Oxford Health NHS Foundation Trust – HQ (Out of Hours)

Inspection report

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

Ratings

Overall rating for this location	Good 
Are services safe?	**Good** 
Are services effective?	**Good** 
Are services well-led?	**Requires improvement** 

Overall summary

This service is rated as Good overall. (Previous inspection 7, 8 & 9 November 2016 – Requires improvement overall)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services well-led? – Requires improvement

We carried out an announced focused inspection at Oxford Health NHS Foundation Trust - HQ on 28 March 2018. We undertook this inspection to follow up on breaches of regulation following the inspection in November 2016. We inspected the safe, effective and well led domains during this focussed follow up inspection.

At this inspection we found:

- The provider had reviewed the governance arrangements for all identified concerns from the previous Care Quality Commission inspection report and implemented changes.
- Staff training for basic life support had been completed, but there were still some gaps in chaperoning training for drivers/receptionists. There were also gaps in safeguarding training for GPs.
- The provider showed us their National Quality Requirements data (a key performance measure for out of hours services) for April 2017 to February 2018, which demonstrated some improvements on the previous reported figures although they remained below target for some indicators.
- The provider had undertaken a recruitment programme to improve staffing levels and ensure enough clinical staff were in post.
- The provider had introduced blank printed prescription tracking and monitoring systems since the last inspection, although we found these were inconsistently applied across different sites.
- Cleaning schedules and spot checks had been improved to ensure infection control risks were minimised.
- Recruitment documentation had been reviewed to identify any gaps in stored information. Disclosure and Baring Service (DBS) checks for GPs had improved and those identified as not yet in receipt of a DBS check had been risk assessed.
- Calibration of blood glucose monitoring equipment had been implemented although staff required further training on when a calibration was required.
- The Controlled Drugs (CD) order book at one of the sites (Oxford City) had still not been completed appropriately when they received CD stock into the base.

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

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The areas where the provider **should** make improvements are:

- Continue to review and improve staffing levels with a view to achieving the 98% target for session fulfilment.
- Review calibration of blood glucose monitors and ensure staff are aware of best practice guidelines for use.
- Review arrangements for monitoring and recording chaperone training to ensure it has been completed for all required staff.

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Chief Inspector of General Practice

Our inspection team

This focused inspection was carried out by a CQC inspector.

Background to Oxford Health NHS Foundation Trust - HQ

GP out of hours services in Oxfordshire are provided by Oxford Health NHS Foundation Trust. The service covers the total population of Oxfordshire (approximately 660,000 patients). Between April 2017 and February 2018, the service received 103,683 contacts from patients. Initial assessment when a patient calls for advice and treatment is undertaken by the NHS 111 service operated by South Central Ambulance Service. Once the assessment has been completed the NHS 111 team can book patients directly into the out of hours service. This could involve direct booking for a visit to one of the six out of hours bases or for a further review by the out of hours GPs. The second stage assessment can result in either a home visit, request to attend one of the out of hours centres or immediate telephone advice. All bases also accepted walk in patients (patients who arrived at the service without an appointment or accessed via NHS 111).

