Cambridgeshire Community Services NHS Trust Out-of-Hours Services at City Care Centre

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

Summary of findings

Contents

Overall summary

We carried out an announced comprehensive inspection at Cambridgeshire Community Services NHS Trust GP Out-of-Hours Service on 3 and 4 November 2015. Overall the service is rated as inadequate. Specifically, we found the out-of-hours service inadequate for providing safe and effective services and being well led. It required improvement for providing responsive services but was good in providing a caring service. Our key findings across all the areas we inspected were as follows:

- Patients were at risk of harm because systems and processes were not always in place to keep them safe. For example, the triage process was unsafe because nurses were undertaking tasks without the support of triage protocols and guidance or evidence of appropriate training.
- Staff were clear about reporting incidents, near misses and concerns. However scope for on-going learning and improvement from incidents was limited.
- The system for assessing the competency of staff who were administering medicines under a PGD was not effective.
- Staff files and recruitment procedures were not documented or governed thoroughly.
- There was insufficient assurance to demonstrate people received effective, timely care and treatment. For example, response times for call backs to patients.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.
- Consumable clinical equipment was found to be out of date in some areas, for example gauzes in the storage cupboards and cars.
- Safeguarding referral processes were not audited and there was no process in place to ensure that safeguarding referrals had been tracked and effectively followed up.
- Leadership arrangements were ineffective due to a lack of understanding between the Board and frontline delivery of the out-of-hours service.

Summary of findings

- Governance arrangements were fragmented and ineffective with clinical and managerial leaders having limited oversight of the risks to patients and to staff.

The areas where the service must make improvements are:

- Ensure that all staff who triage patients have been adequately trained to make clinical decisions by telephone and have been assessed as competent to do so. In addition, protocols and guidelines must be implemented in order to guide staff to make safe and appropriate triage decisions.
- Ensure medication administration protocol competency assessments are recorded and kept up to date
- Ensure that the length of time patients wait for definitive clinical assessment is robustly monitored and managed to ensure patient care does not suffer.
- Implement effective safeguarding referral procedures and ensure that all referrals are followed up and that this is documented.
- There must be a robust process for monitoring clinical equipment, to ensure that it is fit for purpose and that consumable items are in date.
- Governance around staff files and recruitment procedures must be implemented and recorded effectively.
- The service must ensure there are sufficient and appropriately trained staff on site in order to keep patients safe. Contingency arrangements must be agreed for staff to follow when last minute gaps in GP cover arise.
- Clear governance and leadership arrangements must be implemented to ensure that clinical and managerial leaders understand and can mitigate risks to patients and staff and have an effective oversight of the performance of the out-of-hours service at all times.

The areas where the service should make improvements are:

- Records should be kept of all clinical supervision for both doctors and nurses.
- Provide communication with all staff regarding service changes taking place.
- Ensure that National Quality Requirement (NQR) key performance indicators are met each month in respect of definitive clinical assessments, face to face consultations and call backs from a health care professional.
- Appropriate and effective clinical audits should be implemented to ensure that the service can identify areas for development and learning.
- Learning relating to incidents should be shared with all relevant staff in order to facilitate a culture of on-going improvement.

On the basis of the ratings given to this service at this inspection, I am placing the service into special measures. This will be for a period of six months. We will inspect the service again in six months to consider whether sufficient improvements have been made. If we find that the service is still providing inadequate care we will seek to de-register the location and not the provider.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The service is rated as inadequate for providing safe services and improvements must be made. The service did not operate effective systems to manage and review risks to vulnerable children, young people and adults. Protocols for medication administration were not always recorded or assessed for competency. We found a number of pieces of consumable equipment were out of date, for example gauzes in the storage cupboards and cars. The service was unable to provide assurance of safe staff recruitment.

Are services effective?

Inadequate

The service is rated as inadequate for providing effective services and improvements must be made. Staff had the skills, knowledge and experience to deliver effective care and treatment. Data showed that care and treatment was not always delivered in line with National Quality Requirements. There was a lack of evidence that quality improvement processes were in place to improve patient care. There had been several occurrences of a gap in GP cover for the service.

Are services caring?

Good

The service is rated as good for providing caring services. All patients said they were treated with compassion, dignity and respect. Patients were asked for their consent before any care or treatment was started. Patients were also kept informed with regard to their care and treatment throughout their visit to the out-of-hours service.

Are services responsive to people's needs?

Requires improvement

The service is rated as requires improvement for providing responsive services. Patients told us that they were happy with their experience of using the out-of-hours service and getting the support they needed. The service was equipped to meet patients' needs although signage was not clear in assisting patients finding services at the City Care Centre. Complaints were appropriately managed and learning from complaints shared with staff that were directly involved.

