# Staffordshire House

## Inspection 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 location | Good |
|---|---|
| Are services safe? | Good |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive? | Good |
| Are services well-led? | Good |

# Overall summary

**This service is rated as good overall. The previous inspection on 21 March 2018 rated the practice as requires improvement.**

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

Following our comprehensive inspection at Staffordshire House on 21 March 2018 the location was rated as requires improvement for the Staffordshire Out of Hours (OOH) service with a requires improvement rating for the safe, effective, responsive and well-led key questions, good for the caring key question.

We carried out an announced comprehensive inspection on 20 September 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 delays in treatment being provided.
- The skill mix and staffing levels had been reviewed and we saw that safe care and treatment was now being provided in a timely way.
- 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 medicines were comprehensive and effective. Prescriptions were securely stored and their use was monitored.
- The recruitment of new personnel into the governance team had strengthened arrangements and supported an overarching governance framework for systems and processes.

The provider had recruited and trained associated healthcare professionals and reduced the dependence on GPs.

- Patients' care needs were seen to be assessed and delivered in a timely way according to their needs. The service had improved performance against the Local Quality Requirements which monitored clinically effective and responsive care. For example, home visit response times showed sustained improvement and achieved contractual targets for the past three months.

There was one area of the service where we recommended that the provider should make improvements:

- Continue to improve the evidence to support that mandatory training has been completed by GPs.

**Professor Steve Field** CBE FRCP FFPH FRCGPChief Inspector of General Practice

## Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser and a second CQC inspector.

## 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 telephone triage and 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 seven 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 week days, 8am to midnight weekends and bank holidays)
- Robert Peel Hospital, Tamworth (7.30pm to 11.30pm week days, 9am to 11pm weekends and bank holidays)
- Queen's Hospital, Burton-on-Trent (6.30pm to 8am week days, 24 hours weekends and bank holidays)
- Staffordshire House (6pm to midnight week days, 8am to midnight weekend and bank holidays)
- Haywood Hospital, (6pm to midnight week days, 8am to midnight weekend and bank holidays)
- Royal Stoke Hospital (24 hour opening every day of the year)

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

During our inspection we visited the headquarters in Stoke-on-Trent along with the OOH sites at Staffordshire House and at Robert Peel Hospital, Tamworth.

The service received approximately 128,000 contacts in 2017. On average, approximately half of these contacts are referred by the NHS 111 service (the service receives 900 referrals per week via NHS 111). Of these an average of approximately 40% are received on weekdays and 60% of contacts are made at weekends. The other pathways into the service are from accident and emergency (A&E), walk in centres, a direct healthcare professional telephone line, minor injuries and patients' own GPs.

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

Good

# Are services safe?

At our previous inspection undertaken on 21 March 2018 we rated the safe domain as requires improvement. The areas identified as in need of improvement were:

- Failure to review a child with possible sepsis within 12 hours could have resulted in death.
- Unfilled gaps on the GP rota resulting in patients not seen in a timely manner.
- Some incidents had not been entered through the incident reporting process leading to missed opportunities to learn, improve and minimise the possibility of reoccurrence.
- The calculations that the rota was based on needed reviewing.

At this inspection we found that improvements had been made:

**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 GP working locally, supported by regional safeguarding leads.
- 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 12 referrals in July and August 2018, nine for adults and three 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 (IPC) measures. The Out of Hours (OOH) sites we visited were clean and tidy; regular IPC 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 medications (including controlled medicines) 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. The rota team had been strengthened to provide increased coverage of hours. The provider had increased the support from advanced nurse practitioners (ANPs) and introduced a team of home visiting paramedics since the last inspection. We saw that key performance indicators

Good

# Are services safe?

(KPIs) were being achieved. Staff spoke positively about the improvement in filling rotas since the previous inspection and the dependence on GPs had been reduced.