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

- Oxford City Out of Hours base – East Oxford Health Centre, Manzil Way, Oxford, OX4 1XD. This is a dedicated out of hours facility located in a large health centre. It is open from 6.30pm to 8am (overnight) Monday to Saturday and from 8am on a Saturday through to 8am Monday morning. This centre is also open on bank holidays from 8am to 8am the next day.
- Witney Out of Hours base – Witney Community Hospital, Welch Way, Witney, OX28 6JJ. It is open from 6.30pm to 8am (overnight) Monday to Saturday and from 8am on a Saturday through to 8am Monday morning. This centre is also open on bank holidays from 8am to 8am the next day. The out of hours provision is co-located with a minor injuries unit that is also managed by the Trust and accepts walk in patients either directly or via the minor injuries unit.
- Abingdon Out of Hours base - Abingdon Community Hospital, Marcham Road, Abingdon OX14 1AG. At Abingdon the out of hours provision is co-located with a minor injuries unit that is also managed by the Trust and accepts walk in patients either directly or via the minor injuries unit. It is open from 6.30pm to 8am (overnight) Monday to Saturday and from 8am on a Saturday through to 8am Monday morning. This centre is also open on bank holidays from 8am to 8am the next day.
- Henley Out of Hours base - Townlands Memorial Hospital, York Road, Henley, RG9 2EB. This service is co-located with a minor injuries unit which is also managed by the Trust. Nursing and paramedic staff are able to work between both services. The out of hours service is open from 6.30pm to 11pm every weekday and from 8am to 11pm at weekends and on bank holidays. When the base is closed overnight services are provided from either the Abingdon or Oxford City bases.
- Bicester Out of Hours base - Bicester Community Hospital, Piggy Lane, Bicester, OX26 6HT. This site is located alongside a first aid unit also managed by the Trust. The out of hours service is open from 6.30pm to 11pm every weekday and from 8am to 11pm at weekends and on bank holidays. The overnight service for the north of the county is then provided from the Banbury base.
- Banbury Out of Hours base - Horton General Hospital, Hightown Road, Banbury, OX16 9AL. The out of hours service shares this facility with the outpatients department of the Horton General Hospital. It is open from 6.30pm to 8am (overnight) Monday to Saturday and from 8am on a Saturday through to 8am Monday morning. This centre is open on bank holidays from 8am to 8am the next day. The out of hours service is close to the hospital emergency department and accepts patients from this department who require primary care treatment.

We visited Oxford City and Bicester bases and the Corporate services at Littlemore Mental Health Centre during this inspection.

Patients can access information from the service website: www.oxfordhealth.nhs.uk

Good

Are services safe?

During the last inspection in November 2016 we found concerns with staff recruitment files, staff training, staffing levels and medical equipment calibration logs. In addition, we observed issues with medicines and prescription management. During this inspection, the provider demonstrated the breaches of regulation had been reviewed and improvements made. However, there were still some areas that had not been completed or fully embedded.

We have rated the service as good for providing safe services.

Safety systems and processes

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

- We reviewed the provider recruitment processes and found not all GPs who worked for the service had received an appropriate Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The provider had identified four GPs as not having an up-to-date DBS check. All four GPs had applied for an enhanced DBS check and the provider had undertaken individual risk assessments. The risk assessments included evidence of other DBS checks through another employer for two GPs and evidence of inclusion on the General Medical Council (GMC) performers list for all four GPs. (The GMC performers list is a mandatory requirement for GPs to be registered. The GMC is informed of any criminal convictions by the police when they occur, which would be identified through a check of the performers list as well as a DBS check).
- We looked at staff training records and found not all GPs had received up-to-date safeguarding training appropriate to their role. The provider had decided that safeguarding training should be updated every three years. The training matrix we viewed documented 102 active GPs working for the service, of whom six had no record of any training dates for child safeguarding. A further four GPs were overdue their update for level three safeguarding children by four or more years. One GP was overdue their update by eight days at the time of the inspection. The provider had reminded GPs their training was due and had recently introduced a buddy system to follow this up with GPs. Many of the GPs were employed in other healthcare services and had received up to date training but had not yet shown the provider evidence of this.
- The provider had offered chaperone training to drivers and reception staff, although not all staff had undertaken the training. We looked at training records and found 54 of the 78 staff listed as receptionist/driver had received either online or face-to-face training. The 24 who had not yet received training were in receipt of a power point presentation which the provider had organised to present to new starters on induction. The presentation outlined the role and responsibilities of a chaperone and what to do in the event a trained chaperone was not available. GPs were made aware if their allocated driver was not chaperone trained before they commenced their shift. If a chaperone was deemed necessary during a home visit, the service would arrange for a driver with chaperone training to attend. Patients were offered alternative options for arranging a chaperone at the bases, such as attending a different base or re-arranging their appointment. The provider showed us an updated matrix after the inspection which showed the majority of staff had now received chaperone training, with only six staff requiring it.
- All reception/driver staff had received basic life support training.
- There was an effective system to manage infection prevention and control. At the Oxford City base, the provider had ensured the disposable curtains had been changed at the correct interval and according to best practice. The Bicester base had been monitored to ensure cleaning standards had been met. We found furniture used for patient examinations to be clean and free from dust or debris.
- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. We viewed a random selection of blood glucose monitoring equipment and found they had been calibrated regularly according to manufacturer instructions. However, the calibration was not always being carried out when the testing strips were changed (with a new lot number). Once this was pointed out to the provider, they took immediate action to inform staff of the checking procedure and identified designated personnel at each site to maintain oversight.

