Staffordshire House

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?	Requires improvement
Are services well-led?	Requires improvement

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This service is rated as requires improvement overall. The previous inspection on 22 March 2017 rated the practice as requires improvement.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Requires improvement

Are services well-led? – Requires improvement

Following our comprehensive inspection at Staffordshire House on 22 March 2017 the location was rated as requires improvement for the Staffordshire Out Of Hours (OOH) service with a requires improvement rating for the safe, effective and well-led key questions, good for caring and responsive key questions.

We carried out an announced comprehensive inspection on 21 March 2018 to monitor that improvements had been made.

Our key findings from this inspection were as follows:

- We found improvements had been made to manage risks relating to shared learning from significant events and incidents.
- The recruitment process had been strengthened and there were effective systems and policies governing the health, welfare and safety of people. These included training for all staff who acted as chaperones and criminal checks on all staff.
- Systems for the management of medicines including controlled drugs were comprehensive and effective. Prescriptions were securely stored and their use was monitored.
- The provider had taken steps to implement changes in relation to the governance. The recruitment of new personnel into the governance team had strengthened arrangements and supported an overarching governance framework for systems and processes. These arrangements were supported by a new Director of Quality and Nursing recruited to the Vocare Group.
- Patients' care needs continued to not always be assessed and delivered in a timely way according to need. The service had not met all the Local Quality Requirements used to monitor clinically effective and responsive care. For example, waiting times for some clinical assessments, and long delays overnight posed risks to patient safety.

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

Importantly, the provider must:

Summary of findings

- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment
- Ensure care and treatment is provided in a safe way to patients.

The provider should:

- Continue to improve the evidence to support that mandatory training has been completed by GPs.
- Review the training and clinical supervision for paramedics new to primary care.

For more information on these requirements, please refer to the requirement notice at the end of this report.

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

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 adviser, three CQC inspectors and an inspection manager.

Background to Staffordshire House

Staffordshire House is part of the Vocare Group, recently acquired by Totally Plc. This service provides a GP led Out of Hours (OOH) service, known locally as Staffordshire Doctors Urgent Care (SDUC) and provides a service for a population of approximately 1,200,000 patients in Staffordshire. SDUC also provides the 24 hour NHS 111 service across the whole of Staffordshire commissioned under a separate contract to the OOH service (and registered with the Care Quality Commission (CQC) as a separate location). Vocare have approximately 2,000 employees and deliver GP OOH and urgent care services to approximately 9.2 million patients nationally. The population of Staffordshire includes the more deprived urban areas in and around Stoke-on-Trent as well as the more affluent areas in south Staffordshire with pockets of deprivation around Cannock, Tamworth and Burton upon Trent. The GP led OOH service is accessed through NHS 111, providing face-to-face consultations 24 hours a day to patients across Staffordshire. This service is based at the organisation's headquarters at Staffordshire House, in Stoke-on-Trent. Staffordshire House provides OOH care between 6.30pm and 8am Monday to Friday. At weekends and bank holidays (b/h) the service provides 24 hour access. As part of the OOH service there are eight OOH sites which open at varying times and days; the locations are:

- County Hospital, Stafford (6.30pm to 8am, peripatetic site with Cannock)
- Cannock Chase Hospital (6.30pm to midnight, 8am to midnight weekends and b/h)
- Samuel Johnson Hospital, Lichfield (7.30pm to 11.30pm week days, 9am to 11pm weekends and b/h peripatetic with Tamworth)
- Robert Peel Hospital, Tamworth (7.30pm to 11.30pm week days, 9am to 11pm weekends and b/h)
- Queen's Hospital, Burton-on-Trent (6.30pm to 8am week days and 24/7 weekends and b/h)
- Staffordshire House (6pm to midnight week days, 8am to midnight weekend and b/h)
- Haywood Hospital, (6pm to midnight week days, 8am to midnight weekend and b/h)
- Royal Stoke Hospital (24/7)

The peripatetic model allows clinicians to be moved around the centres dependent on where the demand is most.

During our inspection we visited the headquarters in Stoke-on-Trent along with three of the six currently used OOH sites: Haywood Hospital, Burslem; County Hospital, Stafford and Samuel Johnson Hospital, Lichfield.

The service received approximately 128,000 contacts in 2017. On average approximately 40% are received on weekdays and 60% of contacts are made at weekends.

Further details can be found by accessing the provider's website at www.sduc.nhs.uk

Requires improvement

Are services safe?

