data from the GP national patient survey published in July 2016 found:

- 66% of patients responded positively when asked how quickly care was received (National average 62%).
- 90% of patients had confidence and trust in the person or people they saw or spoke with (National average 90%).
- 72% of patients responded positively when asked about their overall experience of the out of hours service when their GP surgery was closed (National average 70%).

Care planning and involvement in decisions about care and treatment

Patient feedback from the comment cards we received told us that they felt involved in decision making about the care and treatment they received. They also told us 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.

Results from the provider's own survey carried out in February 2017 showed:

- 67% of respondents stated that the explanation from the health professional was very good or excellent.

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.
- Some pre-printed information leaflets were available for patients in the urgent care centres (UCCs) that we visited. For example there was a leaflet for parents entitled 'How to recognise if your child is seriously ill'. This informed patients on what symptoms to look out for and the appropriate action to take. There was also information leaflets in the UCCS for dementia and to support carers.
- There was a hearing aid loop at each UCC to aid patients with a hearing impairment.
- Staff told us that a card was left with each patient following a home visit when an ambulance was

requested to take the patient to hospital. The card included the ambulance response time requested, the reference number for the booking and advice to call the NHS 111 service if the ambulance was delayed.

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.

- Home visits were available for patients whose clinical needs resulted in difficulty attending the service.
- There were accessible facilities, baby-changing facilities, a hearing loop and translation services available (to be provided within 15 minutes of the initial contact).
- Clinics consisted of 15 minute slots that could be reduced to 10 minutes by the clinician when appropriate.
- The provider supported other services at times of increased pressure. For example, the service had been highly commended by the commissioners for the support provided to the emergency department at the local hospital in North Staffordshire during Christmas 2016.
- The service utilised Typetalk, a telephone relay service which supports deaf, deafblind, hard of hearing and speech impaired people to communicate with others via telephone.
- Staff conducted comfort calls to patients who were for instance, awaiting a home visit; staff explained that they were often able to reassure patients that they would be seen and gave them a further indication of when the visit would take place.
- The service was able to access the mental health crisis team or single point access for rapid response community matrons. There were direct referral pathways in place for patients experiencing poor mental health who attended the urgent care centre or the out of hours service.
- An information leaflet was available for parents entitled 'How to recognise if your child is seriously ill'. The leaflet detailed symptoms to look for and appropriate actions to be taken.
- Three prescribing pharmacists had been recruited to address the shortage of clinicians. The pharmacists provided face-to-face consultations to patients.
- The key performance indicators used by the provider evidenced that the service was not meeting the needs of patients at weekends.

Access to the service

The service was open between 6pm and 8.30am Monday to Friday, and 24 hours at weekends and on bank holidays. The urgent care centres (UCCs) were spread throughout Staffordshire. There were plans to open a further three centres as part of the new tender.

Patients could access the service via NHS 111 (NHS 111 is a telephone-based service where callers are assessed, given advice and directed to a local service that most appropriately meets their needs). For example, this could be a GP service (in or out of hours), walk-in centre or urgent care centre, community nurse, emergency dentist, emergency department, emergency ambulance, late opening pharmacy or home management. The service did not see 'walk in' patients and those that did walk in were told to ring NHS 111 unless they required urgent medical care in which case they would be stabilised before being referred on. 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 and from the National Quality Requirements scores indicated that in most cases patients were seen in a timely way.

- In the national GP patient survey, a total of 66% of patients responded positively when asked how quickly care was received (National average 62%).
- Four of the 30 reviews on the NHS Choices website praised the provider for a quick service although four criticised the service for the delayed call backs.
- As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 143 comments, 32 made specific references to the prompt service provided. There were four negative comments from patients who said they had to wait for their appointment.

Listening and learning from concerns and complaints

The service 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 responsible person who co-ordinated the handling of all complaints in the service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- We saw that information was available to help patients understand the complaints system. There was a summary leaflet and a paper form for patient to complete.

The total number of complaints in the last 12 months equated to 100 (0.09% of contacts). We looked in detail at two of these complaints received and found that these were satisfactorily handled, dealt with in a timely way, with openness and transparency. Lessons were learnt from individual concerns and complaints and also from analysis of trends. We saw that actions were taken as a result to improve the quality of care. For example, one complaint we looked at was made following a delayed home visit. A letter of acknowledgment was sent to the complainant within one week, a detailed investigation was undertaken and a summary of the findings sent. This letter included advice to the complainant on what to do if they were dissatisfied with the response. We saw that as a result of this complaint, a new process had been implemented to minimise the risk of repeat. An email was sent to staff informing them to refer any case to the team leader when a patient is unable to get to a UCC or has refused an appointment.