Risks to patients

Good

Are services safe?

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

- There were arrangements for planning and monitoring the number and mix of staff needed. We looked at staff rotas for the 11 month period from April 2017 to February 2018 and found the provider had fulfilled 92% of the staffing shifts agreed with the Clinical Commissioning Group (CCG). This had improved by 8%, from 84% in 2016/17, although the figures still remained below the 98% target for fulfilment set by the CCG.
- There was an effective system in place for dealing with surges in demand. For example, the provider undertook a weekly review of vacant or low staffing for the upcoming weekend so action could be taken to mitigate risk during busier times. The provider could make arrangements to centralise services if required, whilst still offering appropriate cover to the geographic area.
- When there were changes to services or staff the service assessed and monitored the impact on safety. For example, service disruptions and low staffing were raised as significant events and placed on a risk register for board review.

Safe and appropriate use of medicines

The service had systems in place for appropriate and safe handling of medicines, although these were inconsistently applied across the bases.

- The service had reviewed the management of prescription stationary at five bases (Henley, Witney, Banbury, Bicester and Oxford City). Blank printed prescriptions were packaged into lots of 20 and placed in an envelope with a crib sheet. These packs were then placed in a safe at the different locations. When a prescribing clinician was due to start their shift a pack was removed from the safe and the blank prescriptions placed in the printer they would be using. Each prescription number was individually logged on the crib sheet and a patient ID number was added next to the prescription issued to account for its use. Any unused or voided prescriptions were placed back in the envelope with the crib sheet which documented the number given out and the number returned. We reviewed the arrangements at the Oxford City base and the Bicester base and found disparity in how they were managed. At the Oxford City base the crib sheet was not filled with the patient ID so it was unclear which prescriptions had been used or voided. At the Bicester base we viewed a random sample of prescription packs and logs and found the tracking system appeared to be fully embedded.
- The Controlled Drug (CD) order book at the Oxford City base had not been completed to demonstrate when CDs had been received into the base. We reviewed the order book and found six CD orders from November 2017. Only one had a received signature and was not dated. The remaining five were not signed or dated, which did not provide a cohesive or safe audit trail for the tracking of CDs through the service. The provider was unable to determine a direct cause for the oversight and told us they would review the process for receiving CDs at the Oxford City base. We reviewed the CD order book at the Bicester base and found all orders had a received signature and date according to the provider policy and best practice.
- We saw evidence the emergency medicines at the Banbury site were regularly checked and stored in one location, thus ensuring easy and quick access.

Good

Are services effective?

We rated the service as good for providing effective services.

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. Providers are required to report monthly to their clinical commissioning group (CCG) on their performance against the standards which includes: audits, response times to phone calls, whether telephone and face to face assessments happened within the required timescales, seeking patient feedback and actions taken to improve quality.

During the last inspection in October 2016, we noted the provider had been experiencing a low number of available clinical staff throughout 2016, which had resulted in the provider not attaining some of the quality requirements.

The provider had made a significant effort to recruit additional staff and was almost at full establishment. At the time of this inspection the provider still required 4.5 whole time equivalent (WTE) Emergency Care Practitioners and 1.98 WTE Advanced Nurse Practitioners.