- We reviewed the OOH rota and a sample of the key performance indicators for April to June 2018 and found that the rota team were now able to fill rota slots to meet the forecasted requirement.
- 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 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. We viewed records for GPs that evidenced the completion of appraisal and revalidation.
- 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 their condition changed or worsened. A 'recognition of the acutely ill patient' pathway had been implemented to support clinical decision making. This included an 'early warning scoring tool' and a 'risk strategy for sepsis'.

**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.
- Clinicians made appropriate and timely referrals in line with up to date evidence-based guidance.

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.

**Safe and appropriate use of medicines**

Processes were in place for checking medicines, including those held at the service and 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 optimisation 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 (MHRA).
- The provider held a Home Office licence to permit the possession of controlled medicines within the service and held stocks of controlled medicines (medicines that require extra checks and special storage because of their potential misuse). Staff received training in the management of controlled medicines and standard operating procedures were in place that set out how controlled medicines 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 medicines.
- Processes were in place for checking medicines, including those held at the service and 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 Vocare.

**Track record on safety**

The provider had effective systems and processes that monitored safety within the service:

- 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 written up terms of reference for this group. 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 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 drills included a review of any areas of improvement identified.
- There was an effective system for receiving and acting on safety alerts.

**Lessons learned and improvements made**

- The SDUC governance team led on the process of recording, reporting and learning from incidents. Staff had access to Datix (an electronic system that allows learning from incidents to be shared). SDUC had adopted this as their system of choice for recording all incidents. All identified incidents were reported to team leaders and those of a clinical nature were investigated by a service medical lead.
- There was an 'adverse event' policy that included an action plan and 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 to improve the service following an incident or complaint. Staff newsletters were circulated monthly, and a central website allowed learning to be shared within the Vocare Group. Clinical directors discussed incidents at 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 monthly and this included a review of the level of harm caused. Since the previous inspection, there had been 130 incidents reported, none of which had resulted in severe harm being caused. Lessons were reported to staff through newsletters. Of the 130, 93 had been investigated and closed; the remaining 47 were still under investigation with the oldest incident having been recorded on 10th July 2018.
- There was a document that tracked each incident including any action taken and noted when the incident was closed.
- Joint reviews of incidents were carried out with partner organisations and monitored by a quality team that represented the Staffordshire Clinical Commissioning Groups (CCGs).
- We reviewed incidents recorded since the previous inspection and found the process effective. For example, following a prolonged delay over verification of a patient death, home visiting paramedics were trained to perform the task and resulted in a significant overall reduction in the wait time from over six hours to under two hours.

Good

# Are services effective?

At our previous inspection on 21 March 2018 we rated the effective key question as requires improvement. The areas identified as in need of improvement were:

- The service repeatedly failed to meet the target for a response in less than two hours.
- The response times to home visit requests resulted in potential risk to patients when waiting to be seen.
- Paramedics were not receiving the level of 1-1 supervision that should be provided to clinicians new to primary care.

We saw that improvements had been made and now rate the service as good 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 described how 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 audits were completed each quarter for each clinician.
- Care and treatment was delivered in a coordinated way which considered 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 when concerns and risk factors such as high blood pressure were identified.
- There was a system in place to identify frequent callers and patients with particular needs, for example, patients with mental health problems were triaged to assess their mental capacity. Children under six months and patients nearing end of life had a pathway to be followed that requested a 20 minute response and an urgent face to face consultation.

**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 the Clinical Commissioning Groups (CCGs) 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 three contracts (the provider previously had four contracts but this was the first inspection since the contracts for Staffordshire South East and Stafford and Cannock had been combined).

We looked at the performance indicators, which provided a clear and consistent way of assessing performance. In particular we looked at the indicators which provided 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 June 2018 to August 2018 regarding response times. We saw that the service had made significant improvements and performance was close to or achieving the contractual target for a response in less than two hours. This was the case in each of the three contracts, for example; data for the period June 2018 to August 2018 showed:

In North Staffordshire:

- The combined performance for the up to two hours indicators had improved from 90% for January 2018 to 94%, the target was 95%.
- The performance for a healthcare professional from the service to call back or visit a service user within 60 minutes had been divided into a 30 minute and 60 minutes response time. The performance was 88% for and 100% respectively. The 30 minute target was a call back target. The 60 minute response time was for a call

back or centre visit. In January 2018, 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 Staffordshire East:

- The combined performance for the up to two hours indicators was 94%, the target was 95%. In January 2018, the performance was 87%.
- The performance for a healthcare professional from the service to call back a service user within 60 minutes was 89%. The target was 95%. The performance in January 2018 was 71%.