Our findings

At our previous inspection undertaken on 22 March 2017 we rated the safe domain as requires improvement. The areas identified as in need of improvement were:

- Learning outcomes from significant events were not always embedded in policy and process.
- Staff who acted as chaperones had not always received appropriate training and had not always been checked through the disclosure and barring system (DBS).

We continued to rate the service as requires improvement for providing safe services.

At this inspection we found:

Safety systems and processes

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

- The provider had systems to safeguard children and vulnerable adults from abuse. There was a safeguarding lead who was a local clinical support manager, supported by a service safeguarding lead.
- The service worked with other agencies to support patients and protect them from neglect and abuse. For example, clinical staff told us about referrals they had made to child protection services. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Staff had received up-to-date safeguarding and safety training appropriate to their role. Staff we spoke with knew how to identify and report concerns. Policies were seen to be up to date and relevant, for example; they included the modern day definitions for vulnerable adult safeguarding. The service had made 10 referrals in February 2018, eight for adults and two for children. A quarterly safeguarding newsletter had been introduced in July 2017. This included details of the safeguarding leads, shared learning and information on training events. The Vocare regional safeguarding leads started group meetings in March 2018.
- There were effective systems to manage infection prevention and control measures. The Out of Hours (OOH) sites we visited were clean and tidy; regular audits were carried out at each centre. There were systems for safely managing healthcare waste.
- We found medical equipment was regularly calibrated. An asset register of clinical equipment was in place and the medical equipment we checked was within the expiry dates. Medical devices such as defibrillators (used to treat a cardiac arrest) and pulse oximeters (used to measure blood oxygen levels) were available.
- Vehicle and driver checks were carried out regularly; a random sample of 30 completed check sheets were audited monthly. We found vehicles to be well maintained and clean. Policies governed the safe transport and storage of medicines (including controlled drugs) and equipment when in transit. These included storage arrangements in adverse weather conditions.

Risks to patients

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

- The provider had appropriate safety arrangements, including Control of Substances Hazardous to Health (COSHH) and health & safety within the workplace policies, which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction and refresher training. We found comprehensive risk assessments, for example for fire and lone working that covered each centre.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups. However safe staffing levels were not always achieved. For example, some staff we spoke with told us that filling rotas at weekends continued to be an issue. We also saw that key performance indicators (KPIs) were not achieved even when rota forecast requirements had been achieved. This would imply that the calculations used to

determine how many staff are required need revision. In addition we saw examples of when remote triage staff rostered to work in this service were taken to fill gaps elsewhere in Vocare's services.

- We reviewed the OOH rota and saw vacancies within the rota for OOH clinicians. The workforce shift analysis carried out by the provider confirmed there were unfilled shifts and gaps within clinical staffing which impacted on the service being able to provide a timely service.
- Training records showed that face to face basic life support training (BLS) had been planned or completed by all staff. The provider encouraged GPs to provide evidence of their training although only 56% had evidenced completion of their BLS training. Vocare had changed their recruitment policy to request that when GPs did not produce evidence of completion of BLS training, they must book on a course within one month of starting or they would not be employed. The BLS training included use of an automated external defibrillator. Defibrillators were available at each OOH site, in addition to those carried within the vehicles.
- Clinical staff we spoke with knew how to identify and manage patients with severe infections, for example sepsis.
- Staff told patients when to seek further help such as if there condition changed or worsened.

Information to deliver safe care and treatment

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

- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- During times of high demand or limited clinical support, patients could wait for longer than national guidance specifies to receive appropriate care and treatment.

The CQC received a number of statutory notifications in which the provider identified patients who had passed away while within the service, for example; where a home visit had been requested. These had been reviewed appropriately and the deaths were expected and not caused by any delay in treatment or care from the OOH service. However, we found examples of patients who had shown red flags but not been seen within acceptable timescales; for example a child with signs of sepsis who was not seen for 12 hours. The provider recorded this as a significant event that prompted an investigation. However we also saw examples of similar delays that the provider seemed unaware of and had not investigated.

Safe and appropriate use of medicines

Processes were in place for checking medicines, including those held at the service and also medicines for the OOH vehicles. Staff kept records of medicine checks including accurate stock recordings. During our visits to OOH sites we found a stock list for medicines at the OOH sites was available.

- 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 adopted in accordance with the Medicines and Healthcare products Regulatory Agency guidance (PGDs are a written set of instructions that provide some registered healthcare professionals a legal framework to supply and/or administer specified medicines to a pre-defined group of patients without them having to see a prescriber).
- 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 for misuse). Staff received training in the management of controlled drugs and standard operating procedures were in place that set out how controlled drugs were managed in accordance 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.