Are services well-led?

Inadequate

The service is rated as inadequate for being well-led and improvements must be made. The trust had clearly set out its vision and values for the service and staff we spoke with wanted to provide an excellent service. There was a documented leadership structure and most staff felt supported by local management but not by the Trust's leadership team. Availability of information about staff

Summary of findings

training was limited and personnel files of employed staff were incomplete. There were robust policies and procedures in place to govern activity and governance meetings held to discuss organisational risks. However, there was a lack of understanding between the Board and frontline delivery of the service which meant that board members were unaware of gaps in service delivery. Leaders were not aware of the risks to patients and staff that we identified, demonstrating that the governance and leadership arrangements in place were ineffective.

Summary of findings

What people who use the service say

We received 24 comment cards which all contained positive comments about the service, the staff and the care received. However, one comment card mentioned an unpleasant attitude from one member of staff and another commented on long waiting times but otherwise the feedback received from patients was complimentary about the service. Patients described the service as 'quite good', 'good' and 'excellent' and staff as 'helpful' and 'attentive and respectful'. Patients that we spoke with and comments on cards indicated that patients were satisfied with their involvement in decisions about their care and treatment. Comment cards noted patients found the service's premises to be clean and had no concerns about cleanliness or infection control.

Areas for improvement

Action the service MUST take to improve

- Ensure that all staff who triage patients have been adequately trained to make clinical decisions by telephone and have been assessed as competent to do so. In addition, protocols and guidelines must be implemented in order to guide staff to make safe and appropriate triage decisions.
- Ensure medication administration protocol competency assessments are recorded and kept up to date
- Ensure that the length of time patients wait for definitive clinical assessment is robustly monitored and managed to ensure patient care does not suffer.
- Implement effective safeguarding referral procedures and ensure that all referrals are followed up and that this is documented.
- There must be a robust process for monitoring clinical equipment, to ensure that it is fit for purpose and that consumable items are in date.
- Governance around staff files and recruitment procedures must be implemented and recorded effectively.
- Ensure there are sufficient and appropriately trained staff on site in order to keep patients safe. Contingency arrangements must be agreed for staff to follow when last minute gaps in GP cover arise.
- Clear governance and leadership arrangements must be implemented to ensure that clinical and managerial leaders understand and can mitigate risks to patients and staff and have an effective oversight of the performance of the out-of-hours service at all times.

Action the service SHOULD take to improve

- Records should be kept of all clinical supervision for both doctors and nurses.
- Provide communication with all staff regarding service changes taking place.
- Ensure that National Quality Requirement (NQR) key performance indicators are met each month in respect of definitive clinical assessments, face to face consultations and call backs from a health care professional.
- Appropriate and effective clinical audits should be implemented to ensure that the service can identify areas for development and learning.
- Learning relating to incidents should be shared with all relevant staff in order to facilitate a culture of on-going improvement.

Cambridgeshire Community Services NHS Trust Out-of-Hours Services at City Care Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC lead inspector and consisted of a GP specialist advisor, a nurse specialist advisor, a practice manager specialist advisor and a second CQC inspector.

Background to Cambridgeshire Community Services NHS Trust Out-of-Hours Services at City Care Centre

The GP out-of-hours service for Peterborough and surrounding area is provided by Cambridgeshire Community Services NHS Trust. The out-of-hours service provides care to patients who require urgent medical attention from GPs and nurses outside of normal GP opening hours. The trust employs GPs, nurses, health care assistants and support staff who are directly employed or engaged on a sessional basis to deliver care to patients. The out-of-hours service is part of the Ambulatory Services Unit of the trust. The out-of-hours service reported information on quality, workforce, performance and financial matters to the Ambulatory Clinical Operational Board of the trust.

The service operates from 6.30pm until 8am Monday to Thursday, and 6.30pm Friday until 8am Monday and all public holidays. Initial telephone contact with the out-of-hours service is through NHS 111, a service provided by Herts Urgent Care.

The service provides care to a population of approximately 188,000 people residing in the area and operates from the City Care Centre in Peterborough. It shares these premises with a minor injury and illness unit which is run by Lincolnshire Community Health Services NHS Trust. Information from Public Health England dating from June 2015 states that the health of people in Peterborough is varied compared with the England average. Deprivation is higher than the national average and about 22.0% (9,400) children live in poverty. Life expectancy for both men and women is lower than the England average. We previously inspected Cambridgeshire Community Services NHS Trust in May 2014, with the exception of the GP out-of-hours service, and found them to be 'Good' overall.

Detailed findings

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services under the Care Act 2014.