During this inspection we viewed unverified national quality requirements (NQR) data for the year April 2017 to February 2018. The provider's performance against NQR included:

- NQR 4: audit a random sample of patient contacts and act on the results of the audit. A random sample of at least 1% of patient contacts per GP was completed every year. The provider set a standard of a score of 17 out of a maximum of 22 as a target. This standard exceeded the national recommendation of a minimum score of 14. When the audit identified GPs falling below this standard the provider demonstrated that action was taken to support the GP to improve their performance. For example, by offering coaching, mentoring and further training. Data showed that 99% of GPs were attaining the consultation minimum standards, with 86% attaining a score of 17 or above (the standard set by the service).
- NQR 10: Face to face assessment (urgent), commence definitive clinical assessment within 20 minutes of arrival at an Out of Hours (OOH) base. Data showed that out of 400 patients defined as in need of urgent assessment 328 (82%) had been assessed within 20 minutes when the target was 95%. This had improved from the 2016 reported figure of 74%.
- NQR 10: Face to face assessment (non-urgent) commence definitive clinical assessment within 60 minutes of arrival at an OOH base. There had been 4,861 contacts with patients with non-urgent needs. Of these 4313 (89%) had received their clinical assessment within the 60 minute target. This had improved from 87% in 2016 but still remained below the 95% target.
- NQR 11: match the skills of clinicians available with peaks of demand in the service. The provider demonstrated that adjustments in staff rosters were underway to increase staffing levels at peak times and reduce the staff cover during times of lowest demand. A recruitment program had recruited additional suitably skilled and experienced staff. Data from the provider showed that 9,786 (92%) of the target 10,583 shifts had been filled since April 2017. This had improved from 84% in 2016 although it remained below the 98% target.
- NQR 12: Face to face consultations. The NHS 111 service had direct access to book patients, whom they have assessed through NHS Pathways, into the OOH bases. This was achieved via a link into the provider's computer system. NHS 111 provided information including the patient's demographics, the clinical assessment and priority. This ensured that information was correct and reduced the need for the patient to repeat their history. Other patients could be booked in by out of hours clinicians when they talked to the patient on the telephone.

Achievement against the standards was mixed, between April 2017 and February 2018:

- Patients classified as in need of urgent consultation following definitive clinical assessment to be seen within two hours at an OOH base: The provider had achieved 81% (5,738 out of 7,000) face to face consultations at an out of hours base within two hours of assessment for those patients classified as urgent. This had reduced from the 2016 figure of 82% and remained below the 95% target.
- Patients classified as in need of less urgent consultation following definitive clinical assessment to be seen

within six hours at an OOH base: The provider had achieved 25,138 out of 25,925 (97%) face to face consultations within six hours for patients classified as routine. The target was 95%.

- Patients classified as urgent requiring a face to face consultation at their place of residence to be seen within two hours following definitive clinical assessment: Out of 6,460 patients, 6,133 (95%) had been seen within two hours in their place of residence. This had improved from 94% in 2016 and was in line with the target of 95%.
- Patients classified as less urgent requiring a face to face consultation at their place of residence to be seen within six hours following definitive clinical assessment: Face to face consultations with patients assessed as less urgent in their place of residence was achieved for 3,939 (98%) out of 4,031 patients within six hours. The target was 95%.

The provider was aware of the below target achievement for NQR 10 and carried out a monthly breach report to determine if there were any clinically significant breaches and raised them as a significant event. For example, between November 2017 and February 2018 four patients who had breached their times for consultation were deemed to have a significant clinical risk and were reported as an incident.

We looked at the unverified total breach figures for all patient contacts from November 2017 to February 2018. During this period there had been 35,875 patient contacts recorded. Of these, 4% were recorded as a breach.