In Staffordshire East:

- The combined performance for the up to two hours indicators was 96%, the target was 95%. This was 89% in January 2018.
- The performance for a healthcare professional from the service to call back a service user within 60 minutes was 85%. The target was 95% (of note in July there was two breaches that resulted in a score of 72% represented two out of 11 calls). The performance had been 69% in January 2018.

We had previously found the performance was lower at weekends. This trend had improved and the number of times the service breached response times had reduced significantly. For example, in July 2017, telephone triage had 186 breaches in total, in July 2018 this was 43 telephone triage breaches. The service showed how planned improvements in timescales for patients to be seen had been implemented and had now proven effective, mainly due to the use of home visiting paramedics to reduce the dependency on GPs.

Other areas such as a clinical assessment for all routine patients (between two and six hours) were now meeting contractual targets:

In North Staffordshire:

- The combined performance for between two and six hours indicators was 97%, the target was 95%. The performance in January 2018 was 91%.
- The performance for a service user to be contacted within six hours when their GP practice was closed was 98%. The target was 95%. The performance in January 2018 was 91%.

In Staffordshire East:

- The combined performance for between two and six hours indicators was 97%, the target was 95%. The performance in January 2018 was 92%
- The performance for a service user to be contacted within six hours when their GP practice was closed was 97%. The target was 95%. The performance in January 2018 was 93%.

In Staffordshire East and Stafford and Cannock:

- The combined performance for between two and six hours indicators was 99%, the target was 95%. The performance in January 2018 was 93%.
- The performance for a service user to be contacted within six hours when their GP practice was closed was 99%. The target was 95%. The performance in January 2018 was 93%.

The provider had recruited and trained paramedics to the home visiting service having agreed contractual changes with each of the contract holders. As a result, the response times for home visits had been reduced significantly:

- The compliance rates for urgent home visits was 50% in December 2017 and had improved to 88% in August 2018. On Sundays in December 2017 was 48% and in August this was 88%
- Using data for the last four weekends, wait times for urgent home visit requests had averaged two hours seven minutes.
- The average longest wait for a home visit on Sundays for August 2018 was six hours against a target of six hours. The overall average (urgent or routine) for the same time period was 2 hours 45 minutes.

An organisational lead for clinical audit across the organisation was in place and the governance team identified and ran the audits including repeat audit cycles. We reviewed the evidence for quality improvement through clinical audit and found that a comprehensive and systematic audit programme was in place. We saw medicines' audits, which demonstrated clinical effectiveness to meet national standards. The audit programme included regular monitoring of antimicrobial and controlled drug prescribing. The provider has used audit to reduce inappropriate prescribing of high risk medicines and to adopt a proactive approach to suicide risk management. Audit findings were benchmarked against other Vocare organisations and national data. We

found that audits were carried out in response to incidents recorded; for example, the provider audited the time taken to verify death and improved their systems to make the process both more timely and better bereavement support for the families.

**Effective staffing**

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

- 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 59% 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. GPs found not to be working at the required standard were 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 a comprehensive induction and protected learning for education. They received clinical supervision from a GP or advanced nurse practitioner (ANP) on each shift. Paramedics were seen to be working within their competencies and did not treat patients with complex mental health issues, 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, a clinician who had been the subject of a complaint for attitude and behaviour was supported with learning points around terminology and the most appropriate way to respond to patients' ideas, concerns and expectations.

**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. For example, data for 2018 showed that 100% of patients who had attended the service had a notification sent to their registered GP by 8am the following day.
- The service ensured that care was delivered in a coordinated way and where possible considered 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.