How we carried out this inspection

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

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

The inspection team:

- Reviewed information available from other organisations e.g. NHS England.
- Reviewed information from CQC intelligent monitoring systems.
- Carried out an announced inspection visit on 03 and 04 November 2015 including inspecting premises and vehicles.
- Spoke with staff.
- Spoke with visiting health professionals.
- Reviewed the service's policies and procedures.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Inadequate

Are services safe?

Our findings

Safe track record and learning

Safety was monitored using information from a range of sources, including National Patient Safety Alerts. We were provided with a list of alerts which had been received with actions taken after our inspection visit. The trust kept a log which reflected how recent updates had been disseminated since January 2015. We looked at an example of a recent safety update from the Medicines and Healthcare products Regulatory Agency (MHRA) in relation to Ibuprofen and Hydroxyzine. The management team informed us this information was received by the trust's medicine lead for review but no changes were required.

The service carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The service had systems in place to ensure all clinical staff were kept up to date. Whilst the Trust provided us with evidence that NICE guidance was disseminated, the clinical lead was unable to provide this on the day of our inspection.

The service had a policy and an incident recording process which was accessible to all staff. There was a system in place for reporting and recording incidents. We reviewed records of 12 incidents that had occurred since January 2015. There was evidence that the service had identified learning, however there was no evidence that the findings were shared with relevant staff to support improvement of the service provided. Staff told us they were directly involved with the incident process if appropriate but might not know about it if they were not involved, thus limiting the scope for on-going learning and improvement. After our inspection visit the service provided us with a detailed analysis of every incident which included their rationale of how conclusions were made. We were assured that incidents were reviewed and dealt with appropriately. In addition there was one incident reported as serious since January 2015 and investigation was on-going at the time of the inspection.

We saw that serious incidents were managed at trust level but it needed to consider the threshold for serious incidents within the out-of-hours environment. We found that the trust's serious incident policy description did not include or define medication related errors. Feedback and learning from serious incidents that had occurred across the trust and not just the out-of-hours service was fed back through board meeting minutes and team meetings. We saw minutes that measures were implemented as a result, for example further training on paediatric assessment.

Reliable safety systems and processes including safeguarding

The service did not operate effective systems to manage and review risks to vulnerable children, young people and adults. Staff told us referrals were made electronically when necessary and recorded on the electronic system. The policy stated that when a safeguarding referral was made and the referring health care professional had not received an update within 72 hours, the referral needed to be followed up, however this was not being actioned. This also meant there was no evidence of outcome or feedback on referrals that had been made by staff. Staff had received role specific training on safeguarding. We were shown a matrix dating to September 2015 for training during the inspection which informed us that for children's safeguarding 100% of staff had received level 2 training and 50% of staff had received level 3 training, with further completion planned before the end of November 2015. For vulnerable adults 100% of staff had received training. The service's minimum target was 90%.Staff we interviewed knew how to recognise signs of abuse in older people, vulnerable adults and children.

There were comprehensive safeguarding policies held centrally by the trust and the correct information, including contact details, was available on site but not directly to hand for clinicians. The service had a dedicated lead for safeguarding, although staff were not aware who it was; when asked we got differing answers from staff.

Drivers who were not trained were responsible for observing and monitoring the waiting area. There were also occasions when no direct observation occurred. As a response to feedback after the inspection a system to ensure continuous oversight was implemented.

There was a chaperone policy. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Staff told us nurses acted as chaperones and chaperoning was undertaken by trained staff. We were shown evidence that criminal record checks through the Disclosure and Barring Service (DBS) took place.

Inadequate

Are services safe?

Medicines management

We checked medicines and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures. Records showed fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. All prescriptions were reviewed and signed by a GP or nurse prescriber before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the service and kept secure at all times. We saw comprehensive records of prescribing guidance that were aligned with local protocols. There was a guideline document in place for the prescribing of anti-microbial medication, for common conditions seen by nurse prescribers. The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance.

The system for assessing the competency of staff who were administering medicines under a PGD was not effective. We saw evidence that nurses had been signed of as competent to administer the medicines referred to under a PGD; however for one member of staff, this was signed as recently as the day of our inspection despite this member having worked at the service for two years. After the inspection the service informed us that staff who were not signed off on PGDs did not administer medication that were regulated by these until PGDs were signed and competency assessed.

Cleanliness and infection control

We observed the premises to be clean and tidy. The premises were cleaned twice daily by an external company. We saw there were cleaning schedules in place and cleaning records were kept. Comment cards noted that patients found the premises clean and had no concerns about cleanliness or infection control. We found that the vehicles we inspected were also clean. Consultation rooms we viewed did not have disposable curtains, but staff informed us there was a system to ensure the curtains were clean. An infection control policy and supporting procedures were in place. There was a lead responsible for infection control, however not all staff knew who this was. Staff received induction training about infection control specific to their role and should receive updates.