Requires improvement

Are services safe?

- Processes were in place for checking medicines, including those held at the service and also medicines bags carried in the out-of-hours vehicles. Of note, the medicines management procedures for the medicines boxes going out were highly effective.
- 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.
- Staff prescribed, administered or supplied medicines to patients. They told us they gave advice on medicines in line with legal requirements and current national guidance. There was evidence of actions taken to support good antimicrobial stewardship, for example; the service audited antimicrobial prescribing. This was done on a group level within the Vocare group.

Track record on safety

The service had improved the governance and oversight of safety since our previous inspection:

- The provider had written health and safety policies and a health and safety committee was made up of Vocare staff from across the group; staff 'ambassadors' had a set of written terms of reference provided by the management team. There were risk assessments in relation to safety issues. An independent health and safety risk assessment had been carried out at each of the OOH sites and a 'health and wellbeing' schedule was in place; managed within the human resources department.
- Fire risk assessments had been carried out for all sites in January 2018. All staff had completed fire safety training, team leaders and managers were trained as fire marshals. Annual service plans were in place to maintain the fire extinguishers and the fire alarm. The fire alarm and emergency lighting were tested weekly and fire evacuation drills carried out every six months. These included a review of any areas of improvement identified.
- There was an effective system for receiving and acting on safety alerts.
- Joint reviews of incidents were carried out with partner organisations and monitored by a quality team that represented the Staffordshire Clinical Commissioning Groups (CCGs). For example, the service reviewed prescribing with a patient's GP when the wrong medicine had been prescribed.

Lessons learned and improvements made

- The provider had improved processes for reviewing and investigating when things went wrong. The SDUC governance team led on the process of recording, reporting and learning from incidents. Staff had access to an electronic system (Datix, an electronic system that allows learning from incidents to be shared, SDUC have adopted this as their system of choice for recording all incidents) for recording incidents. All staff had access to raise incidents on the Datix system. Non-clinical incidents were investigated by the operational team and incidents of a clinical nature were investigated by the clinical team. However concerns remained that incidents in relation to unsafe waiting times were not always reported to management, and that staff had become desensitised to such incidents.
- There was an 'adverse event' policy that included an action plan that provided a flow chart detailing what to do having identified an incident. This included reference to the duty of candour principles.
- There was a clear process in place for sharing any learning with staff following an incident or complaint to improve the service. Staff newsletters were circulated monthly, a central website allowed learning to be shared within the Vocare Group. Clinical and operational staff reviewed incidents at daily, weekly and monthly meetings.
- Staff we spoke with understood their duty to raise concerns and report incidents and near misses. Clinicians could raise incidents to the service via the incident reporting process.
- The provider analysed incidents on a monthly basis and this included a review of the level of harm caused. In February 2018, there had been 145 incidents reported, 132 had resulted in no harm being caused, seven in low harm and six in moderate harm. None of the incidents had resulted in severe harm being caused. Lessons were reported to staff through newsletters. Of the 145 in February 2018, 130 had been investigated and closed; the remaining 15 were still under investigation. Operational delays were the main reason for incidents, 74 of the 145 had been raised for operational breaches that resulted in a call to the emergency services.

Requires improvement

Are services safe?

- The Datix system tracked each incident including any action taken and noted when the incident was closed. However, we found the incident reporting system did not include risks found in delayed treatment when checking contacts during one Saturday in March 2018. The provider told us this would be reviewed and added to the Datix system following the inspection.
- We reviewed a 'serious incident' (SI) report for a patient when a delayed blood result had resulted in increased risk to a patient. The investigation was thorough and detailed; however the recommended action for a new blood test policy had been drafted, sent to the CCG for approval but had not been completed. The target date for completion was 1 August 2017. The provider submitted a draft procedure following the inspection.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 22 March 2017 we rated the effective key question as requires improvement. The areas identified as in need of improvement were:

- The service was not meeting performance standards at weekends.
- Some staff were unable to access patient summary care records.

Although some improvements had been made, we continued to rate the service as requires improvement for providing effective services.

At this inspection we found:

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice. Staff we spoke with evidenced that they assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed through clinical consultation reviews. A total of five telephone calls and/or notes audits were completed each quarter for each clinician.
- Care and treatment was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. For example, the patient record system had special notes for those patients requiring specific care. Team leaders contacted GP practices to advise of concerns when risk factors such as high blood pressure were identified.
- There was a system in place for healthcare professionals to be responded to within a 30 minute response time.