The governance team told us that they picked up any trends in complaints. For example; a trend related to the lack of empathy shown to patients who presented with symptoms of miscarriage was identified from investigating complaints from one of the UCCs within the Vocare Group. The resultant actions included:

- The clinical support manager (CSM) planned to meet with staff from the early pregnancy assessment unit (EPAU).
- The CSM planned to obtain patient information leaflets from the EPAU to be made available to clinicians at each UCC.
- Staff from the EPAU to be invited to undertake a development session for staff at Staffordshire Doctors Urgent Care Limited (SDUC) on communicating with patients in relation to miscarriage.

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. There had been management changes in 2016 but the last 12 months had seen stability in staff turnover. The provider was commissioned to provide the out of hours service under four separate contracts with differing end dates, but efforts had been made in conjunction with the commissioners to simplify the procurement and monitoring. These included:

- A combined monthly meeting across Clinical Commissioning Groups (CCGs) to review the quality of the service. Plans to further integrate the community services, the NHS 111 service, the emergency department at the hospital and the out of hours provision from primary care. For example, the establishment of a clinical hub where direct booking for the urgent care centres (UCCs) could be made by the NHS 111 service.
- The service had a mission statement and staff knew and understood the values.
- The service had a robust strategy and supporting business plans that reflected the vision and values and were regularly monitored.

Governance arrangements

The service had an overarching governance framework that supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- The provider had a good understanding of their performance against National Quality Requirements and key performance indicators. These were discussed at senior management and board level. Performance was shared with staff and the local clinical commissioning group as part of contract monitoring arrangements.

There were a number of areas where governance arrangements needed strengthening:

- Service specific policies were available to all staff. However, we found examples of when the policies were not reflected in practice. For example,
- The policy for oxygen storage in vehicles stated that the temperature should be maintained between 18 and 23 degrees. However staff told us that they used the guidelines from the supplier that had greater tolerance but this was not detailed nor was there any instruction on what to do should temperatures fall out of these parameters.
- Staff told us that chaperones had been provided using untrained staff who stood outside of the curtain.
- There were effective arrangements for identifying and recording risks. However, implementing mitigating actions was not always effective. For example,
- The audits carried out on clinicians had not always been acted on in accordance with policy.
- The procedure for dealing with abnormal laboratory results had resulted in a new policy being implemented. However, some GPs told us there were continuing issues with access to test results from the laboratory and were unaware of any guidance.

Leadership and culture

During and following the inspection, the provider demonstrated they had taken action as a result of our findings to improve the service and ensure high quality care. This included a review of the clinical governance from senior management in the Vocare Group and suspension from the rota of a GP pending further investigation.

Staff spoke of a 'no blame' culture and told us the management were approachable and always took the time to listen to them. Staff we spoke with at the UCCs felt well supported from the headquarters and spoke positively of how team leaders were accessible and communicative.

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).This included support training for all staff on communicating with patients about notifiable safety incidents.
The management team encouraged a culture of openness and honesty. The service had systems in place to ensure that when things went wrong with care and treatment:

Are services well-led?

Requires improvement

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

- The service gave affected people 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.

- There were arrangements in place to ensure the staff were kept informed and up-to-date. These included newsletters, a shared intranet platform and emailed communication.
- 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.

- The service had gathered feedback from patients through surveys and complaints received. For example, the NHS Friends and Family Test and postal surveys.
- The service had gathered feedback from staff through annual management away days, both for the executive and the regional teams. The provider told us that these days were used to learn lessons from internal reflection and develop future plans.

The provider had identified patient engagement as an area for improvement and had implemented a coin rating system where patients posted a coin into a box in the reception to rate the service. To improve communication with patients in the area, the provider had planned a patient engagement programme to start with an open day planned for April 2017 and invited local patient participation groups to attend.

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 scheme focussing on social prescribing, advising patients what services may best meet their needs and then making direct referrals into them. Other planned developments included new technology to share special notes to improve communication and information between health professionals, in addition to plans to make use of mobile application and video consulting technology.