Staff we spoke with told us that they had access to online infection control training. 92% of staff had received training, against a target of 90%.

Equipment

Staff told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments and there were sufficient stocks of equipment and single-use items required for a variety of interventions. We found a number of pieces of consumable equipment were out of date. For example, we found that there were out of date gauzes in storage and response cars and out of date catheterisation equipment in two response cars. This was replaced when we raised it.

Staff told us that all equipment was tested and maintained regularly and we saw evidence that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of calibration of relevant equipment was in date.

Staffing and recruitment

A review of six staff files demonstrated that staff were not always recruited in accordance with the policy and an array of information was either incomplete or missing. For example, there were missing references, Disclosure and Barring Service records and confirmation that a robust induction programme had been completed. After the inspection visit we were informed that this information was stored centrally. Without any effective systems in place to evidence the recruitment procedures of staff, the trust was putting patients at potential risk of being treated by inappropriately qualified staff. The service also employed nurses provided by an agency. The service relied on the agency to inform them of recruitment procedures and evidence of recruitment checks for the staff they provided. Recruitment and/or checks on candidates may be carried out by a party other than the provider. In this case, providers must assure themselves that all checks are complete and satisfactory.

Inadequate

Are services safe?

There were arrangements in place to check the annual registration of GPs with the General Medical Council and of nurses with the Nursing and Midwifery Council.

The service used nurses to undertake telephone triage before referring patients to a GP, advanced nurse practitioner or emergency care practitioner. The nurses undertaking these telephone duties did not have access to robust systems to assist them in the triage process. There was no telephone assisted software in place, nor were guidelines readily available to assist and ensure the safety of the assessment process.

In addition, we saw no evidence that nurses had undergone supervised practice and examination following a specialist course in the use of telephone assisted software. The service informed us that they delivered training through an electronic presentation. However there was no system in place to assess staff's competency following their training. Nurses undertaking telephone triage are also expected to have been trained in extended skills such as history taking and minor illness. We were not provided with evidence that this was the case. The service provided us with a list of support mechanisms it considered to have in place for nurses which included mandatory training, induction, identification of previous experience, shadowing opportunities of other staff and services, training with the lead GP, monthly training sessions, team meetings, working alongside nurse practitioner each shift, informal peer reviews and monthly audits. Due to poor governance of staff files we were not able to confirm which took place consistently or not. Other than mandatory training and telephone consultation audits there was a considerable lack of evidence that above practices were effectively taking place despite the service outlining these as available support.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. Emergency buttons were present in the consulting and treatment rooms, electronically via the computer system and physical buttons that raised an alarm. The consultation rooms were set up so that it could be difficult for staff to access the physical emergency button.

All staff received annual basic life support training and there were emergency medicines available in the treatment area. The service had a defibrillator available and oxygen with adult and children's masks. Emergency medicines were accessible to staff in a secure area of the premises and all staff knew of their location. All the medicines we checked were in date and fit for use.

The service had a business continuity plan in place through means of a business impact analysis for major incidents. The plan highlighted significant risk and what actions staff should take.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Calls dealt with by the out-of-hours service were initially triaged by NHS 111. These calls were then referred to the out-of-hours service to respond within the timeframe set by NHS 111.We looked at the previous three months' performance against the National Quality Requirements (NQRs - are quality standards set out for GP out-of-hours services) This data showed the service was not always meeting requirements. It also showed that the service didn't have a clear vision for improvement or clear measures of their own effectiveness, or that clear targets had been set.

For example, in August 2015:

- NQR data for telephone advice via a call back by a health care professional within 20 minutes showed that the out-of-hours service was 80% compliant for 10 calls.
- NQR data for telephone advice via a call back by a health care professional within 60 minutes showed that the out-of-hours service was 100% compliant for 23 calls.

In September 2015:

- NQR data for telephone advice via a call back by a health care professional within 20 minutes showed that the out-of-hours service was 47% compliant for 17 calls.
- NQR data for telephone advice via a call back by a health care professional within 60 minutes showed that the out-of-hours service was 43% compliant for 30 calls.

In October 2015:

- NQR data for telephone advice via a call back by a health care professional within 20 minutes showed that the out-of-hours service was 100% compliant for two calls.
- NQR data for telephone advice via a call back by a health care professional within 60 minutes showed that the out-of-hours service was 88% compliant for 24 calls.