Good

# Are services effective?

- Risk factors, where identified, were highlighted to patients and their normal care providers so additional support could be given.
- Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs.

**Consent to care and treatment**

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

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

Good

# Are services caring?

At our previous inspection on 21 March 2019 we rated caring as good.

We continued to rate 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 and a non-judgemental attitude towards patients who had mental health problems.
- When receptionists telephoned people to book Out of Hours (OOH) 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.
- The service had significantly improved the wait times for verification of death.

A total of 109 Care Quality Commission comment cards were received. The comments were positive about the service received, four out of the 109 contained mixed comments with no theme. The positive comments were generally around the care received; and highlighted a caring approach from staff and a well organised service. The comment cards were collected from each of the urgent care centres, 49 of the 109 responses came from the Cannock centre and 31 from the Burton on Trent centre.

The provider obtained feedback from service using a total of 100 patient questionnaires sent out quarterly in each area. These included a pre-paid envelope for completed questionnaires to be sent back. An external company collated the results and provided data every six to eight weeks. Data from May 2018 showed:

- 93% of respondents thought the overall service was good, very good or excellent.
- 83% of respondents were satisfied with the time it took to see or speak with a healthcare professional.

**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 provider 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 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.

- 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.

Good

# Are services responsive to people's needs?

At our previous inspection on 21 March 2018 we rated the responsive key question as requires improvement. This was because:

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

We saw that improvements had been made and now rate the service as good 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. Data for the last three months showed these visits were consistently performing above the 80% achievement target for response times.
- There were accessible facilities, baby-changing facilities, a hearing loop and translation services available (100%had been provided within the target time of 15 minutes following 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.
- In 2018, 47 patients required an interpretation service, all of whom were provided access to interpreters within 15 minutes of the initial contact. Each reception area had a British Red Cross multilingual booklet that contained translations of basic questions for patients.
- 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. Comfort calls did not always include a clinical reassessment of their symptoms, but a system had been implemented to identify when a call should be made, a protocol had been implemented on whether a clinician should make the call. There was a formal process for non-clinical staff to identify patients whose condition was worsening and those at risk due to delays. The comfort calls were audited and results showed no patients had been left at risk of harm.
- The service could 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 when demand was low, 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.

Patients were 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 consistently performing above the 95% target for prioritising clinical assessment of calls other than an emergency.

- The service had improved its performance for patients having timely access to clinical diagnosis and treatment. Data obtained from the service regarding timescales for face to face consultations showed the service was meeting 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 now being met.
- 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. The comfort call prompt sheet had been adapted to help staff recognise any deterioration in the condition of a patient waiting to be seen or spoken to by a clinician. Following the implementation of the new prompt sheet, comfort calls were reviewed and no risk to patients had been found. Comfort calling rates for March 2018 to August 2018 achieved the 95% contractual target.
- The OOH sites in Staffordshire regularly closed due to the model used where clinicians were allocated to where the need was greatest. The provider assured us that every patient was tracked through the system to ensure care was provided when needed.

**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 2018.

- A total of 32 complaints were received since the March 2018 inspection, this included all the urgent care centres and represented 0.1% of total contacts. In August 2018 there had been four complaints received (0.04% of the patient contacts for the month), a decrease from the nine complaints received in the month of August 2017.
- The provider analysed the complaints and tracked each one through until closed. Previously the main cause for complaint was delays in receiving care and treatment that accounted for approximately half of all complaints received. However, this was not a current theme and attributed for six of the 32 complaints.
- The response time to complaints between April and July 2018 varied between seven and 14 days with the longest response time 30 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.

We found that complaints were satisfactorily handled and following the steps taken were being handled in a timely way. For example, the family of a deceased patient complained that a diagnosis had not been given. A member of the governance team had visited the family in their home and explained that the patient's wishes had been respected having refused to be told the diagnosis.

- Monthly themes and trends around complaints such as delays and cancellations in care and access to treatment were reported to the clinical commissioning group.
- The service had improved the shared learning by dedicating one in four of the weekly governance meetings; that included team leaders; for lessons learnt and shared good practice, with trends identified from

Good

# Are services responsive to people's needs?

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.