- November 2017: There were 189 breaches recorded (3% of total consultations), with an average breach time of 47 minutes. 22% of these were below 10 minutes and 29% between 11 and 30 minutes. The longest breach was 332 minutes for a telephonic consultation for a routine patient.
- December 2017: There were 445 breaches recorded (4% of total consultations), with an average breach time of 88 minutes. 14% of these were below 10 minutes and 22% between 11 and 30 minutes. The longest breach was 728 minutes for a telephonic consultation for a less-urgent patient.
- January 2018: There were 360 breaches recorded (4% of total consultations), with an average breach time of 72 minutes.15% of these were below 10 minutes and 18% between 11 and 30 minutes. The longest breach was 420 minutes for a base visit for a less-urgent patient.
- February 2018: There were 438 breaches recorded (5% of total consultations), with an average breach time of 69 minutes. 18% of these were below 10 minutes and 22% between 11 and 30 minutes. The longest breach was 434 minutes for a telephonic consultation for a less-urgent patient.

During the last inspection we noted the provider had maintained an open and honest dialogue with the commissioners whilst recruitment and service planning was underway. During this inspection we found evidence that the provider was maintaining their communication and had reviewed staffing requirements and service provision. We found the provider had;

- Clearly identified the staffing requirements needed to meet the NQR's and provide safe and effective services.
- Reviewed the use of the service to identify peaks and troughs in demand to plan the numbers of staff required for each shift operated.
- Reviewed the types of care and treatment required by patients to match the skills of staff to the treatments required. This enabled the provider to change the skill mix of staff to closely match demand and assist in future recruitment.
- Maintained close contact with their commissioners on progress made in recruiting the required number of staff.

Coordinating care and treatment

- At the last inspection staff identified concerns with the portable IT equipment not gaining a signal in some remote areas, resulting in staff needing to return to base to complete patient records appropriately. The service had received new IT equipment in January 2017 which had resolved this problem.

Requires improvement

Are services well-led?

We rated the service as requires improvement for leadership.

Governance arrangements

- The service had reviewed their governance arrangements since the last inspection in November 2016 and made a number of improvements to become compliant with the regulations. However, there were still some areas where the governance arrangements required improvement.
- The provider had initiated matron walk arounds at each site to ensure cleaning standards were monitored. The concerns we found at our previous inspection had been resolved.
- Recruitment files had been reviewed to update them with any missing information. The GP files without a DBS check had been identified, DBS applications submitted and appropriate risk assessments made.
- Most staff training was monitored and updated regularly. For those staff who had not completed training, a reminder was sent to them and a designated member of staff was responsible for following this up if the training remained incomplete. However, there were still some GPs who had not completed, or shown evidence of completing, safeguarding training and the chaperone training records did not accurately reflect the number of staff trained.
- Processes had been established for the monitoring and tracking of blank prescriptions. The process was noted to be inconsistently applied at the Oxford City site, despite the matron walk around including reviewing the prescription tracking process. The provider told us they would review the tracking procedure at Oxford City as this was not currently providing suitable tracking arrangements.
- The controlled drugs (CD) order book at Oxford City had not been completed in accordance with provider policy or best practice guidelines. The provider told us they were reviewing the delivery of CDs to Oxford City and considering having them requested and delivered at another base, where staff were compliant with completing the CD order book. In the interim, they would add checking the CD order book to the regular matron walk around.
- Staffing levels were monitored regularly and the provider recruitment programme had increased staff provision. Recruitment was still ongoing and the provider was reviewing skill mix to ensure future recruitment took this into account. Regular reviews of high demand shifts ensured services could be rearranged to offer cover from a different base or set of bases when staffing levels restricted opening all sites. Fulfilling agreed staffing targets for clinical sessions had improved but remained below the 98% standard. The provider had recognised the increasing demand for services during the winter months which had impacted on staffing levels. They were continuing to review staffing shortages and review the impact this was having on patient care.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** There were limited systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • Child safeguarding training for all GPs had not been recorded or was incomplete. • The tracking of blank printed prescriptions was inconsistent between different out of hours bases. • Audit trail of CDs throughout the service should be maintained according to guidance. This include maintaining the records of the receipt of CDs. **This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**