There were some variations in relation to the timeliness of face to face consultations. For example, in August 2015:

- NQR data for contact with the GP or other local service within 2 hours showed that the out-of-hours service was 78% compliant for 449 calls.
- NQR data for contact with the GP or other local service within 6 hours showed that the out-of-hours service was 98% compliant for 317 calls.
- NQR data for contact with the GP or other local service within 12 hours showed that the out-of-hours service was 100% compliant for 98 calls.

In September 2015:

- NQR data for contact with the GP or other local service within 2 hours showed that the out-of-hours service was 79% compliant for 358 calls.
- NQR data for contact with the GP or other local service within 6 hours showed that the out-of-hours service was 100% compliant for 302 calls.
- NQR data for contact with the GP or other local service within 12 hours showed that the out-of-hours service was 100% compliant for 72 calls.

In October 2015:

- NQR data for contact with the GP or other local service within 2 hours showed that the out-of-hours service was 77% compliant for 439 calls.
- NQR data for contact with the GP or other local service within 6 hours showed that the out-of-hours service was 98% compliant for 330 calls.
- NQR data for contact with the GP or other local service within 12 hours showed that the out-of-hours service was 100% compliant for 114 calls.

The service provided monthly quality reports to the board.

Management, monitoring and improving outcomes for people

There was a lack of evidence that quality improvement processes were in place to improve patient care. The service indicated in their monthly quality reporting that they were fully compliant and audited a minimum of 3 cases per GP or nurse and all cases for new GPs for the first three consultations which equated to around 3% of contacts. These audits were undertaken by the GP lead or staff peers using the Royal College of General Practice (RCGP) adapted toolkit and feedback was provided to

clinicians via email or during meetings. Consultations with patients (face to face and telephone) were audited in areas which included history taking, clinical assessment and signposting to other services. We saw that where performance required improvement this had been identified during reviews. However, there was no evidence that appropriate action had been taken to manage the required improvements. When we reviewed the audit, the lead GP informed us that they did not maintain a summary or collate a report of these audits. The lead GP reviewed the audit notes using a methodology which was not sufficiently robust. Staff told us that the Trust had adopted the RGCP toolkit in order to ensure and consolidate improvements through clinical audit, yet this toolkit had not been adhered to. The audits were also not peer reviewed or moderated and as such could not provide assurance that they were accurate or, as a result, provided safety netting.

Effective staffing

We reviewed staff training records but could not identify if all staff were up to date with attending mandatory courses. We were shown a matrix dating to September 2015 that indicated staff mandatory training levels were between 63% and 100%. Every GP was appraised annually, and revalidated every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England. As most of the GPs working in the out-of-hours service had substantive posts working for other services, such as GP practices, much of this information was held elsewhere. The out-of-hours service did not always have up to date information in staff files to show that the GPs had been revalidated. The lead GP informed us they undertook "mini-appraisals" for regular out-of-hours GPs to feed into their formal appraisals but not all of these had been done.

We saw some evidence that clinical supervision took place with the GPs. GPs had supervision as part of their induction and after that there was peer review of consultations using the RCGP audit tool. Nevertheless we found that there was no robust system in place to ensure that results were collated, analysed and reported into governance assurance systems by the lead GP. GPs received feedback about their audit at their "mini appraisals".

Nursing staff told us senior clinical staff undertook regular reviews of clinical notes for each individual and provided written feedback to the individual. We saw that where performance required improvement this had been identified. However, there was no evidence that appropriate action had been taken to manage the required improvements.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staff told us they were often very busy and felt they could not always have their lunch break due to their workload. After the inspection we were provided with evidence of a rota system that was in place for all the different staffing groups to ensure that enough staff were on duty. However, there had been several occurrences where the out-of-hours service had operated without GP cover over the last year and as such did not always adhere to their rotas. We were notified that approximately a week and a half after our inspection there had been another occurrence of no GP cover for one shift. We were informed in the case of GP absence the lead GP provided resilience GP cover from home during the weekends as a "backstop" and children under four years of age were referred to Accident and Emergency. The service highlighted their difficulty in recruiting additional staff due to favourable terms and conditions provided by agencies and the development of local GPs providing out-of-hours care elsewhere through the Prime Minister's Fund programme.

Information sharing

The out-of-hours service used an electronic patient record system. Information provided through the NHS 111 service and from local GPs about patients was accessible to clinicians through this system. The system was also used to document, record and manage care patients received. Information relating to patient consultations carried out in the out-of-hours period was transferred electronically to patients' GPs by 8am the next day in line with NQRs. Any failed transfers of information were the responsibility of the duty manager to follow up to ensure GPs received information about their patients. NQR data for August 2015 showed that the service sent 317 out of 319 patient reports with details of consultations before 8am.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we

Inadequate

Are services effective?