Good

# Are services well-led?

At our previous inspection on 21 March 2018 we rated the well-led key question as requires improvement. The areas identified as in need of improvement were:

- Safety incidents found during the inspection had not always been reported which prevented clinical oversight from the leadership team.
- Improvements were required in the percentage of GPs who had provided evidence that mandatory training had been completed for basic life support and safeguarding.
- The service was consistently underperforming against the key performance indicators.

At this inspection we found improvements had been made and now rated the provider as good for providing well-led services.

**Leadership capacity and capability**

During and following the inspection, the provider demonstrated they had acted as a result of our findings to improve the service and ensure high quality care. This included:

- A review of the skill set of staff who monitored the triage queue.
- Any breach in response time that resulted in a 999 call or admission the emergency department was reviewed by a member of the clinical team to ensure risks to patients were identified and managed appropriately. These were monitored at daily risk meetings.
- A review of the comfort calling procedure that included additional staff training and monitoring through audit.
- A review of the terms and conditions to optimise recruitment opportunities.
- The development of the home visiting paramedic (HVP) role.

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. Positive comments from staff centred around the improvements that had resulted from the use of HVPs. We spoke with paramedics who were positive in their responses on training and clinical support provided. Staff spoke of a 'no blame' culture and told us the management were approachable and took the time to listen to them.

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 partners 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.

- The Staffordshire Out of Hours (OOH) clinical leadership team had been strengthened with the addition of two posts; a Regional Clinical Director and a Regional Medical Director
- 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 health and care services which are the best in the world' and defined its role to be 'the urgent healthcare provider and partner of choice for the NHS which would allow Vocare 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.

Good

# Are services well-led?

- 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**

The provider had strengthened the leadership and governance arrangements. The management team were positive about the impact of actions taken to increase clinical time to deliver high-quality sustainable care. This was supported by comments from staff and patients:

- 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 were planned to encourage a learning culture.

**Governance arrangements**

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 Regional Clinical Director and a Regional Medical Director and established quality meetings, a reporting mechanism for escalation and workshops for shared learning. Staff we spoke with were positive about these improvements, the clinical supervision provided during shifts.

**Managing risks, issues and performance**

The governance systems and processes to identify and manage risks and issues had been strengthened. Where patients were at potential risks due to delayed treatment, this information was captured and acted on.

Prior to our inspection the CQC liaised regularly with the provider and 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 and had resulted in sustained improvement.

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 contract monitoring arrangements. Processes to manage current performance regarding delivering timely care when treatment was urgent had been improved and any risks to patients was monitored daily.

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 evidence of sustained improvement against the key performance indicators.

**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 daily to review any risk and discuss any complaints or incidents reported. Findings were feed into a weekly governance meeting.

Good

# Are services well-led?

- 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. Internal engagement with staff was encouraged through staff ambassadors.

- 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 1,284 responses in August 2018 showed 96% would recommend the service to family or friends.
- 'You said, we did' boards were displayed in waiting areas at the urgent care centres. For example, one comment from a patient expressed concerns with waiting times. The provider had responded with an explanation of how patient care is prioritised according to needs through a triage system.
- SDUC engaged with other urgent care services such as the ambulance and local NHS hospital Trusts.
- 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 several 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.
- The provider had implemented a new rota system that improved the flexibility to change the rota and allowed interface with a mobile phone application to improve efficiency of communication between the rota team and the clinical workforce. A new forecasting tool was planned to support rota planning.
- A care home project was underway to review the need for home visits as findings highlighted that many of the home visit requests. A review of visits requested had highlighted that many of these care home visits could be managed through the NHS 111 service preventing the need for a visit. SDUC were seeking 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 facilitated by a clinical advisor who contacted 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 project named 'black pear'. This involved a piece of software which enabled different clinical systems to be accessed through the OOH service. The project aimed to link in with GP practices and the community healthcare team.