Monitoring care and treatment

From 1 January 2005, all providers of out-of-hours services were required to comply with the National Quality Requirements (NQR) for out-of-hours providers. (The NQR are used to show the service is safe, clinically effective and responsive and a new set of NQRs has been developed and is due for implementation in 2018). In Staffordshire, the provider is required to report monthly to their clinical commissioning group (CCG) on their performance against a set of key performance indicators 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). This data set has been used to monitor performance while a new set of NQRs was under development. There is a set of key performance indicators known as 'dx' codes that are common across each of the four contracts.

We looked at the performance indicators, which provide a clear and consistent way of assessing performance as they help inform our decisions about the quality of care. In particular we looked at the indicators which provide timescales for patients to receive face to face clinical appointments following a clinical assessment (whether in an OOH site or in the patient's place of residence). We reviewed these as our previous inspection had shown the service was not meeting contractual targets. We looked at data for October 2017 to January 2018 with regard to response times. We saw that the service repeatedly failed to meet the target for a response in less than two hours. This was the case in each of the four contracts, for example; data from January 2018 showed:

In North Staffordshire:

- The combined performance for the up to two hours indicators was 90%, the target was 95%.
- The performance for a healthcare professional from the service to call back a service user within 60 minutes was 81%, the target was 95%.

In South East Staffordshire and Seisdon Peninsula:

- The combined performance for the up to two hours indicators was 87%, the target was 95%.
- The performance for a healthcare professional from the service to call back a service user within 60 minutes was 71%. The target was 95%.

In Staffordshire East:

- The combined performance for the up to two hours indicators was 90%, the target was 95%.
- The performance for a healthcare professional from the service to call back a service user within 60 minutes was 68%. The target was 95%.

In Stafford and Cannock:

Requires improvement

Are services effective?

(for example, treatment is effective)

- The combined performance for the up to two hours indicators was 88%, the target was 95%.
- The performance for a healthcare professional from the service to call back a service user within 60 minutes was 70%. The target was 95%.

These figures average out the performance over a full week. We found the performance was lower at weekends, for example; on the weekend of 10th and 11th March we found that four out of seven patients reviewed were at risk due to waiting excessive lengths of time for clinical assessment. For example, a baby with possible sepsis was not clinically reviewed within 12 hours of contact.

As a result 11 cases had been investigated in 2017 under the provider's serious incident policy. The service showed how planned improvements in timescales for patients to be seen were underway, for example; the use of paramedics to reduce the dependency on GPs. However clinical capacity was impacting on timescales for patients to have a face to face appointment. This was seen to be the case when gaps in rotas could not be filled and also when the staffing levels had been achieved.

Other areas such as a clinical assessment for all routine patients (between two and six hours) were not meeting contractual targets:

In North Staffordshire:

- The combined performance for between two and six hour's indicators was 91%, the target was 95%.
- The performance for a service user to be contacted within six hours when their GP practice was closed was 91%. The target was 95%.

In South East Staffordshire and Seisdon Peninsula:

- The combined performance for between two and six hour's indicators was 92%, the target was 95%.
- The performance for a service user to be contacted within six hours when their GP practice was closed was 93%. The target was 95%.

In Staffordshire East:

- The combined performance for between two and six hour's indicators was 97%, the target was 95%.
- The performance for a service user to be contacted within six hours when their GP practice was closed was 97%. The target was 95%.

In Stafford and Cannock:

- The combined performance for between two and six hour's indicators was 89%, the target was 95%.
- The performance for a service user to be contacted within six hours when their GP practice was closed was 89%. The target was 95%.

The response times to home visit requests had been identified as an area of concern with potential risk to patients when waiting to be seen. The provider had introduced paramedics to the home visiting service having agreed contractual changes with each of the four contract holders. Although delayed home visits continued to be a concern, the wait times had been reduced. The provider sent data that showed improved performance for the weekends when the demand on the home visiting service was at its most and the performance at its lowest:

- Compliance rates for urgent home visits on a Saturday had increased by 19%.
- Wait times for urgent home visit requests had increased over the Christmas period but decreased to under the two hour target in February 2018.

The data was from a 10 week period from 3 December 2017 to 5 February 2018. The performance highlighted that an overall performance had been achieved. However, the timeframe was not sufficient to evidence that this performance was sustained.

The service was meeting some of the key performance indicators in each of the four contracts. For example, the service achieved 100% performance in reporting on results or tests, and responding to medicine enquiries.