(for example, treatment is effective)

spoke with understood the key parts of the legislation and were able to describe how they implemented it in their service. There was a patient consent policy in place which provided guidance to staff.

Mental capacity was part of the trust's mandatory training for staff working for the out-of-hours service. An audit of staff training showed that 71% of directly employed staff had received mental capacity training at the time of our inspection.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We obtained the views of patients who used the out-of-hours service through the CQC comment cards patients had completed. We received 24 comment cards which all contained positive comments about the service, the staff and the care received. However, one comment card mentioned an unpleasant attitude from one member of staff and another commented on long waiting times but otherwise the feedback received from patients was complimentary about the service. Patients described the service as 'quite good', 'good' and 'excellent' and staff as 'helpful' and 'attentive and respectful'.

The trust also collected feedback about the service on an on-going basis. As part of the NQRs, out-of-hours services are required to regularly seek feedback from people that have used the service and report any action taken to improve quality to commissioners. The service was unable to provide us with data on this but informed us that a new system to capture this was used from October 2015. Feedback from patients received by Healthwatch had proven difficult to differentiate whether the patient referred to the out-of-hours service or one of the other services housed in the same premises. Healthwatch acknowledged that improvements needed to be made in how feedback was obtained by Healthwatch for the separate services to avoid confusion.

We observed throughout the inspection that members of staff were courteous and helpful to patients both attending and on the telephone and that people were treated with dignity and respect. Staff told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We saw that staff were careful to follow the service's confidentiality policy when discussing patients' treatments so that information was kept private. Patients were called from the waiting room individually and taken to a consultation room. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. The service's switchboard and the telephone triage nurse were located away from the reception desk and waiting room and could not be overheard.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the manager and record it as an incident. The incidents we reviewed contained two incidents that related to abusive behaviour, of which one referred to police involvement and one referred to a GP feeling humiliated. Appropriate actions had been taken in response to the concerns raised.

Care planning and involvement in decisions about care and treatment

Patients that we spoke with and comments on cards indicated that patients were satisfied with their involvement in decisions about their care and treatment. Clinicians were alerted to special notes from the patient's usual GP if these were available. Special notes are a way in which the patient's usual GP can raise awareness about their patients who might need to access the out-of-hours service, such as those nearing end of life and their wishes in relation to care and treatment.

Staff had a good understanding of consent and involving patients in decision making. A range of information was made available to clinical staff around capacity and decision making to support them in their work. This included up to date policies, case studies and training. For patients who did not have English as a first language, a translation service was available if required.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the service was not always responsive to patients' needs. Although they had systems in place to maintain the level of service provided, these systems were not utilised effectively. Identified patient needs were not always being met in a timely manner as data in this report indicates. Patients referred to the out-of-hours service were triaged by the NHS 111 service (which was provided by a different trust) who handled the initial call. Patients were then referred to the out-of-hours service by the NHS 111 service. After referral we saw that patients received further triage and clinical assessment over the phone by nurses in the out-of-hours service. Furthermore, where necessary, triage and assessment over the phone or in person by a GP, at the service or at the patient's home. This meant that in some cases patients would have to explain their signs and symptoms up to three times to different staff before they were invited to attend the service or received a home visit. During busy times emergency patients were potentially at risk of harm when waiting times extended: we were told that patients who were invited to attend the service for a consultation were seen on a first come first serve basis and not given appointment times. After the inspection the Trust advised this was not the case and patients would be seen as a priority dependent on their need or disability upon arrival

Tackling inequity and promoting equality

The out-of-hours service understood and responded to patients with diverse needs and those from different ethnic backgrounds. For patients who did not have English as a first language, a translation service was available. The premises were easily accessible to patients who used a wheelchair and for pushchairs with level access throughout, electronic doors, wide passage ways and disabled toilets available.

Access to the service The service operated from 6.30pm to 8am Monday to Thursday and from 6.30pm until 8am Friday to Monday inclusive. The service was also open 24 hours a day over bank holidays. Basic information was available to patients about how and where to access the service on the service's website. This included information about how to get to the service and the explanation that it was not a walk-in service. Comments were made by staff and on patients' comment cards that, especially during weekends, the waiting room could become very busy. Partly because the service shared this waiting room with the minor injury and illness unit. There was limited signage available to advise patients where the out-of-hours service was once they arrived at the premises. There was a sign outside which was poorly lit. To resolve this, the staff had put a sign in the entrance area advising patients that the out-of-hours service was at the premises, with information of how to obtain care. Access to the building was by ringing the doorbell after which patients were identified. Upon reviewing the incidents that had occurred in the service we reviewed an incident that involved a patient that had collapsed in the waiting room. Staff were made aware of this by another patient who had been waiting to see a GP. The patient who subsequently collapsed had entered the building unknowingly when another patient had exited and hence staff were not aware of this patient's presence. Upon notification staff attended to the patient immediately and were able to provide treatment there and then. This was reviewed as a security incident and the service had reinforced the importance of staff escorting patients.