Since our previous inspection an organisational lead for clinical audit across the organisation had been introduced. We reviewed the evidence for quality improvement through clinical audit and found that an audit programme had been introduced since our previous inspection. We saw medicines' audits, which demonstrated clinical effectiveness to meet national standards, such as antimicrobial prescribing. The provider has used audit to reduce inappropriate prescribing of high risk medicines. This was benchmarked against other Vocare organisations and national data.

Effective staffing

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

Requires improvement

Are services effective?

(for example, treatment is effective)

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff. Clinicians we spoke with spoke positively about the induction process and they were given time to shadow colleagues as part of the process.
- The provider had an effective system for monitoring training requirements by individual staff members. Electronic records were kept for each staff member and contained up to date records of training completed and dates when refresher training was due. Training needs had been identified for each role. SDUC had amended its recruitment policy to improve the number of GPs who provided evidence of completed training. For example; for safeguarding children level three, where only 60% of GPs had provided evidence that the training had been completed.
- The provider had a process to provide staff with ongoing support; this included appraisal. At our inspection in March 2017, we found that GP audits highlighted issues had not always been acted on appropriately due to staff shortages. The local clinical director told us that the approach had changed, and that now, any GP found not to be working at the required standard was either supported and monitored to ensure changes in practice or not used in which case they would be reported to the local accountable officer.
- The provider could demonstrate how it ensured the competence of staff employed in advanced roles by audit of their clinical decision making.
- Staff were made aware of external training opportunities provided free by the local hospital and distance learning courses provided by a local college. Staff were given the information to enrol and the opportunity to complete training if they left SDUC's employment.
- We saw examples of internal training provided by the local and regional clinical directors, for example; in telephone triage.
- Paramedics were supported clinically during their shifts and were provided with an education; however they did not receive the level of 1-1 supervision that should be provided to clinicians new to primary care. Paramedics did not treat children, pregnant women or palliative patients.

There was a clear approach for supporting and managing staff when their performance was poor or variable. For example, it had been recognised as part of a significant event process that one clinician had not prescribed a medicine in accordance with guidelines. This clinician was involved in a supportive process to review their performance.

Coordinating care and treatment

Staff worked together with other organisations to deliver effective care and treatment.

- We saw records that showed all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- There were established pathways for staff to follow to ensure callers were referred to other services for support as required. For example, if a patient required admission to hospital or a home visit by a district nurse.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- The service ensured that care was delivered in a coordinated way and where possible took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- There were clear arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that required them.

Helping patients to live healthier lives

Staff told us they supported patients to manage their own health and maximise their independence.

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

Consent to care and treatment

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

Requires improvement

Are services effective?

(for example, treatment is effective)

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

Good

Are services caring?

Our findings

At our previous inspection on 27 March 2017 we rated caring as good. We made a recommendation that the provider should improve the availability of patient information to help patients understand their condition.

We rated the service as good for caring.

Kindness, respect and compassion

Staff we observed treated patients with kindness, respect and compassion.

- Staff displayed an understanding and non-judgmental attitude to all patients. For example, staff members displayed an understanding towards patients who had mental health problems.
- When receptionists telephoned people to book OOHs appointments they provided them with clear information.
- There were arrangements in place to respond to those with specific health care needs such as end of life care and those who had mental health needs. We saw these patients received care in a timely way such as attending a patient requiring end of life care. Although we saw delays in home visits, there was no evidence of the service failing to meet the timescales required for urgent home visits for patients with end of life care needs such as pain management.

A total of 85 Care Quality Commission comment cards were received. The comments were generally positive about the service received. There was a theme of positive comments around the care received; two comments mentioned a delay in treatment. The comment cards were collected from each of the urgent care centres, 54 of the 85 responses came from the Burton on Trent centre.

The national GP patient survey asks patients about their satisfaction with the OOH service. The survey results were reported on by the Clinical Commissioning Group (CCG). Combined patient satisfaction rates for the six CCGs were in-line or above the national averages. Data from the GP national patient survey, collected during January to March 2017, and last published in July 2017 found:

- 87% (previously 90%) of patients had confidence and trust in the person or people they saw or spoke with (national average 87%).
- 67% (previously 72%) of patients responded positively when asked about their overall experience of the OOH service when their GP surgery was closed (national average 70%, previously 72%).

The provider had commissioned an external questionnaire to obtain feedback from service users. However at the time of the inspection, the first set of results had not been collated.

Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- The service was aware of the requirements under the Accessible Information Standard. There was a hearing loop system for people with a hearing impairment. There were facilities for those that required sign language interpretation. British sign language interpreters required advanced booking.
- Staff had access when necessary to the services NHS 111 Directory of Services (DOS). The DOS is a central directory about services available to support a particular person's healthcare needs and this is local to their location.
- Patient information leaflets were available in the urgent care centres (UCCs). For example; there was a booklet for patients that detailed the options for where patients could attend giving guidance of when each was appropriate.
- Staff 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.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

Good

Are services caring?

- 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 understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 22 March 2017 we rated the responsive key question as good. We made the following recommendation:

- Continue to explore ways to meet the target response times for patients to be seen at weekends.

We rated the service as requires improvement for providing responsive services. At this inspection we found:

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, although data showed these were not always timely or undertaken in line with national requirements.
- 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 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 example, 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. However this did not include a reassessment of their symptoms, leaving deteriorating patients at risk due to the long delays in home visiting
- 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.
- The facilities and premises were appropriate for the services delivered.
- The service was responsive to the needs of people in vulnerable circumstances. For example, health care professionals caring for vulnerable people could call the service and receive a call back from a GP within a specified timescale.

Timely 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. The provider operated a model that moved clinicians between centres dependent on demand. This often resulted in urgent care centres being closed; patients were advised of the nearest centre that was open.

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.

Feedback received from patients from the GP National Patient Survey indicated that in most cases patients were seen in a timely way.

Patients were not always able to access care and treatment from the service within an appropriate timescale for their needs.

- The NHS 111 service directed the OOH service to call back some patients within timescales. The clinician calling back used their clinical knowledge and experience to assess the next course of clinical action required and the urgency of the need for medical attention for the patient's symptoms to be managed. This could be telephone advice, an appointment at an OOH site or a home visit. Data from the local performance indicators showed that the service was not always meeting the 95% target for prioritising clinical assessment of calls other than an emergency.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- Patients did not always have timely access to clinical diagnosis and treatment. Data obtained from the service regarding timescales for face to face consultations showed the service was unable to meet the targets around seeing an emergency either at an OOH site or at home and seeing non-urgent patients at an OOH site in a timely manner. Data showed those timescales for patients required to be seen within two hours for a consultation in an OOH site or those required to receive a home visit were not being fully met. Staff told us that the delays happened at weekends and the targets were met on week days. However the data used an average weekly performance and did not break down by day suggesting that the performance at weekends was significantly below the target.
- Where patients were experiencing a delay for an assessment or treatment there were arrangements in place to 'comfort call' a patient to ensure their condition had not changed or worsened and to support patients awaiting a home visit or a clinical call back within a timescale which might not be met. Patients also received a call back when a home visit had been recommended as the course of action required.
- The comfort calling policy was to provide a comfort call every two hours. This was a reassurance call not a clinical assessment. It was policy to provide a comfort call before breaching the response time to a home visit request. There was a comfort call prompt sheet and an audit tool. Comfort calling rates for January to March 2018 achieved the 95% contractual target.

- The OOH sites in Staffordshire occasionally closed due to unfilled clinical shifts, which meant patients could have a distance to travel to receive face to face clinical assessment. These closures were mainly due to the model used where clinicians were allocated to where the need was greatest. Discussion with the commissioners and the provider highlighted that there was disagreement on how often centres should close. The provider assured us that every patient was tracked through the system to ensure care was provided when needed. Minutes of meetings we saw highlighted that centres were closed on occasion due to no GP being available.

The results from the NHS Patient Survey published in July 2017 showed that the satisfaction rates for timely care from the service had decreased since the March 2017 inspection but performance remained similar to the national average. The results showed 63% (previously 66% in July 2016) of patients responded positively when asked how quickly care was received compared to the national average of 61% (previously 62% in July 2016).

Listening and learning from concerns and complaints

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

- A total of 128 complaints were received in 2017, this included all the urgent care centres and represented 0.1% of total contacts.
- The provider analysed the complaints and identified the main cause for complaint was delays in receiving care and treatment. This accounted for approximately half of all complaints received.
- The response time to complaints had been poor, but additional resources had been added and had improved response times from July 2017. For example, the longest response time in January 2017 had been 239 days and, the average response time was 79 days. This had improved through 2017 and in December, the longest response time had been 16 days and the average response time was six days.
- The provider had implemented a two tier approach to managing complaints. This consisted of formal complaints that were taken through the formal process and informal complaints that could be closed without the need for a formal investigation.
- Shared learning sessions were held with staff and communicated to all staff through a regular newsletter.