Listening and learning from concerns and complaints

The trust had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.

There was a designated responsible person who handled all complaints. All complaints were shared with the trust. None of the patients we spoke with or comments on the comment cards we received had ever needed to make a complaint about the out-of-hours service.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The trust had a clear vision to provide high quality care to the diverse communities they served to make their lives better. Staff we spoke with confirmed they wanted to provide excellent patient care but were not all aware of the trust's vision and values.

The trust informed us they had taken on the out-of-hours service following a transfer of the service in March 2012. The Trust had decided not to bid for the out-of-hours contract when it is due to be renewed September 2016. To ensure a smooth transition of the service once its contract ended, the trust had implemented steps in planning for the change of provider. For example, we saw minutes of board meetings which referred to discussions regarding reaching an agreement or a memorandum of understanding with another out-of-hours provider to provide support to the service for the remainder of the out-of-hours contract.

The out-of-hours service leadership consisted of a general manager and lead GP, the latter was responsible for clinical aspects in the service.

Governance arrangements

The trust maintained a risk register.

Governance meetings were held at the trust's executive level and had no direct involvement from out-of-hours staff, including the lead GP. Performance and risks were mainly managed at a trust level with the general manager representing the out-of-hours service.

Monthly integrated governance analysis reports were produced by the trust for the Ambulatory Services Unit of which the out-of-hours service was part. These reports contained information on quality, workforce, performance and financial matters and were recommended for reviews by the Ambulatory Clinical Operational Board (again, of which the out-of-hours service were part). When we reviewed minutes of several Ambulatory Clinical Operational Board meetings we were not provided with assurance that out-of-hours service representatives attended these meetings, namely the lead GP. There was no system for the lead GP to report to the board, neither was there evidence of any scrutiny by the board of the out-of-hours service.

The trust had a range of policies and procedures in place to govern activity and these were available to staff. We were not provided with any evidence that confirmed staff had read the policies but staff we spoke with were able to explain the content when asked.

There was a clear staffing structure and staff were aware of their own roles and responsibilities. However staff weren't all aware of the responsibilities the senior leadership team held, for example they didn't know who the safeguarding lead was.

There was not an effective programme of clinical audits to monitor quality and systems to identify where action should be taken to improve the service.

The service held quarterly staff meetings but these were not always attended by all staff as they were not always held at times staff could attend. As clinical staff worked unsocial hours the main method for disseminating information was via email and through the patient safety newsletters. We saw one example of a newsletter that had been sent to staff.

There were systems in place to monitor and assess quality, for example:

- The service used a self-assessment tool completed by the manager and staff to form the basis of a monthly multi-disciplinary review of key quality indicators. This tool produced a score based on the assessment which in turn informed the executive team of the current state of the service and was seen as an early warning indicator so that matters could be addressed in a timely way.
- The service maintained an overview of its quality performance using a quality dashboard tool to ascertain levels of compliance on various subjects such as mandatory training, incidents, patient experience and workforce related matters.

Despite the quality dashboards in place, the Board was unaware of the risks identified by CQC on inspection, demonstrating that the governance arrangements in place were ineffective. The systems to escalate risks and issues were not robust, therefore the board were not sighted on any of the concerns identified during this inspection.

Contract review meetings were held with commissioners to discuss performance against the contracts.

Are services well-led?

Inadequate

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

We were informed after our inspection that the out-of-hours lead GP was clinically overseen by the provider's medical director, who was a Consultant Paediatrician, and by a non-executive director, who was a trained GP. Initially we were not provided with evidence that meetings occurred between the lead GP and the Medical Director. After our inspection we were provided with evidence that emails were exchanged evidencing support and discussion between the lead GP and Medical Director.

Leadership, openness and transparency

Although the trust prioritises safe, high quality and compassionate care they did not demonstrate that they have robust systems to run this service and ensure high quality care. There was local visible local leadership but staff told us they did not feel valued by the trust and felt uninformed about the future plans for the out-of-hours' service. Staff we spoke with told us they felt well supported by their direct management and felt confident they could raise concerns but felt that the service worked in isolation to the rest of the trust.

There was a local leadership structure with both operational and clinical leads within the service. However, some of the responsibilities for the service were managed at trust level. There was a communication gap between trust level and local leadership for ensuring policies and procedures were being followed.

Contract review meetings were attended by the general manager who was also the lead nurse. There was no direct GP representation at these meetings. The Trust told us that they were satisfied with this arrangement.

The GP lead also had several other roles externally and this had resulted in them only being available to provide 11 hours clinical leadership a week in the out-of-hours service.

Seeking and acting on feedback from patients, public and staff

The out-of-hours service gathered patient feedback on an on-going basis. We saw a matrix that indicated patient satisfaction was assessed in April 2015 for three patients, with 100% satisfaction and in May 2015 for 10 patients of which no score was available. The service also used the Friends and Family test to assess patient satisfaction. In September 2015 the service had received 23 patients' feedback with a satisfaction score of 87%. The service had a whistleblowing policy which was available to all staff. Staff we spoke with told us that they were aware of the whistleblowing policy.

Continuous improvement

Staff we spoke with felt they had occasional opportunities to attend courses and other development opportunities, for example nurse seminars and they were supported to attend these. It was a challenge for staff to attend all training due to the hours they worked. E-learning was available for staff and the service monitored mandatory training levels. We were shown a matrix dating to September 2015 that indicated staff mandatory training levels were between 63% and 100%. The manager also informed us that monthly, non-mandatory, training sessions on a variety of topics was made available to staff but we were not provided with evidence of topics and attendees.

Due to poor governance of staff files we were not able to confirm which took place consistently or not. Other than mandatory training there was a considerable lack of evidence that training was effectively taking place despite the service outlining this as available support, as described throughout this report.

Staff appraisals were completed during the previous year and had actions agreed but there was no historical evidence that appraisals had been done previous and whether these had actions to be followed up. The manager also informed us that regular supervisions were undertaken but not documented. We saw evidence of audits that were undertaken by the GP lead or staff peers using the Royal College of General Practice (RCGP) adapted toolkit and feedback was provided to clinicians via email or during meetings.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment (1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include- (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; (c) ensuring that persons providing care or treatment to service users have all the qualifications, competence, skills and experience to do so safely; (e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way. We found that the registered person was not protecting service users against the risks associated with unsafe triage. Protocols, guidelines and appropriate training had not been provided to support and guide staff who make clinical decisions by telephone. We found that the registered person was not protecting service users against the risks associated with the need to ensure equipment is checked and fit for purpose. We found that the registered person was not protecting service users against the risks associated with the need to ensure safe prescribing through effective PGD competency checks and authorisations.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment (1) Service users must be protected from abuse and improper treatment in accordance with this regulation.(2) Systems and processes must be established and operated effectively to prevent abuse of service users.(3) Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. We found that the registered person was not protecting service users against the risks associated with safeguarding referral procedures and to ensure these were followed up and recorded.
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1). Such systems or processes must enable the registered person, in particular, to – (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of the service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; (d) maintain securely such other records as are necessary to be kept in relation to – (i) persons employed in the carrying on of the regulated activity; (f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

This section is primarily information for the provider

Requirement notices

We found that the registered person was not protecting service users against the risks associated with maintaining securely an accurate, complete record in relation to persons employed in the carrying on of the regulated activities.

We found that the registered person was not protecting service users against the risks associated with failure to undertake meaningful clinical audits.

We found that the registered person was not protecting service users against the risks associated with the need for having effective governance systems in place to enable service leaders to maintain an accurate and up to date view of risks within the service.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. We found that the registered person was not protecting service users against the risks associated with maintaining sufficient numbers of qualified, competent, skilled and experienced staff.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed (1) Persons employed for the purposes of carrying on a regulated activity must- (a) be of good character; (b) have the qualifications, competence, skills and experience which are necessary for the work to be performed by them. (2) Recruitment procedures must be established and operated effectively to ensure that persons employed meet the conditions in – (a) paragraph (1)

This section is primarily information for the provider

Requirement notices

(3) The following information must be available in relation to each such person employed-

(a) the information specified in Schedule 3, and

(b) such other information as is required under any enactment to be kept by the registered person in relation to such persons employed.

(5) Where a person employed by the registered person no longer meets the criteria in paragraph (1), the registered person must-

(a) take such action as is necessary an proportionate to ensure that the requirement in that paragraph is complied with, and

(b) if the person is a health care professional, social worker or other professional registered with a health care or social care regulator, inform the regulator in question.

We found that the registered person was not protecting service users against the risks associated with ineffectively operated recruitment procedures to ensure that the persons employed meet the conditions set out in Regulation 19.

We found that the registered person was not protecting service users against the risks associated with the lack of availability of information in relation to each person employed - the information specified in Schedule 3.