We found that complaints were satisfactorily handled and following the steps taken were being handled in a timely way. For example, a review of one complaint that related to a delayed home visit in October 2017 showed that an investigation had been completed by 19 October, and as an outcome, clinical practitioners were to review the queue for home visit requests during busy periods.

- Monthly themes and trends around complaints such as delays and cancellations in care and access to

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

treatment were reported to the clinical commissioning group. For example, in February 2018, six of the 11 complaints were related to delayed treatment and waiting times.

- The service had improved the shared learning by dedicating one in four of the weekly governance meetings; open to all staff that worked within the service; for lessons learnt and shared good practice, with trends identified from complaints as well as specific complaints being a standing agenda item. Issues that stemmed from complaints were discussed at the monthly quality and safety meeting and included on staff newsletters.

Are services well-led?

Requires improvement

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

Our findings

At our previous inspection on 22 March 2017 we rated the well-led domain as requires improvement. The areas identified as in need of improvement were:

- Policies and procedures did not always govern activity, for example; the appropriate use of chaperones.
- Performance reviews on staff had not always been acted on appropriately, for example; we found examples of GP failed audits that had not been acted on appropriately when standards were not being met.
- Governance arrangements needed further strengthening in certain areas, for example; learning outcomes from significant events were not always implemented.

At this inspection we found that although some improvements in governance had been made, we continued to rate the provider as requires improvement for providing well-led services.

Leadership capacity and capability

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 cases highlighted where delayed treatment put patients at potential risk.

Staff spoke of a 'no blame' culture and told us the management were approachable and took the time to listen to them. Staff we spoke with at the urgent care centres (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 and training for all staff on communicating with patients about notifiable safety incidents. The leadership 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:

- 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 the 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.

Vision and strategy

- Vocare had a corporate vision 'for this country to be part of the heath and care services which are the best in the world' and defined it's role to be 'the urgent healthcare provider and partner of choice for the NHS which will allow them to provide better clinically led, evidenced based, innovative and sustainable services for patients'. This was accessible on the provider's website.
- Staff we spoke to were aware of the vision, values and strategy and their role in achieving them. Posters were clearly displayed in the Staffordshire House building.
- The senior management team had formalised a localised strategy to develop an integrated urgent care model, especially with the NHS111 service. Staff worked across both services and urgent care practitioners were being multi-trained; e.g. paramedics were trained as urgent care practitioners, able to work in all areas of the urgent care system.
- The provider aimed to work with system partners to improve patient care and address areas where performance fell below the required targets.
- SDUC are part of the alliance board across North Staffordshire (a group of multidisciplinary providers that included acute trusts, community trusts, a mental health trust and a GP federation). Work included a care home project; run with the GP federation, that explored how OOH can support care homes.

Culture

Are services well-led?

Requires improvement

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

The provider had strengthened the leadership and governance arrangements. The management team were aware of the need to increase clinical time to deliver high-quality sustainable care.

- Staff felt respected, supported and valued within the individual OOH sites they worked in.
- They told us they were able to raise concerns. All staff had access to the Datix system and were clear on the line management arrangements.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- The provider was aware of and had systems in place around compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- There were organisational policies for providing all staff with the development they needed, for example; support with revalidation. Staff we spoke with had received appraisals in the last year.
- Shared learning events with workshops had been introduced to encourage a learning culture.

Governance arrangements

At our March 2017 inspection, we found that governance arrangements needed strengthening. This was because:

- We found examples of when policies were not reflected in practice.
- Risks identified had not always been acted effectively to minimise the possibility of reoccurrence

The service had strengthened the governance framework to further support 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 local key performance indicators. These were discussed at senior management and board level. Performance was shared with staff and the local clinical commissioning group as part of contract monitoring arrangements.
- The provider had recruited a quality lead, a clinical governance manager and established quality meetings, a reporting mechanism for escalation and workshops for shared learning. Staff we spoke with were positive about these improvements, in particular the improved communication since our March 2017 inspection

However , there were areas of governance that still required strengthening:

- Safety incidents found during the inspection which had not been reported which prevented clinical oversight from the leadership team.
- Although a new system had been implemented, improvements were required in the percentage of evidence GPs who had completed mandatory basic life support and safeguarding training.

Managing risks, issues and performance

- The governance systems and processes to identify and manage risks and issues were effective where risks had been identified. However, we found examples of where patients were at potential risks due to delayed treatment, but this information had not been captured and acted on. The provider reviewed the cases identified following the inspection and told us that an investigation had been initiated. When risks had been identified, the provider had effective systems or process to assess, monitor and improve the quality and safety of the services. However, the outcomes regularly referred to gaps where clinician's shifts could not be filled.
- Prior to our inspection the CQC liaised regularly with members from Staffordshire's Clinical Commissioning Groups to discuss actions in relation to the staff shortages. We reviewed the action plan to reduce home visit wait times. We saw actions had been taken but it was too soon to see sustained improvement.
- The service had failed to achieve compliance with the local indicators that monitored urgent situations, those assessed as in need of treatment within two hours. Staff told us that this was due to continuing problems in finding enough clinicians to fill the shifts to the level predicted by the planning tool. However we saw examples of when the shifts had been filled to the levels calculated using the planning tool; but capacity remained an issue.
- Leaders had an understanding of service performance against the national and local key performance indicators. Performance was regularly discussed with the local clinical commissioning group as part of

Are services well-led?

Requires improvement

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

contract monitoring arrangements; however, processes to manage current performance in regard to delivering timely care when treatment was deemed as urgent had not improved leading to continued risks to patients.
- The service had produced an action plan to reduce the delayed waiting times for home visit requests. Staff we spoke with told us the plan; together with the introduction of home visiting paramedics; had improved the situation. Data provided suggested signs of improvement although it was too soon to see that this had been sustained. We found potential risks to patients associated with delayed visits on a Saturday when the Vocare National Triage Service (VNTS) had been unavailable (the VNTS was a support service provided from Vocare headquarters to support regional services using clinical assessment via telephone).

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and sustainability were discussed in relevant meetings where staff had sufficient access to information. Meetings were held on a Friday to review the weekend requirements and on a Monday to assess the performance at the busiest times.
- The service used a set of local indicators to monitor performance and the delivery of quality care which they reported on monthly.
- The service submitted data or notifications to external organisations such as Clinical Commissioning groups (CCGs) as required. Statutory notifications to the CQC were made when required in a timely manner.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

- Systems were in place for staff to give feedback and be involved in service development.
- We saw there was a locally produced monthly newsletter and a monthly clinician's newsletter.
- The service encouraged patients to provide feedback through the NHS Friends and Family test. Forms were available at each OOH site. Results from 502 responses in February 2018 showed 95% would recommend the service to family or friends.
- SDUC engaged with other urgent care services such as the ambulance and local NHS hospital Trusts.
- Internal engagement with staff was encouraged through staff ambassadors.
- The provider was seen to be recruiting service users to form a patient forum.
- SDUC had developed links with the local Healthwatch team in Stoke-on-Trent to provide patient feedback on the service.

Continuous improvement and innovation

The provider had a number of initiatives underway, most of which addressed the need to make best use of clinical time and reduce the workload on GPs.

- In response to delayed home visits, the service had introduced home visiting paramedics following approval from the commissioners. This planned to release pressure on the GPs who had been the only clinicians able to perform home visiting.
- A care home project was underway to review the need for home visits as findings highlighted that many of the home visit requests came from nursing homes and a review of them suggested that some of these could be managed through the NHS 111 service preventing the need for a visit. SDUC were looking for support from other agencies already involved in care home work streams.
- Urgent call requests from the NHS 111 service were being validated to minimise non-urgent cases that had been passed through as urgent. This had started in February 2018 and the provider reported a reduction of approximately 10% or urgent calls entering the OOH clinical queue. This was being facilitated by a clinical advisor contacting each of the urgent transfers from the NHS 111 service. A flow chart and guide had been developed for the call advisors.
- SDUC planned to improve the flow of information through a piece of software named 'black pear'. This software performed system inter-operability allowing different clinical systems to be accessible from the OOH service and aimed to link in with GP practices and the community healthcare team.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Delays in treatment led to potential risks to patients. In particular: • Failure to review a child with possible sepsis within 12 hours – could have resulted in death. • Unfilled gaps on the GP rota have resulted in patients not been seen in a timely manner. • Some incidents had not been entered through the incident reporting process; missed opportunities to learn, improve and minimise the possibility of reoccurrence. • The calculations that the rota is based on needed review.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not have sufficient trained staff in place to meet the needs of patients. In particular: • Targets for responding to patients within a two hour target were consistently not met. • Risks to patients held in a queue were not assessed in a timely manner. • The target response times to home visit requests were often not met, most notably at weekends.